



COMPASS

NEIGHBORCARE HEALTH

COMPASS

Toolkit 2015

Care of Mental, Physical  
and Substance-Use Syndromes

PRESENTED BY:

neighborcare  health.



COMMUNITY  
HEALTH PLAN  
of Washington™

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## About the Neighborcare Health COMPASS Toolkit

In association with **Community Health Plan of Washington**, Neighborcare Health has instituted the **COMPASS (Care of Mental, Physical and Substance-Use Syndromes) program**, a team-based model designed to improve the care of patients with depression and diabetes and/or cardiovascular disease. Implementation was supported by a Centers for Medicare and Medicaid Innovation (CMMI) award. The lessons learned by Neighborcare Health prompted the team to create this resource for others to use and to offer easily accessible materials for those interested in initiating a similar program. This toolkit includes background information about collaborative care and provides a robust description of how one Federally Qualified Health Center (FQHC) implemented this model for patients with chronic medical and mental health conditions.

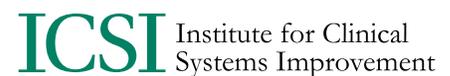
The toolkit also includes a comprehensive compendium of information and tools, from job descriptions for team members to specific technology needs. Sample worksheets, letters and protocols are provided, as are detailed recommendations for training, enrollment and outreach, outcomes measurement and more. Neighborcare Health team members have learned valuable lessons on process improvement and future enhancements, which are also included.

➔ **The Appendix contains a trove of useful tools.**

**TIP** Please use this toolkit freely and adapt the materials to fit your needs. Click on links (➔) to find additional resources. Read the stories and the comments from team members and patients to see how this program has impacted lives.

This **COMPASS** toolkit was created by a team of providers, administrative staff, and others from **Neighborcare Health** and **Community Health Plan of Washington**, with valuable input from the **Institute for Clinical Systems Improvement** and the **Advancing Integrated Mental Health Solutions (AIMS) Center** at the University of Washington. Thank you to the organizations and staff members who supported this program and to the Neighborcare Health patients who participated. They continue to be our best teachers.

For more information, or to provide comments, please email [COMPASSinfo@neighborcare.org](mailto:COMPASSinfo@neighborcare.org).



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# I. EXECUTIVE SUMMARY

Assisting patients with concurrent medical and behavioral conditions can be one of the most challenging aspects of primary care. Models of care management that add multi-disciplinary support to the primary care team have been shown to improve both clinical and financial outcomes. Collaborative care management is being used increasingly for management of both mental and physical health conditions. Evidence shows that the effect of mental illness such as depression on chronic medical diseases such as diabetes and heart disease is both significant and bi-directional. One model that addresses the psychiatric and medical comorbidities is COMPASS (Care of Mental, Physical and Substance Use Syndromes), a team-based approach for a specific population of patients with depression and either diabetes or heart disease, which utilizes integrated behavioral health and medical consultation and care managers.

In 2012, Centers for Medicare and Medicaid Services (CMS) allocated a three-year Health Care Innovation Award to develop the COMPASS model of care. Eighteen million dollars was awarded with the goal of demonstrating the effectiveness of the collaborative care management model for Medicare and Medicaid patients by improving patient health outcomes, the patient's experience of care and the affordability of care (Berwick's Triple Aim, 2008).

Community Health Plan of Washington (CHPW) is one of ten organizations participating in the COMPASS collaborative. Neighborcare Health, a Federally Qualified Health Center and one of the community health centers in the CHPW network, was engaged to participate in the implementation of the COMPASS program under the CMS Innovation award and began enrolling patients in April 2012. Neighborcare Health is the largest provider of care for Medicaid and uninsured patients in the Seattle area.

## The COMPASS model has seven key components:

### 1. INTAKE:

A thorough initial evaluation to measure condition severity and assess the patient's readiness for self-management support

### 2. REGISTRY:

Use of a computerized registry system to track and monitor the patient's progress, including tracking the patient's depression scores and glycosylated hemoglobin, LDL cholesterol and blood pressure levels

### 3. MANAGEMENT:

A Care Manager to provide guideline-based, collaborative care management with the goal of controlling risk factors associated with management of depression, control of medical disease, and self-care activities; and to provide patient education and self-management support, coordinate care with the primary care physician and other consultants, and provide active follow-up

### 4. CONSULTANTS:

Consulting medical and psychiatric physicians provide a weekly review of cases with the Care Manager and recommend changes in treatment or further evaluation from an expert consultant

### 5. TREATMENT REVISION:

Treatment intensification when there is a lack of improvement

### 6. RELAPSE PREVENTION:

Relapse and exacerbation prevention

### 7. QUALITY IMPROVEMENT:

Aggregate data evaluation and quality improvement

Neighborcare Health successfully instituted the COMPASS model of care in each of its clinic sites, using Care Managers of varied backgrounds along with an Internist Medical Consultant, who is the medical director of one of the clinic sites, and a Psychiatric Consultant from the University of Washington. The Care Managers offer intensive, hands-on support for patients with depression and either diabetes or heart disease (or both). Most patients have other medical and mental health illnesses, including substance abuse. Virtually all have significant social stressors that profoundly affect the self-management of their conditions. To date, 178 patients have been enrolled.

Outcomes data to date shows a substantial improvement in clinical parameters. Of those with a Hemoglobin A1c > 8 at baseline, 47 percent saw an improvement. Forty-eight percent of the total patients had an improvement in their PHQ-9 depression score of five points or greater.

Based on independent review of CHPW claims data, initial financial outcomes have also been favorable, with lower inpatient costs and variably diminished Emergency Department (ED) costs. Per member per month cost savings have been realized as well, consistent with evaluations of other collaborative care models. ➔ [See Appendix for a review of potential cost savings from implementing COMPASS.](#)

Patient and provider satisfaction survey results are not yet available. Anecdotal evidence suggests high satisfaction in both groups.

Of note is that the Neighborcare Health patients, by and large, have significant social stressors, including homelessness, substance abuse, chronic unemployment, and a severe lack of social support, that deeply impact their health and their ability to progress toward clinical improvement. These issues are frequently the primary concern of the patient, taking precedence over a specific clinical target such as HbA1c level. Care Managers work along with primary care providers and medical and psychiatric consultants to address the immediate needs of the patients while also emphatically and continuously impelling improvement in medical and mental health conditions.

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*“A systematic process provides the team with the opportunity to address the needs that the patient determines are most important, as well as those that the providers see as most important. In doing the former, the road is paved for the latter.”*

— A CHPW COMPASS Physician Advisor

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*“I thank my team for establishing a good rapport. I think it is really critical in building trust; I trust her and they trust me. I hold up my end and have to be accountable for the things I need to do. My Care Manager is great at breaking it down for me so I can understand what my responsibilities are in my health. I’m doing much better and sleeping better and my heart’s better and my diabetes is better. Now I have an apartment and everything is just going better thanks to this program and thanks to our close relationship and the mutual trust and respect that we’ve built. That’s all I really got to say. It’s a great program. Without that I probably wouldn’t even be here, I’d probably be dead.”*

— A Neighborcare Health COMPASS patient

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## II. THE PROGRAM

**C**OMPASS is a collaborative care management program that includes concurrent treatment of both mental health and medical conditions. Clinical targets are determined for the entire population, based on evidence-based goals for specific chronic conditions. Treatment is tailored to achieve those objectives (“treat to target” goals). Patients are co-managed with their primary care providers, by a group consisting of Medical and Psychiatric Consultants and Care Managers, with the addition of necessary administrative oversight and support. Based on a model of team-based integrated care that has been shown to be effective in improving clinical outcomes, reducing costs, and improving patient satisfaction, COMPASS is a national demonstration involving eight implementation partners with clinical practice sites and two research entities.

### **The National Consortium partners include:**

- Institute for Clinical Systems Improvement (ICSI) (the Consortium leader, as well as one of the practice sites)
- Community Health Plan of Washington with Neighborcare Health
- Kaiser Permanente Colorado
- Kaiser Permanente Southern California
- Mayo Clinic Health System
- Michigan Center for Clinical Systems Improvement
- Mount Auburn Cambridge Independent Practice Association
- Pittsburgh Regional Health Initiative
- AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington (providing technical assistance)
- HealthPartners Institute for Education and Research (the evaluation leader)



### III. COLLABORATIVE CARE MANAGEMENT

Many mental illnesses, such as depression, anxiety, and post-traumatic stress disorder, are chronic in nature and require regular monitoring by health care providers. These conditions can have a powerful impact on quality of life, on physical health, and on one's ability to manage other medical problems. Patients with mental health conditions often present in, and/or are treated in, primary care settings. Integrating mental health treatment and monitoring into primary care management has been shown to be extremely effective in improving the burden of disease.

Collaborative Care Management is a specific type of integrated care model developed at the University of Washington by Drs. Wayne Katon and Jürgen Unützer, with a focus on specific patient populations. Using a system to track progress and evidence-based protocols, a trained behavioral health professional embedded in the primary care setting provides brief interventions in coordination with a patient's primary care provider and a consulting psychiatrist, who makes treatment recommendations when a patient is not improving as expected. The primary care provider reviews recommendations from the Psychiatric Consultant and is responsible for initiating changes in treatment. Working together with the patient, the behavioral health provider, primary care provider, and Psychiatric Consultant create a comprehensive team of mental health and medical practitioners to provide ongoing care.

More than 80 randomized controlled trials to date have shown that Collaborative Care leads to better patient outcomes, better patient and provider satisfaction, and lower health care costs. Unützer's original Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) study randomized more than 1,800 adults with depression to usual care in a primary care setting or to a collaborative model of care. Patients receiving collaborative care reported less depression and physical pain and improved functioning and higher quality of life. In addition, costs were lower in the collaborative care arm of the study (Unützer, 2002).

Collaborative Care Management has been shown to be effective in patients of all ages, and for patients with many mental health and medical conditions, including

depression, anxiety, chronic pain and for those with co-morbid diabetes, cancer and cardiovascular disease. It has been used mostly in primary care practices but has also been shown to be successful in other settings, including school-based clinics and OB/GYN practices.

#### **There are five core principles of collaborative care management:**

##### **1. Patient-Centered Team Care**

Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals.

##### **2. Population-Based Care**

Each care team shares a defined group of patients tracked in a registry. Teams track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation.

##### **3. Measurement-Based Treatment to Target**

Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

##### **4. Evidence-Based Care**

Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition.

##### **5. Accountable Care**

Providers are accountable and reimbursed for quality of care and clinical outcomes.

The website for the AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington offers detailed information on: collaborative care; the evidence supporting its benefit; core principles; implementation; and a resource library.  See [COMPASS Resources](#).

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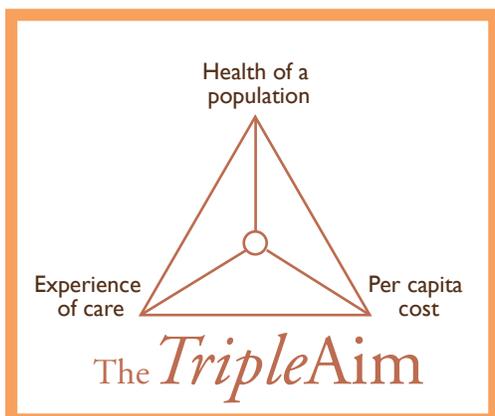
## IV. COMPASS AND COLLABORATIVE CARE

### Care, cost, and experience

COMPASS was created by the Consortium partners, expanding the Collaborative Care Management model to include team-based treatment of not only mental health conditions but also specific medical illnesses. The multi-disciplinary team of caregivers has been expanded to include medical as well as psychiatric consultants, with a Care Manager instead of a specialized behavioral health professional providing direct patient interaction.

In addition to Katon's work on the integration of behavioral health into primary care settings, the COMPASS intervention builds on other foundational approaches to improving health care. For example, Patient Centered Medical Home (PCMH) principles are recognized as important guides to care, including the 2014 NCQA (National Committee for Quality Assurance) Standards: enhance access and continuity; team-based care; population health management; plan and manage care; track and coordinate care; and measure and improve performance.

The fundamental goal of the COMPASS model is to achieve the Triple Aim for a subset of medically and socially complex patients: improving the health of the population; the patient's care experience; and the affordability of care for these patients (Berwick, 2008).



The Triple Aim goals for the COMPASS program supported by the CMS Innovation Award:

### HEALTH OF A POPULATION

#### Improve

- Depression outcomes
- Diabetes control
- Hypertension control

### EXPERIENCE OF CARE

#### Increase

- Clinician satisfaction
- Patient satisfaction

### PER CAPITA COST

#### Expand

- Workforce roles

#### Decrease

- Costs
- Unnecessary hospital & Emergency Department (ED) use

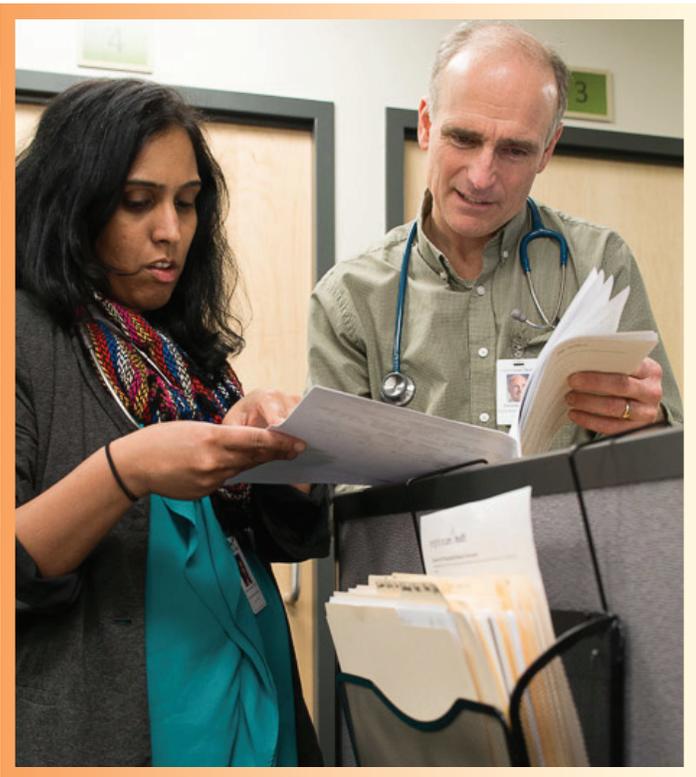
## Depression and chronic medical illness

The COMPASS program focuses specifically on individuals with poorly controlled depression and diabetes and/or cardiovascular disease. The opportunity for significant improvement in disease control is substantial in such patients.

Because of the high prevalence of diabetes and cardiovascular disease in the adult population and because costs are significantly higher when depression is present concurrent with these medical illnesses, the COMPASS program focuses on these conditions (Unützer, 2009 and others). Also, just as the presence of depression influences outcomes and costs for patients with chronic medical conditions, the reverse is also true (Katon, 2011 and others). In addition, recent studies suggest increased mortality in patients with depression and heart disease; the recently published OPERA-HF trial demonstrated a five-fold increase in mortality in patients with heart failure who had moderate to severe depression compared with those with no or mild depression (Cleland, 2015).

## Specific target goals for the Neighborcare Health COMPASS population

- Achieve depression improvement shown by a decrease in PHQ-9 by 5 points or a PHQ-9 score of less than 10 for 40% of the patients
- Improve diabetes and hypertension control rates by 20%
- Decrease unneeded hospitalizations and Emergency Department visits
- Improve patient and clinician satisfaction with care process by 20%
- Reduce health care costs of Medicare and Medicaid patients, which relies in the short run almost entirely on reduction of unneeded hospitalizations and Emergency Department visits



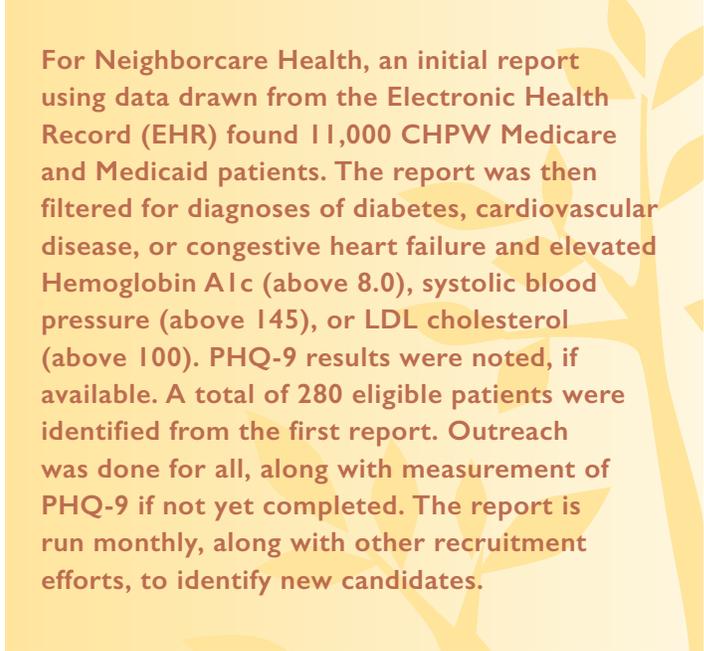
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## V. NEIGHBORCARE HEALTH AND COMMUNITY HEALTH PLAN OF WASHINGTON

Community Health Plan of Washington, based in Seattle, recruited Neighborcare Health as the community health center that would incorporate the COMPASS program into its primary care sites. CHPW was formed in 1992 by the community and migrant health centers throughout the state of Washington that serve as the safety net for the underserved. The CHPW network now consists of 21 community health centers, including Neighborcare Health, operating more than 122 clinic sites, and serving more than 340,000 members. The majority of patients have Medicaid, with the remainder enrolled in Medicare Advantage and the Health Benefit Exchange. CHPW is the only not-for-profit health plan serving Medicaid members in Washington state.

Founded more than 40 years ago, Neighborcare Health is a community health center and the largest provider of primary medical and dental care for low-income and uninsured families and individuals in the Seattle area. It serves more than 54,000 patients each year at 24 medical, dental and school-based sites. More than 91 percent of Neighborcare Health's patients live below 200 percent of the federal poverty limit, 71 percent under 100 percent of FPL. Seventeen percent are homeless or recently homeless.

Neighborcare Health and Community Health Plan of Washington worked together to build the COMPASS program at Neighborcare Health's primary care sites. Early on, CHPW identified patients who were high utilizers of medical services, based on claims data. Because CHPW is the Consortium partner for the COMPASS award from CMS, only CHPW patients at Neighborcare could be enrolled in the program. Since the launch of the COMPASS Program, Neighborcare Health has enrolled 178 patients. As of May 2015, the nationwide consortium partners had enrolled a total of 3,952 patients.



For Neighborcare Health, an initial report using data drawn from the Electronic Health Record (EHR) found 11,000 CHPW Medicare and Medicaid patients. The report was then filtered for diagnoses of diabetes, cardiovascular disease, or congestive heart failure and elevated Hemoglobin A1c (above 8.0), systolic blood pressure (above 145), or LDL cholesterol (above 100). PHQ-9 results were noted, if available. A total of 280 eligible patients were identified from the first report. Outreach was done for all, along with measurement of PHQ-9 if not yet completed. The report is run monthly, along with other recruitment efforts, to identify new candidates.

## VI. UNIQUENESS OF COMPASS IN A FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

In the population of Neighborcare Health patients served by the COMPASS program, social stressors were numerous; the impact of these influences on patients' ability to achieve clinical objectives was profound.

### Serious social stressors

- Homelessness or housing instability
- Serious mental illness
- Substance abuse/dependency
- Past incarceration
- Current or past domestic violence
- Illiteracy
- Gang involvement
- Political refugee status
- Sexual abuse history
- Severe financial stress
- Caring for gravely disabled family member
- Chronic pain
- Severe lack of social support

*65% have three or more*

*40% have four or more*

*19% have five or more*

The Medical and Psychiatric Consultants in COMPASS provide an objective and focused look at current treatment regimens for management of chronic conditions. This provides one of the major benefits of the program. Similarly, the one-on-one attention that Care Managers provide to each patient contributes substantially to improving outcomes. The inclusion of Care Managers on the team is critical to success. Hands-on care, persistent communication and comprehensive management are necessary to motivate patients, to document progress and to assist them in eliminating barriers to success, especially in Neighborcare Health's population. A tenacious approach to engagement, building a therapeutic relationship, and engaging the patient in the health care system are necessary ingredients. Motivational interviewing and promoting behavior activation are cornerstones of this care.

### PATIENT STORY: SM

SM is a young woman with Type I diabetes, chronic substance abuse, depression and poor coping skills who has had multiple hospitalizations for diabetic ketoacidosis. She frequents the Emergency Department (ED) so often that a week without an ED visit is considered by her Care Manager to be a success. Her diabetes is poorly controlled, in part due to crack, methamphetamine, and heroin use and partly due to homelessness and poor social support. She currently lives on the street or in a tent city, with no access to refrigeration to properly store her insulin. She has insight into the potential long-term effects of her diabetes and would like to improve her diabetes control. However, to do that she has to cease using drugs, get off the long waiting list for affordable housing, develop a social support system, and then begin to control her diabetes through medication management, diet, exercise, and a healthy lifestyle.

The Care Manager talks with SM several times a week, encouraging her, supporting her, cajoling her—whatever it takes. She has provided suggestions for drop-in centers where she can store her insulin. In addition, the Care Manager identified a COMPASS program graduate, who also has Type I diabetes and who is now clean and sober after years of drug use and living on the streets. This person wants to “give back” to Neighborcare Health, which he credits with saving his life. He has enthusiastically agreed to be a mentor to SM. The Care Manager plans a joint visit with SM and her new mentor to discuss next steps. Achieving improvement in HbA1c remains a goal for SM but at present the priority is on survival and on overcoming the immediate obstacles in her life.

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## VII. IMPLEMENTATION OF A COMPASS PROGRAM

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### Gap analysis on staffing, infrastructure and resources

In performing a gap analysis before instituting a COMPASS program, it is important to make sure that the organization has supportive leadership, a culture that values team-based care and infrastructure basics to ensure success. Established relationships with external partners, such as medical specialists and community mental health centers, are critical.

#### Essential components include:

- Buy-in from:
  - Senior and middle management leaders, who will be champions of the program
  - Primary care providers and their teams
  - Anyone in the clinic who could potentially refer a patient to the program
  - Community mental health counselors, for coordination of care

**At Neighborcare Health, the senior management is engaged and supportive, providing assistance, improving communications, and initiating connections outside the health center as needed. The Chief Medical Officer has been integral to the team from the onset. He likens COMPASS to a hot-spotting team.**

- Established relationships with community mental health counselors/centers
- A culture that supports team-based care as well as innovation and the willingness to engage in continuous quality improvement

**Each Neighborcare Health primary care team consists of one primary care provider and one medical assistant, with one registered nurse shared between three or four teams. Each clinic site also has a part-time social worker, behavioral health counselor, and nutritionist/diabetes educator.**

- Clinicians, who are known and respected within the organization and whose recommendations will be welcomed by PCPs, to serve as consultants
- A patient registry system, either within an electronic health record (EHR) or freestanding, that can be used for managing the caseload of patients and tracking their clinical measures
- The ability to send communications directly to providers within the EHR
- Access to Emergency Department and hospitalization information
- The bandwidth to take on a new project without significant conflicting priorities
- The capacity to address the social stressors that may be the primary barriers to patients' success, such as having internal social workers on staff
- Financial resources to fund Administrative costs (recognizing that this and similar programs have shown financial success in utilization cost savings)
- Working space for Care Managers and Administrative Coordinators, and meeting space for team meetings. Having team members sit together in one area allows "cross-pollination" to flourish.

## Staff

Specific positions are required for the COMPASS program, with the FTE status of each dependent on the number of potential and enrolled patients. In general, COMPASS staff should be secure working in a collaborative, team-based setting, should be enthusiastic about encouraging patient progress, and should be comfortable trying innovative solutions as challenges arise.

### The Medical Consultant

The **Medical Consultant** is the resource for medical issues for each COMPASS patient, in conjunction with the patient's primary care provider. This consultant:

- Can be an internist or family medicine physician
- Ideally is a known and respected member of the medical center
- Will be needed for two to four hours weekly depending on caseload size with more time initially (see roles below)
- Should have other specific skills and abilities.

➔ See this job description.

At Neighborcare Health, the Medical Consultant is an internist who is the site medical director for one of the clinics in the community health center.

### The Psychiatric Consultant

The **Psychiatric Consultant** provides input on psychiatric management during the weekly team meetings, and as needed in the interim. S/he makes clinical recommendations and also provides continuing education to primary care providers by way of clinical consultation. The psychiatrist:

- Joins team meetings in person or remotely
- Provides continuing education to primary care providers through consultation on individual patients and, if time allows, on specific chosen topics
- Ideally, should have a working relationship with community mental health resources
- Should have other specific skills and abilities.

➔ See this job description.

At Neighborcare Health, the Psychiatric Consultant is a faculty member at the University of Washington, who attends Systematic Case Review meetings, either by phone or in person.



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## The Care Manager

The **Care Manager** may possess any of a number of credentials and experience, including registered nurse, social worker, or mental health professional. The role of the Care Manager extends beyond that filled in Unützer and Katon's earlier models of collaborative care management by a behavioral health provider. This vital team member might have a behavioral health background and gain medical knowledge in this role, but the reverse might equally be the case. A registered nurse can be a Care Manager, acquiring mental health knowledge with specific training and as a member of a COMPASS team that emphasizes cross-disciplinary learning. The Care Manager:

- Has the ability to build a relationship “from scratch”
- Possesses knowledge and comfort with motivating changes in behavior
- Is able to educate patients about chronic physical, mental, and substance use conditions
- Is sensitive to a broad range of patients' needs, cultural backgrounds, and social situations
- Is comfortable communicating with and assisting patients with complex social needs
- Can manage a significant load of complicated patients, with a high degree of independence and flexibility
- Is proficient in several languages (ideally)
- Feels confident communicating recommendations with various members of the health care team
- Should have other specific skills and abilities.

➔ [See this job description.](#)

At Neighborcare Health, the Care Managers are registered nurses, social workers, or mental health professionals.

## The Administrative Coordinator

- Should be comfortable with outreach to patients, by phone, in person, or by mail, including encouraging enrollment and follow-up
- Should be able to manage the details of a database for enrollment and outreach, and have the technical aptitude required to use a patient registry system
- Should be able to seek out patient information such as Emergency Department visits, hospital stays, or specialty visits
- Should assist the Care Manager in compiling patient information for weekly team meetings
- Should have other specific skills and abilities.

➔ [See this job description.](#)

At Neighborcare Health, the Administrative Coordinator is a college graduate with plans to enroll in a nurse practitioner graduate program.

## The Program Manager

- Should be an experienced administrator
- Ideally has clinical expertise in medical or mental health care, or both
- Should be able to identify and facilitate the assimilation of the COMPASS program into daily work within the organization
- Should possess leadership skills necessary to manage a diverse team
- Should be able to voice strong advocacy for the program within the organization and within the community
- Should embrace a Quality Improvement approach to COMPASS

At Neighborcare Health, the Program Manager is the Behavioral Health Manager for the community health center. She has been at Neighborcare Health for many years, has built extensive relationships with community mental health resources and has oversight over other integrated programs.

## Time Requirements

The amount of time each team member spends on COMPASS patients depends on the complexity of patients and the newness of the program. On average:

- **Care Manager:** A panel of 50–60 patients per full-time Care Manager. One-third require intense management; one-third are progressing; and one-third are either poised for discharge or lost to follow-up.
- **Medical Consultant:** between two and four hours per week for Systematic Case Review team meetings, advising the Care Manager on urgent concerns, and on communicating with the PCP. More time at the start of the program is required for education and outreach to PCPs, training team members on clinical topics, and building templates and other infrastructure.
- **A Psychiatric Consultant:** between two and four hours per week, often less, depending on caseload. More time at the start of the program is required for education and outreach to PCPs, training team members on clinical topics, and building templates and other infrastructure.
- **Administrative Coordinator:** Half-time (0.5 FTE) for up to four Care Managers
- **Program Manager:** 0.5 FTE initially, decreasing to 0.2 FTE for ongoing management

## Neighborcare Health's COMPASS TEAM

One Administrative Coordinator (0.5 FTE)

Three Care Managers (2.7 FTE)

- One Registered Nurse
- Two Social Workers (bilingual Spanish/English and Vietnamese/English)
- One Mental Health Professional

One Program Manager (20–50% of 1.0 FTE spent on COMPASS)

One Internist Medical Consultant (approx. two to four hours per week—more initially)

One Consulting Psychiatrist (approx. two to four hours per week—more initially)

Support from senior leadership, including Chief Medical Officer, Chief Executive Officer, and Chief Operating Officer

**NOTE: For fairness and adherence to Neighborcare Health Human Resources policies, these roles are paid the same as analogous roles in the clinics.**

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## Training

COMPASS team members should receive training including:

- Team-based, collaborative care
- Use of the patient registry system and the electronic health record
- Basic clinical overview of depression, diabetes, and heart disease
- Role-playing the team meetings
- Training in use of tools: motivational interviewing, behavioral activation, and brief intervention
- Taping training lessons for future new hires
- Outside training to enhance skill set

In the early stages of implementation at Neighborcare Health, a two-day, in-person training was recorded and a web-based training module curriculum was developed to support ongoing training of new team members. ➔ See Appendix for a link to video modules used by CHPW and Neighborcare Health for training COMPASS and other integrated behavioral health providers. Topics include Collaborative Care, the role of the Care Manager and consulting physicians, motivational interviewing, diabetes education for Care Managers, and more.

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## Patient registry system

A registry, embedded in the EHR or existing as a unique system, is necessary for storage of demographic information, clinical assessment and care plans, patient rosters, tracking measures, and documenting patient progress.

Advantages of an embedded system in the EHR are that one can input data once for both systems, avoiding double entry, and lab and other results can be auto-populated from one system to the other. An advantage of having a stand-alone system is that it is easier to customize and is more “nimble” in serving the specific needs of the program.

The registry should:

- Have the ability to track and manage caseloads
- Support treatment to target (through tracking trends in PHQ-9, HbA1c, BP, LDL, and other measures)
- Support efficient systematic clinical review
- Supply reports to program Managers and clinical leadership to monitor progress toward goals
- Supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of clinical contacts, staffing ratios, and outcomes

The registry system is essential for attainment of the five overall goals that are critical to effective implementation of the COMPASS collaborative care management model: patient-centered team care; population-based care; measurement-based, treatment to target; evidence-based care; and accountable care.

The registry allows Care Managers and others to:

- Direct care of patients on an individual basis
  - The registry system should have all fields needed for patient management, so that the Care Manager can enter and track a list of clinical, demographic, social and behavioral indicators and outcomes for each patient. The fields include the ability to highlight patients for later consultation with the Psychiatric and Medical Consultants.

- Manage a population of patients by Care Managers and other site clinicians and leaders
  - The registry system should allow for sophisticated population management of the panel of patients seen by each Care Manager and the population of patients in the program. This population management reporting should include visual displays of clinical data over time on patient-specific and population-specific levels, with the ability to present data at the level of health centers, clinic sites, clinicians, and Care Managers.
- Supply Quality Improvement data
  - The system should be able to provide information useful to health centers for tracking of quality measures

➡ See the Appendix for a document from the AIMS Center at the University of Washington describing the necessary components of a care management tracking system in more detail.

## Medical and Mental Health Integrated Tracking System (MHITS)

Along with the other community health centers in the CHPW network, Neighborcare Health has had a patient registry system in place since 2007, for use in another collaborative care program integrating behavioral health care into primary care: the Mental Health Integration Program (MHIP). The patient registry that supports MHIP is the Medical and Mental Health Integrated Tracking System (MHITS). It is administered by CHPW and hosted by the AIMS Center at the University of Washington. MHITS is a freestanding, web-based platform that is not integrated into an electronic health record.

MHITS includes the necessary criteria for following and treating patients with chronic mental health conditions, and for managing a population of such patients, and contains a robust patient-centered care plan. However, enhancements were made to MHITS to accommodate COMPASS specifications including the addition of diabetes and cardiovascular parameters and data reporting requirements. ➡ Screenshots of key MHITS features are available in the Appendix.

## Electronic Health Record (EHR)

The electronic health record should have the following:

- Ability to use a “flag” to identify patients enrolled in COMPASS
- Templates for specific chronic diseases, such as diabetes, that can be modified if necessary for COMPASS use
- A template for documenting medical and psychiatric consultant recommendations that includes a disclaimer stating that the consultants have not seen the patient and are making recommendations to be reviewed and acted on by the primary care provider. ➡ See Appendix.
- A patient-centered Care Plan, which can be shared across the COMPASS team, PCP and other providers.

Neighborcare Health uses NextGen as its electronic health record. Team members use a “chronic disease consultation” template to record COMPASS recommendations and Behavioral Health Progress Notes to record each patient interaction and patient progress. Use of a shared care plan is forthcoming.

## Emergency Department Information Exchange (EDIE)

- The State of Washington is fortunate to have a system that provides collective information on Emergency Department visits to every hospital in the state, capturing diagnoses, recommendations, and follow-up plans. Additionally, a patient’s provider, including COMPASS Care Managers, can enter care plans (e.g., “Care management in place with PCP. Please refer patient back to PCP. Contact info = XXX”), follow-up requests, and other instructions (e.g., not to refill certain medications but instead to refer the patient back to COMPASS). The COMPASS Care Managers use EDIE on a daily basis.

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## VIII. ELIGIBILITY CRITERIA FOR THE CMMI COMPASS AWARD

The COMPASS Program, as supported by the CMMI Award, has specific criteria for patient eligibility. For Neighborcare Health, membership in a CHPW Medicaid or Medicare health plan was also required.

### Eligibility

Adult patients with:

- Sub-optimally managed depression (PHQ-9 > 9)
- *AND* treatable, sub-optimally managed diabetes and/or cardiovascular disease

➔ [See the Appendix for details of Neighborcare Health's COMPASS eligibility requirements and outreach resources.](#)

### Priority populations

- PHQ-9 > 9

AND at least one of the following:

- A diagnosis of DIABETES with one of the following:
  - HbA1c  $\geq$  8.0%  
OR systolic blood pressure (SBP)  $\geq$  145 mm Hg  
OR low density lipoprotein (LDL)  $\geq$  100 mg/dl
  - Existing cardiovascular disease (CVD) (e.g. history of ischemic heart disease diagnosis, coronary procedure, CHF or stroke) with one of the following:
    - SBP  $\geq$  145 OR LDL  $\geq$  100 mg/dl
    - Patients 65 years and older with uncontrolled hypertension (SBP > 160)
    - Recent hospitalization related to diabetes or cardiovascular disease

Notably, this model of care can be adapted to include other conditions, and stands as an example of the advantages of collaborative, integrated care for groups with special needs or circumstances, including co-occurring medical and behavioral health conditions.

## IX. IDENTIFYING ELIGIBLE PATIENTS

There are numerous sources to mine for potential enrollees.

- Automated Data (claims) or Notification by facility
  - Health Plan claims reports of high utilizers
  - Hospital discharges
  - Emergency Department visits
- Registry systems
  - Diabetes panels
  - Cardiovascular disease panels
  - Depression registry
- Electronic Health Record Query
  - Depression diagnosis
  - Diabetes diagnosis
    - Diabetes and HbA1c  $\geq$  8.0%
    - OR Diabetes and SBP  $>$  145mmHg
    - OR Diabetes and LDL  $>$  100ml/dl
  - Existing cardiovascular disease (CVD) (history of ischemic heart disease, coronary heart disease, congestive heart failure, or stroke)
  - Existing CVD AND systolic blood pressure  $\geq$  145 mmHg
  - Existing CVD AND low-density lipoprotein (LDL)  $\geq$  100 ml/dl
- Additional referrals from clinic-based team members
  - Diabetes educators
  - Primary care provider team
  - Patient services representatives
  - Nurses
  - Medical assistants
  - Mental health counselors

➔ See the Appendix for a list of qualifying ICD9 codes.

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*“Sometimes, when I see a particular patient’s name on my schedule, I inwardly groan. I know the patient has huge needs and I know I can’t fix them. Having COMPASS allows me to refer the patient to a team that can spend much more time than I can, focusing on the patient’s social issues as well as, or perhaps more importantly than, their clinical goals. It’s better for all of us.”*

— A Neighborcare Health Primary Care Provider

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## X. OUTREACH AND ENROLLMENT

The Administrative Coordinator and Care Manager play a vital role in seeking out and enlisting patients in the program.

To enroll eligible patients, the Administrative Coordinator may:

- Get lists of eligible prospective patients
- Review Electronic Health Record (EHR) for confirmation of eligibility (e.g., current insurance status, still a Neighborcare patient, qualifying clinical parameters)
- Send COMPASS introduction letter to patient (from patient's primary care team)
  - ➔ See Appendix for sample letter.
- If positive response, set up initial assessment with Care Manager (phone or in person).
  - ➔ See Appendix for phone script.
  - See below for more information on the Initial Assessment.
- If no response, call patient up to three times until reached.
  - NOTE: Use of a language-appropriate person to do outreach is recommended. An interpreter service helps but is not ideal.

- Keep a detailed Excel spreadsheet of outreach attempts, including reminders of patients to call in later months and “Never Call” patients.

Once a patient is enrolled, the Administrative Coordinator:

- Adds a COMPASS designation to the patient's EHR record
- Adds the patient to the registry system
- Adds COMPASS designation and care guidelines in the Emergency Department Information Exchange (EDIE), identifying the patient's Care Manager and including additional recommendations as needed
- Notifies PCP of patient enrollment

The Care Manager may:

- Attempt to reach eligible patients in the clinic during a provider visit
- Encourage PCPs to refer patients to COMPASS. Patient buy-in may be stronger if the suggestion comes from a known, trusted provider.

At Neighborcare Health, there have been relatively few referrals to COMPASS from primary care providers. Possible reasons include:

- Care Managers not being embedded at all sites, so they are not “in plain sight” to keep the program at the forefront in the minds of PCPs' and their teams.

- Neighborcare Health has several different programs for special populations. Some PCPs expressed frustration that they couldn't keep straight the eligibility criteria for each program.
- For this CMS-funded collaborative, only CHPW patients were eligible. It proved difficult for PCPs to check insurance status as another step in the referral process.

## XI. ENGAGEMENT

The process of engaging the patient requires flexibility and resilience on the part of COMPASS team members, particularly the Care Manager. Each patient has unique needs; different types of encouragement and support may be needed. Some standard processes are to:

- Engage patient with initial phone contact
- Conduct a 60-minute assessment, preferably in person but by phone if necessary) to identify health goals, basic needs, barriers to effective management of chronic conditions
  - ➔ [See Appendix for the Initial Health Assessment guide for Care Managers.](#)
- Use active listening in order to identify and clarify patients' highest priorities — even if they differ from care team priorities
- Provide assistance toward addressing patient priorities in order to build rapport
- Meet patients where they are.  
Move together from that point.
- Schedule follow-up appointment
- Recognize that there may be barriers in addition to language differences
  - Lack of phone
  - Transience or lack of stable home address
  - Mobility issues
  - Unstable insurance status or PCP site

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*“I like doing most of the early contact with a patient, even though the Administrative Coordinator could do much of it. It gives me a chance to get to know the patient and start building a rapport. It’s also less confusing for the client.”*

—A Neighborcare Health COMPASS Care Manager

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*Given the time constraints of the primary care nurses and providers, the COMPASS Care Managers provide invaluable support. I have found that Care Managers are able to develop creative approaches to working with patients who struggle with multiple medical conditions as well as myriad social/emotional challenges. A trip to the mall with a patient to go bathing suit shopping (thank you, Cheryl) means our patient is one step closer to getting out of her wheelchair and one step closer to better diabetes control. As a nurse, I could encourage the patient to exercise while she is in the clinic, but without removing the multitude of barriers, it would be very challenging for her to follow through on this request. The Care Managers embody the ideal of “meeting patients where they are” in order to provide the best care possible within a context of social chaos.*

—A Neighborcare Health primary care nurse

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## XII. SYSTEMATIC CASE REVIEW

The Systematic Case Review (SCR) is the weekly meeting of the COMPASS team for review of select patients. It can be held in person or by phone, although for the first several months it is best to conduct all SCR meetings in person. The entire COMPASS team convenes to discuss cases and to share suggestions about individual patients. The SCR meeting also serves as a learning opportunity for team members and is a “gold mine” for cross-disciplinary teaching.

- In each 90-minute session, 25 or more patients can be reviewed. **Priority Patients include:**
  - All new patients
  - All patients recently seen in the ED or hospitalized
  - Patients not at target for HbA1c, PHQ-9, or blood pressure
  - Follow-ups from the previous SCR meeting
  - Patients who have not been reviewed in the past 3 months
  - Patients who are of concern to the Care Manager or who have been out of contact for some time
- Attendees to the SCR meetings can include:
  - Medical Consultant
  - Psychiatric Consultant
  - Care Managers
  - Administrative Coordinator (as needed)
  - Program Manager (as needed)
  - Others (such as the Chief Medical Officer, etc.) as needed

Neighborcare Health conducts SCR sessions weekly, alternating in-person meetings with conference calls. For the first several months, all meetings were conducted in person. The Care Managers lead the meeting. One of the Care Managers (or the Administrative Coordinator) is the Timekeeper and “Driver” of MHITS and EHR screens on an overhead projector.

### SCR preparation

Before the meeting, the Care Manager sends a list of patients due for SCR discussion to the Administrative Coordinator, who prepares a brief summary of each, including PCP designation, most recent lab and PHQ-9 data, ED visits and hospitalizations, and medications. The Care Manager searches the EHR for new information on all of her patients. She also checks to make sure all have appointments scheduled.

➔ See Appendix for an **Initial Case Presentation template (for use in presenting at SCR)** and a **Follow-up Case Presentation template**.

### SCR meeting content

In the discussion of each patient in the SCR meeting:

- A brief presentation of the case is made by the Care Manager, using an **SCR Preparation Checklist**, which contains specific information, determined by the Medical Consultant, to facilitate a comprehensive, actionable presentation by the Case Manager (➔ See Appendix.)
- Relevant patient material from the registry, the EHR, and EDIE is displayed by the Administrative Coordinator
- Medical and Psychiatric Consultants ask questions about current measures, recent medication changes by PCP, barriers, self-care activities, next steps, and adjustments to goals. They follow recognized protocols from national organizations (for example, the Group Health Cooperative Adult and Adolescent Depression Guideline) for treatment adjustments to achieve clinical targets.
- Barriers to progress and addressing of social barriers are discussed by all
- Next steps for the Care Manager are outlined

- Recommendations are created for Primary Care Team based on an up-to-date barrier analysis, including:
  - Medication adjustments
  - Follow-up labs and visits
  - Specialty referrals
  - Use of community resources

### SCR communication and documentation of findings and recommendations

Recommendations must be communicated to the primary care team and, as indicated, to the patient’s community mental health provider, and documented in both the EHR and the registry system. ➔ See Appendix for a sample letter to a community mental health provider.

At Neighborcare Health, the Medical Consultant uses a worksheet (➔ see Appendix) to take notes during the SCR meeting.

### The Neighborcare Health process at the completion of a weekly SCR is as follows:

- **Medical Consultant**—completes a Physician Case Consultation note in the registry (MHITS), including recommendations and tasks for the PCP, PCP Team, and Care Manager
- **Consulting Psychiatrist**—completes a Psychiatrist Case Consultation document in MHITS. The document will include recommendations and tasks for the PCP, PCP Team, and Care Managers.
- **Care Manager**
  - Updates the EHR (NextGen) by copying the consultants’ notes into Chronic Disease Consultation and/or Psychiatric Consult documents.
  - Sends a communication to the PCP via NextGen summarizing the SCR recommendations and asking for feedback.
 

**Example:** *We reviewed XX’s case with the COMPASS team today. The recommendations from the Medical Consultant are in the “Chronic Disease Consult” document for your review. Please let me know if you have any questions or concerns, or if there is anything you’d like to add to the care plan.*
  - A disclaimer is included in the notes, stating that the medical and psychiatric consultants are providing recommendations but have not seen the patient. (➔ See Appendix.)
- **Primary Care Provider**—For effective communication, the PCP remains the provider of record for patients enrolled in COMPASS and is the hub of the care team. The SCR team does not implement any treatment changes independently. All adjustments go through the PCP. Consider using “standing orders” for PCP staff to, for example, order labs recommended by the COMPASS team.

SCR also allows for a detailed look at each patient’s problem list and diagnostic codes. The thorough review of a patient’s treatment plan includes a look for missed or outdated diagnoses and screening tests that are overdue. Additionally, a diagnosis on the Problem List may not

be as detailed as it should be (e.g., Type II diabetes without mention of complication when the patient has nephropathy or another complication mandating a higher complexity code). The Care Manager can work with the PCP team to update problem lists and diagnosis codes.

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## XIII. ONGOING CARE

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### Care Manager — Patient contacts

The Care Manager schedules regular appointments with patients to discuss recommendations, monitor progress, and provide motivation and other support. Typically, patients are seen or contacted by phone every week or two for the first three months.

Care Managers should:

- Foster a collaborative relationship with the patient, working to achieve goals and to suggest and participate in realistic interventions, building on the trust that grows from individualized attention
- Consider every patient contact an opportunity for engagement
  - Look for patients in providers' daily schedules
  - Ask that a patient's call to the clinic (even for cancelling an appointment) be directly transferred to the CM for follow-up
- Arrange for a joint visit with the PCP or PCP team member (for example, a Care Manager may meet with a patient while an RN is applying leg wraps or treating a wound)
- Make frequent follow-up calls with patients, especially those with slow or no progress or new enrollees
- Set intermediate as well as long-term goals, for the team and for patients. Achieving small goals builds confidence in patients and in staff just as meeting big goals does.

- Use available tools and worksheets as needed (➡ [See Appendix.](#))
  - ➡ [Patient Visit Summary](#)
  - ➡ [Sugar Sheet](#)
  - ➡ [Graduation and Relapse Prevention worksheet](#)
  - ➡ [Depression Relapse Prevention Plan](#)
- Develop a relationship with the patient with mutual respect and trust

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*“I feel like [my Care Manager] really listens, inside and out.”*

*— A Neighborcare Health COMPASS patient*

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For Neighborcare Health patients, the Care Manager follows patients with a frequency and intensity determined not only by the patient's clinical needs but also on the individual's availability. It is not uncommon for the Care Manager to have an impromptu meeting with a patient she sees in the clinic waiting room. Having the Care Manager on site at the clinic where patients receive their primary care is useful in facilitating the unscheduled visits that may be crucial to patient follow-up. The Care Manager must be flexible and creative in reaching patients. Meeting at a coffee shop or at a shelter may be the only way to see a patient.

One Care Manager helped a patient make sure her alarm clock was working...so she could keep her ophthalmology appointment...so she could get her cataracts fixed...so she could read her glucometer and measure out her insulin...so she could get her diabetes controlled...to get her HbA1c under 8.0.

### Care Manager — Ongoing search for patient updates

The Care Manager should

- Check EDIE daily, if available, to see if any COMPASS patients have been in the Emergency Department. If yes, then the ED is contacted to get more information.
- Look at hospital admission data and follow up with the hospital for a discharge summary
- Scan provider schedules, if necessary, particularly for hard-to-reach clients
- Regularly “run the list” of their patients, reviewing the EHR for new information

## XIV. MAINTENANCE AND GRADUATION

Once a patient has sustained progress on clinical goals (depression and diabetes and/or cardiovascular disease) and personal goals for three months, the Care Manager should conduct a follow-up contact to confirm progress is still current, and then create a continued care/relapse prevention plan. (➔ See Appendix.) If maintenance is sustained for all parameters for six months, patients may be discharged from the COMPASS program.

- i. Depression parameters:
  - PHQ-9 is less than 9 for three months
  - OR PHQ-9 score reduction of  $\geq 10$  with sustained reduction for at least one month AND medical targets have been reached and sustained for the appropriate amount of time
- ii. Diabetes parameters:
  - TWO HbA1c values of  $< 8$  in three months

**TIP** A summary of the phases is in the [Appendix](#), along with graduation requirements, discharge protocol, and relapse prevention tools. ➔

- iii. Cardiovascular Disease parameters:
  - On a statin as well as other evidence-based recommended medications AND no exacerbations (congestive heart failure) or events (myocardial infarction, stroke) for three months
  - Blood Pressure at goal on two occasions at least one month apart

At the time of discharge from COMPASS, the Care Manager documents in the EHR:

- A Chronic Disease Management plan
- Any red flags/triggers that have been identified
- The patient's goals
- The patient's description of barriers they have faced in achieving their goals
- An explanation from patient regarding why they think they improved

### PATIENT STORY: FN

FN is a 65 year-old obese female with a history of depression with anxiety, as well as Type II diabetes with neuropathy, coronary artery disease, chronic kidney disease, gout, obstructive sleep apnea, and multiple other medical problems. FN first joined the COMPASS program in November 2013 with an initial HbA1c of 8.3 (HbA1c in 2013 prior to COMPASS: 8.3, 11.8, 11.6) and a PHQ-9 of 18 (PHQ-9s in 2013 prior to COMPASS: 17, 22, 14). FN had difficulties prepping meals/shopping for groceries, which resulted in irregular eating and poor management of diabetes. The COMPASS Care Manager referred her to Meals on Wheels. The Care Manager was able to get FN connected with Hopelink to alleviate her difficulty getting transportation to her medical provider visits. FN's Care Manager also scheduled her for a diabetic eye visit and diabetic shoe fitting. New shoes helped FN's mobility around the house and allowed her to get to her many appointments. The Care Manager found resources through Catholic Community Services when the patient received a shut-off notice from Seattle City Light. She also continued to educate FN on her current and new medications and the importance of adherence.

Since joining the COMPASS program, FN's last three HbA1cs have been 6.4–6.5, which are the lowest HbA1cs recorded in patient's chart since 2008. Her PHQ-9 also lowered significantly after joining COMPASS with recent scores being 0, 1, and 8.

## XV. MEASUREMENT

### What to measure

Parameters to measure success in COMPASS follow the goals of the Triple Aim and include:

What to measure:	When:
<b>Clinical results</b> <ul style="list-style-type: none"> <li>■ HbA1c</li> <li>■ Blood pressure</li> <li>■ Cardiovascular events</li> <li>■ PHQ-9</li> </ul>	<i>Per treatment protocols</i>
<b>Cost savings</b> <ul style="list-style-type: none"> <li>■ ER visits</li> <li>■ Inpatient hospital stays</li> </ul>	<i>Baseline, Quarterly and annually</i>
<b>Satisfaction scores</b> <ul style="list-style-type: none"> <li>■ Patient</li> <li>■ Provider</li> <li>■ COMPASS team</li> <li>■ Administration</li> <li>■ Outside collaborators (e.g., community mental health providers)</li> </ul>	<i>Baseline and at one year</i>



## XVI. OUTCOMES

### Clinical

➔ See Appendix for tables demonstrating early outcomes for the entire COMPASS Collaborative population.

Results will be updated in the fall of 2015. The toolkit will be updated with this information when it is available.

Preliminary internal results are available for Neighborcare Health:

- Forty-eight percent of patients had an improvement of more than 5 points in their PHQ-9 score
- In those patients with HbA1c  $\geq$  8 at baselines, 47% had an improvement in HbA1c level

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*“Many times we saw patients benefit from the program, though their clinical measures (such as PHQ-9 or HbA1c) may not have reached target. To see an HbA1c go from 15 to 10 is progress, though not a “measured success.” Similarly, I saw patients’ lives improve dramatically when we helped them alleviate a social stressor, such as homelessness or a fragmented support system. We helped many patients reach their own goals, if not the “treat to target” goals. I still call that success.”*

— A Neighborcare Health COMPASS Medical Consultant

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### PATIENT STORY: NS

NS is a 62 year-old woman with diabetes (HbA1c 11.0), depression (PHQ-9 25), degenerative joint disease, hypertension and hyperlipidemia. The patient’s primary concerns were: knee pain; social isolation with no family or close friends; the recent death of a grandson; and poor sleep with frequent snacking.

The COMPASS team assisted with getting a knee workup underway and arranged for physical therapy to increase mobility and exercise. The team earned the patient’s trust and NS was willing to follow the recommendation to participate in counseling. The Care Manager assisted NS in problem solving regarding diet and self-management and worked with the patient to identify triggers and more healthful response options. She received bus training and instruction in journaling. Five months after enrollment, she feels better than she has in years and is more engaged with her PCP. She continues to have short and long-term goals she wants to achieve. Her HbA1c has improved from 11.0 to 6.2 and her PHQ-9 from 25 to 8.

## Financial

COMPASS Collaborative results will be available in the summer of 2016. Preliminary, internally calculated results for Neighborcare Health show cost savings in both inpatient and Emergency Department costs. It is noted that the number of enrolled patients is not large, and is diminishing as the funding for the program winds down.

Comparison of 2015 CHPW claims data to determine COMPASS patient costs before and after COMPASS enrollment shows substantial savings in inpatient costs per member per month and variable savings in ED costs month to month, likely reflecting the small number of patients measured. Total cost savings are modest. One expectation of the program is that costs in some areas may (fortunately) rise, such as office visits and prescription costs; these are necessary and desirable expenditures of engaging patients in their health care, likely saving dollars down the road.

## Cost of the COMPASS program itself

The expenses required to implement and maintain the program itself are largely related to salaries and benefits. Staffing requirements are proportional to panel size and the needs of the patient population. Instituting or revising a patient registry function and Information Technology costs for running reports must be considered.

## PATIENT STORY: JP

JP is 59 year-old woman who has symptoms of depression and anxiety. Her Problem List includes alcohol use, pancreatitis, cirrhosis, hypertension, hyperlipidemia and chronic pain. Per EDIE, JP had 25 visits to 3 different Emergency Departments from 12/2012-12/2013 for abdominal pain, acute alcoholic gastritis, alcoholic liver disease, alcohol abuse, gastrointestinal bleeding, dehydration, and requests for detoxification. Patient has been known to leave the ED against medical advice, and to be non-adherent with her medications and demanding of pain medication. JP's COMPASS Care Manager persuaded her to establish care at a community mental health center for chemical dependency and depression. The patient soon fired her community mental health providers but later did enter an inpatient detoxification program. The COMPASS team set up a care plan for JP to see her primary care provider at the same time and day bi-weekly to get her on a "regular schedule." The Care Manager continued to encourage JP to attend her specialty appointments and mental health appointments.

JP had 11 total visits with the Care Manager in 2014 and only 4 ED visits since care management started in 04/2014. She has had no ED visits in the past 6 months.

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## XVII. PATIENT, PROVIDER AND STAFF SATISFACTION

### Patient satisfaction

HealthPartners conducted a provider satisfaction survey targeting physicians and mid-level providers at clinics where COMPASS was implemented. Neighborcare Health providers participated in this survey, and results are currently being summarized for publication. Informal feedback obtained through provider interviews conducted as research for this toolkit suggests that providers are enthusiastic and supportive of the COMPASS model of care and that by designating a Care Manager to assist high-need individuals, both the patients and providers benefit. Anecdotally, patients are pleased with the COMPASS Program, with many commenting on how grateful they are for the added support.

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*“I’m not used to having someone care about what happens to me.”*

— A Neighborcare Health COMPASS patient

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*“I don’t usually like listening to other people’s advice, but I trust yours.”*

— A Neighborcare Health COMPASS patient

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### Provider and staff satisfaction

No formal provider satisfaction survey results have been performed to date. Informal evidence suggests that providers are enthusiastically supportive of the COMPASS model of care and that by designating a Care Manager to assist high-need individuals, both the patients and providers benefit.

#### Providers and staff appreciate:

- Learning about social barriers that may not have come up in PCP visits
- Having a Care Manager to aid in behavioral activation, encouragement and problem-solving
- Assistance with accessing community resources
- Having the Care Manager meet with a patient along with the PCP, when appropriate

#### Providers and staff suggest:

- Having a program in place that is open to all patients, regardless of insurance coverage
- Recognizing that recommended interventions may already have been attempted but may not be evident in the EHR; use wording such as “Unless otherwise not indicated, consider adding aspirin to the patient’s regimen.”
- Using the opportunity to update the EHR to include missing information such as medication intolerance
- Making enrollment criteria easy to remember or easily available for PCPs.

- Designating a person who can receive PCP referrals and help determine which patients are eligible for additional services; this person can triage patients appropriately.
- Winning over reluctant PCPs by working with them on a challenging patient and highlighting the ways the COMPASS team can support the PCP.

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*“Our patients have one of five different insurance plans, or are uninsured. It’s hard to institute and maintain a program that is not open to all our of patients.”*

— Neighborcare Health Chief Medical Officer

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## XVIII. PROCESS IMPROVEMENT AND LESSONS LEARNED

COMPASS is best implemented in a learning environment in which staff members are comfortable with process improvement.

- Clinicians should be comfortable with having other providers make care recommendations.
- Those taking on the role of Care Managers should be ready to expand their skillsets to include knowledge of both mental health and medical conditions.
- Leadership should encourage culture shifts that support team-based care.
- All staff should embrace the concepts of comprehensive, integrated care.
- Principles of quality improvement should be followed during implementation and maintenance of the program.
- The entire team should be open to making changes along the way.

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*“I was really impressed by how quickly our Care Managers learned from each other and the Consultants about disease management, given that was not what most of them had trained for. They really stepped up to this new kind of interaction with patients, and just got better and better!”*

*— Neighborcare Health Behavioral Health and COMPASS Program Manager*

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### Some of the lessons learned include:

#### Regular meetings

- An early discovery was the value of regular Process Improvement meetings, held after SCR meetings, to discuss challenges, best practices, and revisions to protocols. In the first six to twelve months of the program, the entire COMPASS Team and the Chief Medical Officer and the CHPW team met for 30 minutes after every SCR, then tapered to every two weeks. The team used these meetings to brainstorm enhancements to the current COMPASS program.

#### On-site access and inclusion

- Consider assigning the clinic site medical director to be the Medical Consultant. Such a leader is likely to already have gained the trust of the providers, and should have skills leading a team. This would also allow for teaching of providers directly under the medical director's supervision and would foster the inclusion of the program in daily work. Having other providers and staff attend SCRs when possible is an option to enhance team building, build awareness, and provide learning opportunities.
- Integrate COMPASS into primary care workflows to support PCP referrals, gain acceptance of the program and facilitate effective communication regarding recommendations.

### Care Manager role

- Embed Care Managers into daily clinic workflow in the primary care sites
- Have Care Managers meet the patients where they are — senior centers, shelters, dialysis centers and adult day centers.
- Consider having the Care Manager carry a cellphone for quick availability to patients

### EHR template

A diabetes visit template would be very helpful in coordinating care between team members, PCPs, and specialists. Ideally the template would include:

- Auto-populated clinical data
- Current and past medications, including reasons for discontinuing, intolerances, or patient preferences
- Most recent labs, immunizations and screening information (including eye and foot exams)
- Dates of Emergency Department visits and inpatient stays

### Other applicable conditions

Expand the program to include patients with other conditions, such as:

- Chronic kidney disease
- High-risk pregnancy
- Hepatitis C
- HIV
- Other mental health disorders, such as chronic anxiety

### Improving well-being

Many of the lessons learned by Neighborcare Health in implementing COMPASS have been incorporated in the processes already noted. One early lesson learned by the Neighborcare Health team is that even if clinical and cost goals are not met, other significant accomplishments can be achieved with the COMPASS model. For example, a measure of “well-being” would likely show improvement for many COMPASS patients.



*“It took a while for the group to get really efficient at reviewing cases in the SCR, but we did some PDSA (Plan, Do, Study, Act) cycles trying different methods of preparing and presenting, and soon got very skilled at it. What a valuable skill to develop for any support roles in Primary Care, just being efficient at getting to the critical information that needs to be shared!”*

— Neighborcare Health Behavioral Health and COMPASS Program Manager



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## XVIII. SUSTAINABILITY

The CMS Award granted funds to support the COMPASS Program for three years. The success of the program is clear: in clinical improvement; financial cost savings; and, at least anecdotally, in enhanced patient and provider satisfaction. This argues for continuation of the program and incorporation of collaborative, team-based care into daily work in clinical settings. This model of care suits both the primary care and specialty care venues and may also be adapted for use in other locales, such as hospitals, chronic care facilities, community mental health centers, dialysis centers, prison medical facilities, and more.

The strength of COMPASS is in both the scrutiny of a patient's treatment regimen and in the identification of obstacles that the SCR provides, as well as in the hands-on attention to motivation and social barriers that the Care Managers afford. Disease management is improved, costs are lower, and patients and providers are (likely) happier; Berwick's Triple Aim is achieved with the COMPASS model. In addition, the dedicated focus on each patient may improve other health parameters as well, including recovery from substance use, completion of prevention and screening recommendations, unveiling of adverse childhood or adult events, and recognition and treatment of other psychiatric illnesses.

“

*“At Neighborcare Health, we fully embrace the concept of a health care home for our patients where they can get medical, dental and behavioral health care in one place. COMPASS is a perfect example of that commitment. COMPASS illustrates that primary care goes beyond the exam room and attends to the unique needs of each patient, while also addressing the challenges of specific populations. This model is a hallmark of the care we will continue to provide in the future.”*

— Neighborcare Health Chief Executive Officer

”

There are relatively few, but important, barriers to sustaining the COMPASS program. Each must be addressed and overcome.

### Funding

The COMPASS Program must have funding support that is permanent and universal. The Program is “self-sustaining,” in that cost savings are realized. However, there are administrative costs, primarily for staff salaries and benefits. The funding could come from payors, but that makes full implementation challenging, given that health centers may have patients covered under a number of different plans, and patients' coverage may change frequently. Instead, funding should cover all patients, regardless of payor. To accomplish this, COMPASS could be enveloped into a Patient Centered Medical Home (PCMH) model of care, funded by Medicaid and Medicare. The PCMH approach and the COMPASS approach dovetail in the team-based management of health center populations.

The Institute for Clinical Systems Improvement leads a payment methodology workgroup, which is developing recommendations for CMS regarding federal reimbursement for this model of care.

### Culture change

The team-based model, whether it is COMPASS, PCMH, or others, requires that providers relinquish some of the autonomy they may have been accustomed to. It also requires other staff members take on new skills and be more flexible in their specific roles. A shift in a center's culture to support a collaborative approach is essential.

## Measuring success

For the Neighborcare Health population, achievement of target goals for depression, diabetes and heart disease was not demonstrated as much as one might have hoped, at least in the short duration of this project. However, most patients improved in those measures, and many more found benefit in the supplementary care provided to them. The Neighborcare Health patients, as one psychiatrist noted, are ones who have not been improving in any program, by any measure, who are not engaged in the health care system. These patients face formidable challenges of daily living and many had given up on trying to improve their health. A measure of “patient well-being” would likely show a compelling upswing, had it been evaluated. Also, the study period for improvement in this program is short. A sustained program would allow for longer-term patient and provider satisfaction measurement and a longer time for patients to achieve goals.

## Competing programs

One PCP expressed frustration that there were several simultaneous programs for patients with specific conditions and that it was hard to keep eligibility criteria straight. This evidence-based collaborative model has been shown to be effective and relatively simple to assimilate into primary care practice. By making this the standard of care, other patient populations can be treated with the same approach, simplifying care management overall.

“

*“The COMPASS program is an efficient way of utilizing measurement-based practice and systematic patient tracking to ensure quality care for some of the most vulnerable patient populations.”*

— Neighborcare Health COMPASS Psychiatric Consultant

”

## XIX. CONCLUSION

Over the past three years, Neighborcare Health's COMPASS patients have benefitted greatly from the program, as have providers and the health plan involved (CHPW). The standard work of the SCR with adherence to treatment protocols and focus on clinical targets, combined with the diverse support given to each patient by Care Managers, from motivational encouragement to finding shelter, has demonstrated that a collaborative model is extremely well suited to the population of a Federally Qualified Health Center. Team-based care accommodates the disparate needs of patients, capitalizes on the unique skills of each team member, and addresses both the care of the population and the needs of each individual.

**TIP** See the Resources page for references.

**TIP** Check out the Appendix that follows for a wealth of materials, more than 30 documents from worksheets to protocols, that the Neighborcare Health COMPASS team has found to be useful. **Please use this toolkit freely and adapt the materials for your own needs.**

### Neighborcare Health COMPASS Toolkit production team

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## COMPASS RESOURCES

### CLINICAL GUIDELINES

Group Health Cooperative Adult and Adolescent Depression Guideline  
[www.ghc.org/all-sites/guidelines/depression.pdf](http://www.ghc.org/all-sites/guidelines/depression.pdf)

### IMPACT

Unützer, J et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002 Dec 11;288(22):2836-45.

### COLLABORATIVE CARE

The website for the AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington, with detailed information on: collaborative care; the evidence supporting its benefit; core principles; implementation; and a resource library  
[aims.uw.edu/collaborative-care](http://aims.uw.edu/collaborative-care)

### MOTIVATIONAL INTERVIEWING

Website for the Motivational Interviewing Network of Trainers (MINT), an international organization of trainers in motivational interviewing  
[www.motivationalinterviewing.org/](http://www.motivationalinterviewing.org/)

### COMPASS TOOLS

List of all COMPASS tools, including an Intervention Guide and Patient Brochure  
[compasscareteams.com/key-documents/](http://compasscareteams.com/key-documents/)

### NEIGHBORCARE HEALTH

More information about Neighborcare Health is available at [www.neighborcare.org](http://www.neighborcare.org). Questions about the COMPASS program can be emailed to [COMPASS@neighborcare.org](mailto:COMPASS@neighborcare.org).

### COMMUNITY HEALTH PLAN OF WASHINGTON (CHPW)

More information about CHPW is available at [chpw.org](http://chpw.org).

### TRIPLE AIM

Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. Health Affairs. 2008 May/June;27(3):759-769



# APPENDIX

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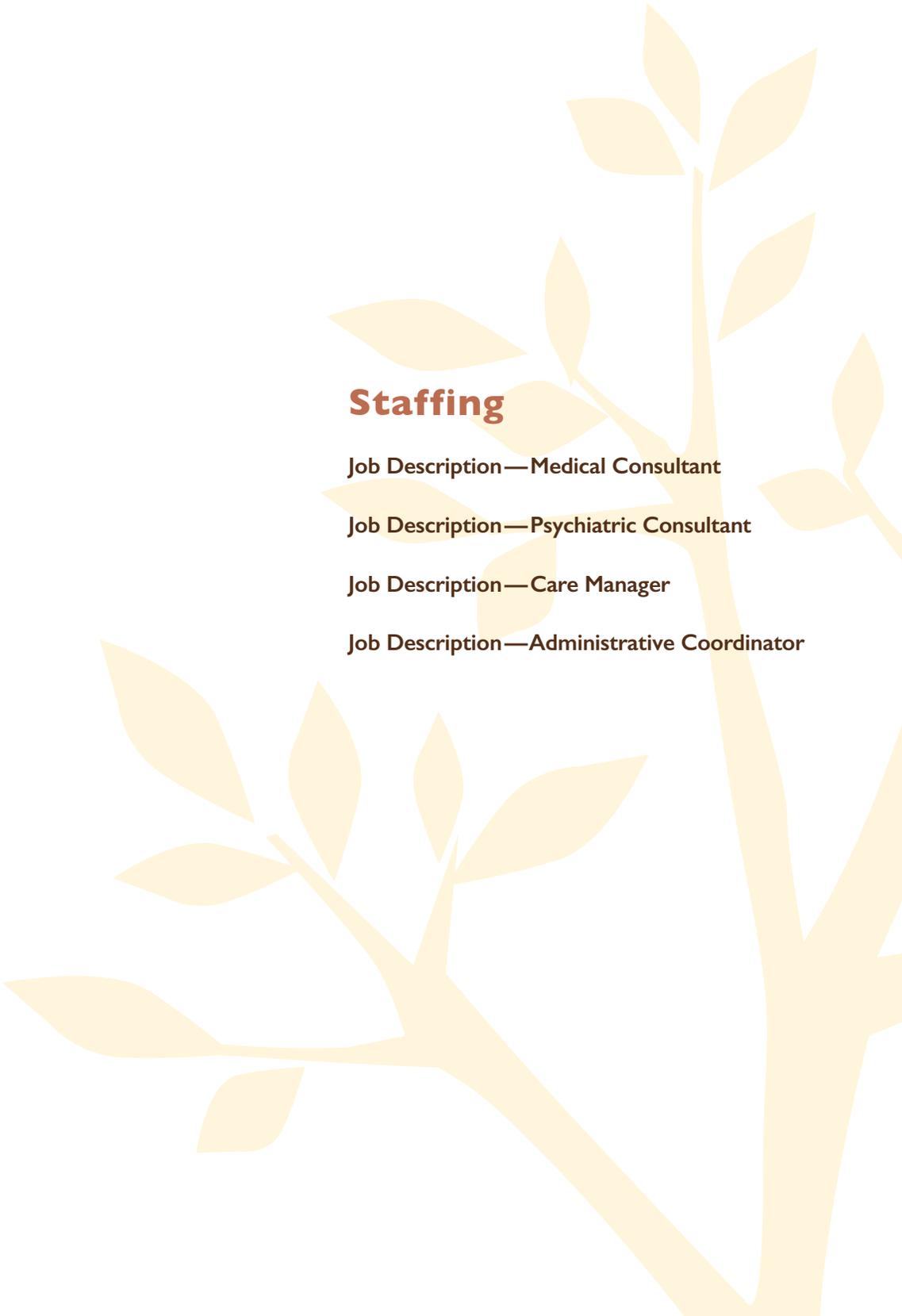
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# APPENDIX



## **Staffing**

**Job Description—Medical Consultant**

**Job Description—Psychiatric Consultant**

**Job Description—Care Manager**

**Job Description—Administrative Coordinator**



**COMPASS**  
Partnering for Mind-Body Health

## **Job Description**

### **COMPASS Consulting Medical Physician**

#### **Position Summary**

- Responsible for supporting collaborative care for patients with both mental health and chronic medical conditions such as diabetes and health disease
- Works directly with care managers, psychiatric consultants and primary care providers to assure that clinical care is optimized, social stressors are addressed, appropriate communication is assured between the collaborative team and primary care providers (PCPs), specialists, and others involved in the care of patients (such as community mental health workers)

#### **Requirements**

- Board-certified and licensed in family medicine or internal medicine
- All relevant clearances mandated by State or regional regulation
- Experience and expertise in working in collaborative or team-based models of care

#### **Desired Skills, Attitudes, and Experience**

- Expertise as a team leader and teacher, able to collaborate with, motivate and educate team members of all skill sets
- Knowledge of behavioral activation, other ways to build self-efficacy, tenacious attention to treatment intensification, humility, curiosity, discipline
- Demonstrated ability to collaborate effectively in a team setting
- Ability to quickly synthesize medical data and formulate effective and evidence-based clinical recommendations
- Excellent communication and relationship skills
- Positive, flexible, and solution-focused attitude

#### **Primary Responsibilities**

- Provide leadership to the COMPASS team
- Provide regularly scheduled (usually weekly) caseload consultation to assigned case managers (CMs)
- Work with the assigned CMs to track and oversee their patient panels and clinical outcomes using a patient registry function or program
- Provide telephonic consultation to primary care physicians (PCPs) as requested



**COMPASS**

Partnering for Mind-Body Health

- Suggest treatment plan changes including medication recommendations for patients who are not improving as expected.
- Discuss patients who need referral for additional specialty care and advise on treatment plans until patients are engaged in such care
- Document in the patient registry recommendations for treatment and/or referrals within 24 hours of consulting with a CM
- Ensure that all protected health information (PHI) in local computer/networks is stored in compliance with HIPAA regulations
- Clearly communicate to CMs and PCPs the limitations of the consultation and treatment recommendations if you did not evaluate the client in person
- Respond to telephone calls from primary care providers and CMs within one business day. Respond to urgent telephone calls within one hour if available
- Respond to email questions/consultations within two business days, sooner if urgent
- Visit each participating clinic at least once when initiating a new consulting relationship and then at least once per year to meet clinic providers and discuss ongoing collaboration.

### **Typical Workload**

A typical workload for a consulting medical physician is at least one to two hours per week, or approximately one hour per week per full-time Care Manager, and includes the following:

- Participation in program coordination, process improvement and planning activities, including training
- Caseload consultation with Care Manager(s)
- Weekly Systematic Clinical Review meetings

Note that additional time may be required during the initial phases of the program.

### **Requirements Especially Relevant to Federally Qualified Health Centers**

- Experience working with underserved, transient populations and clinical co-morbidities (co-occurring mental health, substance abuse, and physical health problems)
- Expertise in practicing medicine with sensitivity to cultural differences, social stressors, and non-English-speaking patients
- Familiarity with community resources for mental health care, specialty referral, and support for social stressors



**COMPASS**  
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## **Job Description**

### **COMPASS Consulting Psychiatrist**

#### **Position Summary**

- Responsible for weekly review of one or more care manager’s caseload of patients with shared accountability for outcomes

#### **Requirements**

- Board-certified and licensed in psychiatry
- Experience treating adult patients with depression
- All relevant clearances mandated by State or regional regulation
- Experience and expertise in working in collaborative or team-based models of care

#### **Desired Knowledge, Skills and Abilities**

- Expertise as a team leader and teacher, able to collaborate with, motivate and educate team members of all skill sets
- Knowledge of behavioral activation, other ways to build self-efficacy, tenacious attention to treatment intensification, humility, curiosity, discipline
- Demonstrated ability to collaborate effectively in a team setting
- Ability to quickly synthesize medical data and formulate effective and evidence-based clinical recommendations
- Excellent communication and relationship skills
- Positive, flexible, and solution-focused attitude

#### **Primary Responsibilities**

- Provide consultation and weekly caseload review to one or more care managers
- Suggest treatment plan changes and/or referral for patients who are not improving based on evidence-based guidelines as agreed upon by the practice
  - All actual prescribing is done by the primary care physicians
  - For patients who are not responding to initial treatment trials in primary care or comorbid behavioral health issues are present, the consulting psychiatrist may determine that the patient needs an extended consultation or a coordinated referral to a mental health provider



**COMPASS**

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- If needed and capable, the consulting psychiatrist could see the patient in the primary care clinic for brief, time-limited consultations
- Provide in-person consultation when at all possible, and provide telephone consultation to the care manager or prescribing primary care physician as needed
- Build effective relationship with Primary Care Team
- Build capabilities of Primary Care Team to care for behavioral illness

### **Typical Workload**

A typical workload for a consulting psychiatrist is at least one-half to one hour per week, or approximately one-half hour per week per full-time Care Manager, and includes the following:

- Participation in program coordination, process improvement and planning activities, including training, as needed
- Caseload consultation with Care Manager(s) as needed
- Weekly Systematic Clinical Review meetings

Note that additional time may be required during the initial phases of the program.

### **Requirements Especially Relevant to Federally Qualified Health Centers**

- Experience working with underserved, transient populations and clinical co-morbidities (co-occurring mental health, substance abuse, and physical health problems)
- Expertise in practicing medicine with sensitivity to cultural differences, social stressors, and non-English-speaking patients
- Familiarity with community resources for mental health care, specialty referral, and support for social stressors



**COMPASS**  
Partnering for Mind-Body Health

## **Job Description** **COMPASS Care Manager**

### **Position Summary**

- Responsible for managing a panel of patients with specified behavioral health and chronic medical co-morbidities that are sub-optimally controlled
- Connects, coordinates, and provides needed services and self-management support
- Engages patients to move from passive to active role in health/team
- Works collaboratively with multiple teams to implement evidence-based care for adult primary care patients, utilizing tools and training from COMPASS (Care Of Mental, Physical, And Substance use Syndromes)
- Proactively monitors population/case load to meet treatment intensification guidelines
- Follows guidelines and shapes decision-making based on practice and/or organizations agreed upon guidelines

### **Requirements**

- Background in nursing, psychology or social work, medical assistant, or health education
- All relevant clearances mandated by State or regional regulations
- Experience and expertise in working in collaborative or team-based models of care

### **Desired Knowledge, Skills and Abilities**

- Strong interpersonal and facilitation skills
- Clinical skills or aptitude in problem-solving and behavioral change strategies, including motivational interviewing and behavioral activation
- Ability to serve as a critical liaison to facilitate connections between people in a collaborative role
- Ability to provide accurate feedback about medical and behavioral health conditions without judgment or discomfort
- Ability and willingness to work in a time-limited, structured, and solution-focused environment
- Ability to advocate on another's behalf
- Ability and willingness to function independently and proactively in a primary care setting
- Comfort with a patient-centered approach that allows the patient's desires around behavioral change to inform the plan of care
- Flexibility to adapt to unforeseen needs or circumstances



## **Primary Responsibilities**

- Perform proactive outreach to identify potentially eligible patients
- Use effective engagement strategies to build a trusting relationship with patients for ongoing partnership
- Conduct initial visits, including detailed history and education about the nature of the targeted conditions and the goals and expectations of treatment
- Use a variety of educational materials, self-management support techniques, and community resources to engage patients, increase their motivation to change, and support patients in establishing healthy lifestyle goals and implementing treatment plans to meet those goals
- Maintain and use a daily registry for population management, including active follow-up for enrolled patients
- Use behavioral activation techniques with patients as an adjunct to other depression treatments
- Clearly and effectively communicate with the patient, primary care physician, consulting psychiatrist, consulting physicians, and any external providers, including informing the primary care physician about the patient’s progress and discussing side effects and the treatment plan with the primary care physician
- Systematically review the caseload with the consulting physicians each week,
- Develop a maintenance plan with patients to help them maintain a healthy lifestyle and, prevent a reoccurrence of symptoms of depression, and maintain the treatment targets for diabetes and cardiovascular disease
- Coordinate services (e.g., primary care physician visits, preventive care schedules, and specialty referrals) and transitions between care settings

## **Typical Caseload**

A typical caseload for a care manager is approximately 50-60 patients at any given time, with a total of approximately 100-150 patients managed over the course of a year.

## **Requirements Especially Relevant to Federally Qualified Health Centers**

- Experience working with underserved, transient populations and clinical co-morbidities (co-occurring mental health, substance abuse, and physical health problems)
- Expertise in practicing medicine with sensitivity to cultural differences, social stressors, and non-English-speaking patients



COMPASS

Partnering for Mind-Body Health

- Familiarity with community resources for mental health care, specialty referral, and support for social stressors



**COMPASS**

Partnering for Mind-Body Health

## **Job Description**

### **COMPASS Administrative Coordinator**

#### **Position Summary**

- Provides support as part of the collaborative care team for patients with both mental health and chronic medical conditions such as diabetes and health disease
- Coordinates, enrolls and monitors patients in a collaborative team-based model of care

#### **Requirements**

- High School Graduation and a minimum of 1 year of working in a health care setting
- Experience working with clients of diverse socio-economic and /or ethnic backgrounds and/or with psychiatric disabilities, chemical dependence, homelessness, low-income and/or life-threatening illness
- Experience in a primary care setting preferred

#### **Desired Knowledge, Skills and Abilities**

- Knowledge of and experience working in a healthcare setting and within interdisciplinary teams
- Knowledge of and proficient in the use of personal computers with the ability to learn and use required software programs
- Ability to observe impeccable professional ethics and confidentiality in working with clients
- Ability to communicate effectively both verbally and in writing
- Ability to demonstrate cultural competence in dealing respectfully with a variety of clients, in terms of ethnic, socio-economic, age, sexual preference, and gender characteristics
- Ability to establish rapport and communicate effectively with patients and providers
- Ability to meet and comply with HIPAA/Confidentiality policies and procedures
- Ability to be detail orientated, multi-task, organize, problem solve and follow up on tasks
- Ability to read, write and communicate in English
- Ability to learn from directions, observations and mistakes and apply procedures using good judgment
- Ability to work independently or as part of a team; ability to interact appropriately with co-workers and patients



**COMPASS**

Partnering for Mind-Body Health

- Ability to work with supervision, receiving instructions/feedback, coaching/counseling and or action/discipline
- Ability to effectively perform job duties under high levels of activity, variety of conditions and restraints
- Ability to demonstrate predictable, reliable and timely attendance
- Knowledge of and ability to perform CPR
- Ability to travel to any of our Neighborcare clinics

### **Primary Responsibilities**

- Run reports to identify eligible patients for integrated care program (e.g., COMPASS Expanded SQL report); screen every 4-6 weeks
- Perform outreach to eligible patients- mail letters, call, see in clinic
- Provide follow-up outreach as necessary
- Document all contacts and contact attempts with eligible patients.
- Schedule initial phone screens w/ care managers
- Add new patients to patient registry and manage changes as needed
- Add Care Management to diagnosis list in electronic health record at initial contact (update as needed)
- Run Emergency Department Information Exchange (EDIE) report to screen for potential new enrollees and to identify current patients who utilized Emergency Department
- Add/edit EDIE care guidelines for all enrolled patients
- Perform preparation for Systemic Clinical Review (SCR) weekly meeting – assist in selecting patients to present, pull labs and all other info needed
- Attend in-person SCR
- Take on new projects as they arise
- Manage the by checking history of patient visits and current care providers, including correct PCP, and organizing lists for rest of Health Home Team
- Assist other Health Home Team members in management of their caseloads, including making reminder calls for patients who have not shown up for visits, discharging patients who are not participating, rescheduling patients who missed appointments and other support tasks as assigned
- Work in partnership and joint accountability with other team members to achieve Neighborcare Health’s Mission, Guiding Principles and Goals
- Represent Neighborcare Health’s mission and programs in a professional manner
- Attend staff meetings as directed by Supervisor
- Work in cooperation and in the interest of patient care with other Neighborcare Health staff, including participating in peer mentoring and information sharing



**COMPASS**

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- Attend professional education programs to enhance professional skills as needed or required

### **Typical Workload**

- A typical workload for an administrative coordinator is 0.5 FTE for four full-time care managers

### **Requirements Especially Relevant to Federally Qualified Health Centers**

- Experience working with underserved, transient populations and clinical co-morbidities (co-occurring mental health, substance abuse, and physical health problems)
- Expertise in practicing medicine with sensitivity to cultural differences, social stressors, and non-English-speaking patients

# APPENDIX

## Training for COMPASS

Training modules

<http://chpw.org/gau/index.htm>

# TRAINING FOR COMPASS

Training modules for COMPASS implementation can be found at: <http://chpw.org/gau/index.htm>

1. CHPW's Experience in Collaborative Care Models
2. Collaborative Care Evidence and Outcomes
3. COMPASS
4. COMPASS Eligibility and Enrollment
5. Collaborative Care Core Elements and Team Roles
6. Role of the Case Manager (known as Care Coordinator in these modules)
7. Diabetes Education for Case Manager/Care Coordinators
8. Motivational Interviewing
9. Challenges for Case Manager/Care Coordinators
10. Role of the Consulting Physician
11. Systematic Case Review



# APPENDIX

## **Registry Systems**

Care Management Tracking System Overview

Patient Registry (MHITS) Screenshots

*Patient Information Page*

*Clinical Assessment*

*Care Plan*

*Current Patients Caseload*

## Care Management Tracking System (CMTS)

Effective management of chronic health conditions such as depression and diabetes requires a coordinated team and shared information. The Care Management Tracking System (CMTS) is a web-based application that facilitates a shared care plan to collaboratively treat common medical and behavioral health conditions. Using an intuitive user interface, CMTS tracks patient progress and goals, identifies patients who need help, and shares information among the entire care team.

### Delivering Better Care

CMTS supports the core principles of effective integrated care that results in better clinical outcomes, higher patient satisfaction, and lower healthcare costs.



**Patient-Centered Team Care.** CMTS facilitates collaboration between providers and patients using shared care plans that incorporate patient goals.



**Population-Based Care.** CMTS tracks patient populations to prevent patients from falling through the cracks.



**Measurement-Based, Treatment to Target.** CMTS tracks clinical outcomes to cue providers when a consultation or systematic change in treatment is needed.



**Evidence-Based Care.** CMTS structures clinical workflows, and uses validated measurement instruments to track patient progress.



**Accountable Care.** CMTS creates transparency and accountability among treating providers and payers.

### Supporting Patient Goals

CMTS supports a patient-centered approach to health care by allowing clinicians to track on patient goals for a specified timeline and with a validated measurement. Cues and reminders facilitate changes in treatment or consultation, and consulting specialists can efficiently review treatment histories and suggest additional diagnostic or treatment strategies. CMTS

- Quickly assesses and triages an entire caseload
- Allows for consultation on more patients, more easily
- Gets more patients better, faster!

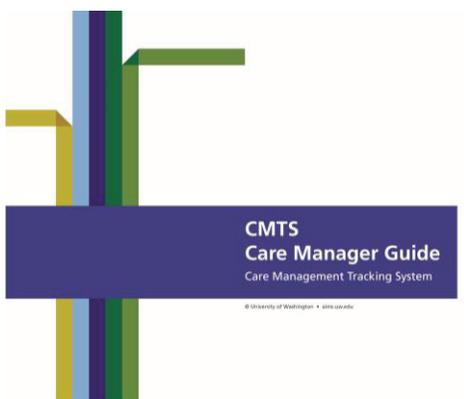
## CMTS Key Functions

- ✓ Provides initial and follow-up contact reminders
- ✓ Flags high-risk patients and indicates when a psychiatric consult is needed
- ✓ Manages a caseload of patients and provides sortable caseload tracking and statistics reports
- ✓ Can be customized to track a variety of common medical and behavioral health problems\*
- ✓ Web-based functionality efficiently shares and coordinates effective patient care across organizations
- ✓ Supports care planning and effective patient encounters
- ✓ Proactively tracks clinical outcomes, cueing providers when a change in treatment is needed
- ✓ Facilitates quality improvement efforts by tracking a defined population of patients
- ✓ Supports the import and export of data
- ✓ Fully HIPPA compliant

\* CMTS has been previously used to track the treatment of depression, anxiety, PTSD, substance use/abuse, hypertension, hyperlipidemia, chronic pain, ADHD, and diabetes.

## Beyond an EMR

CMTS is not a paper or electronic medical record (EMR), nor is it intended to act as a replacement. Medical records are a storehouse of information about a specific patient's care that can be used for clinical, billing, and/or legal purposes. Although some EMRs can use queries or filter functions to cue clinical activities or create specified patients list, most have limited functionality in this regard and need extensive – and oftentimes costly – customization to facilitate the delivery of evidence-based care for specific medical or behavioral health conditions.



## CMTS Support

The AIMS Center offers user guides, video demonstrations, and one-on-one consultations to help clinicians and administrators use CMTS most effectively with the ultimate goal of providing better patient care.

For more information contact [uwaims@uw.edu](mailto:uwaims@uw.edu).

## Patient Registry (MHITS) Screenshots

**Patient Information Page:** contains program and patient demographic information

**Clinical Assessment:** completed at first contact with a patient and includes evaluation of historical and current treatments, social indicators of health, evidence-based screening tools, and initiation of the patient-centered care plan

**Care Plan:** patient-centered care plan tracks patient goals and interventions and can be initiated at assessment and updated at each follow-up visit

**Current Patients Caseload:** interactive patient caseload which displays active patients and their baseline and most recent screener and lab scores in addition to contact and next appointment information and “safety risk” and “psychiatrist consult needed” flags. The caseload can be sorted by first and most recent screener and lab scores to prioritize patients who have not seen improvement. Color-coding of first and most recent screener scores provides a visual queue of improvement.

Patient | Caseload | Tools | Logout
Search Patient : 
Hello, Leslie (Ibrooks-CC)

## PATIENT INFORMATION

**Program Information**

Population : \*  MH/BH  MH/BH (Non-CHP)  Children  CHPW Health Home  CHPW-ESHCN  CMI  COMPASS  FFS Health Home  Moms  Older Adults  Pain Pilot

SBIRT  SIF  Uninsured  Veteran Family Members  Veterans

L1 Clinic : \*

MHITS ID : \*

Care Coordinator : \*

L1 MRN : \*

Enrollment Date : \*  /  /

Primary Care Provider :

**Patient Demographic Information**

Last Name : \*

Date of Birth : \*  /  /

Race :

E-mail :

First Name : \*

Gender :

Ethnicity :

Language (Interpreter Needed) :

**Patient Phones**

PHONE NUMBER	TYPE	BEST TIME TO CALL	RANK
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Patient Addresses**

Type :

Street :

City :  State :  ZIP :

**Emergency Contacts**

Emergency Contact 1 :

Phone 1 :

Relationship :

Emergency Contact 2 :

Phone 1 :

Relationship :

Phone 2 :

# CLINICAL ASSESSMENT

Date of Contact : \*  /  /

## Patient Concerns

History

Describe patient's report of symptoms and their effects on functioning and health.

## Prior Behavioral Health Treatment

Inpatient Hospitalization  Outpatient Mental Health Treatment / Psychotherapy  Inpatient Substance Use Tx  Outpatient Substance Use Tx

Describe Prior Mental Health Tx :

Describe Prior Substance Use Tx/Attempts to Reduce :

## Past Medications

NAME	DAILY DOSE	DURATION	HOW LONG AGO	EFFICACY	SIDE EFFECTS
<input type="text"/>					
<input type="text"/>					
<input type="text"/>					
<input type="text"/>					

## Current Medications

\*  Confirmed with the patient  Confirmed in the patient's medical record  Deferred

NAME	DOSAGE	START DATE
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/> <input type="button" value="today"/> <input type="button" value="📅"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/> <input type="button" value="today"/> <input type="button" value="📅"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/> <input type="button" value="today"/> <input type="button" value="📅"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/> <input type="button" value="today"/> <input type="button" value="📅"/>

## Medication Questions

Side Effects :

ASA Contraindication :

Yes  No

## Significant Medical Problems and History

History

## Social History

Education :

Employment :

Family & Culture :

include significant others and domestic partnerships

Personal :

include trauma, abuse, and other significant life events

Legal History :

Current Supports :

## Barriers to Self Care - Basic Needs / Social Supports

Living situation :

Lives with :

Concerned about housing situation :

Yes  No

Have dependable transportation :

Yes  No

Have someone who can help :

Yes  No

Employment Status :

## Housing Situation

History

**Mental Status Examination**

history

**Outcome Measures (select which measures should appear in this note)**

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> PHQ-9 Depression Scale      | <input type="checkbox"/> GAD-7 Anxiety Scale                                 |
| <input type="checkbox"/> Global Assessment of Functioning Scale | <input type="checkbox"/> CIDI-based Bipolar Disorder Screening Scale         |
| <input type="checkbox"/> Mood Disorder Questionnaire            | <input type="checkbox"/> Internal State Scale                                |
| <input type="checkbox"/> PCL PTSD Screener                      | <input type="checkbox"/> PEG Pain Scale                                      |
| <input type="checkbox"/> Domestic Violence                      | <input type="checkbox"/> The Alcohol Use Disorders Identification Test       |
| <input type="checkbox"/> Drug Abuse Screening Test              | <input type="checkbox"/> Global Appraisal of Individual Needs-Short Screener |
| <input type="checkbox"/> Patient Activation Measure             | <input type="checkbox"/> Caregiver Activation Measure                        |
| <input type="checkbox"/> KATZ ADL                               |  |

**PHQ-9 Depression Scale (Score: )**

history

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
10. If you checked off <u>any</u> problems on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Not difficult at all <input type="radio"/> 0	Somewhat difficult <input type="radio"/> 1	Very difficult <input type="radio"/> 2	Extremely difficult <input type="radio"/> 3	

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**Labs and Vitals**

	CURRENT VALUE	DATE
HbA1c	<input type="text"/> %	<input type="text"/> today <input type="button" value="⌵"/>
Blood Pressure - Systolic	<input type="text"/> mmHg	<input type="text"/> today <input type="button" value="⌵"/>
Blood Pressure - Diastolic	<input type="text"/> mmHg	<input type="text"/> today <input type="button" value="⌵"/>
LDL Cholesterol	<input type="text"/>	<input type="text"/> today <input type="button" value="⌵"/>
BMI	<input type="text"/>	<input type="text"/> today <input type="button" value="⌵"/>

**Smoking Status**

- Yes  No

**Safety/Risk Assessment**

**Past Suicide Attempts :**  Yes  No

**Safety Concerns :**

**Flag as Safety Risk?**

**Summary of Problems**

history

**Working Diagnoses \***

- |   |                                       |   |   |  |   |
|---|---------------------------------------|---|---|--|---|
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Anxiety      | <input type="checkbox"/> Alcohol / Substance Abuse  | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> PTSD          | <input type="checkbox"/> Psychotic Disorder       |
| <input type="checkbox"/> Cognitive Disorder | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Rule Out Axis II Diagnosis | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Congestive Heart Failure |
- Other:

Pending

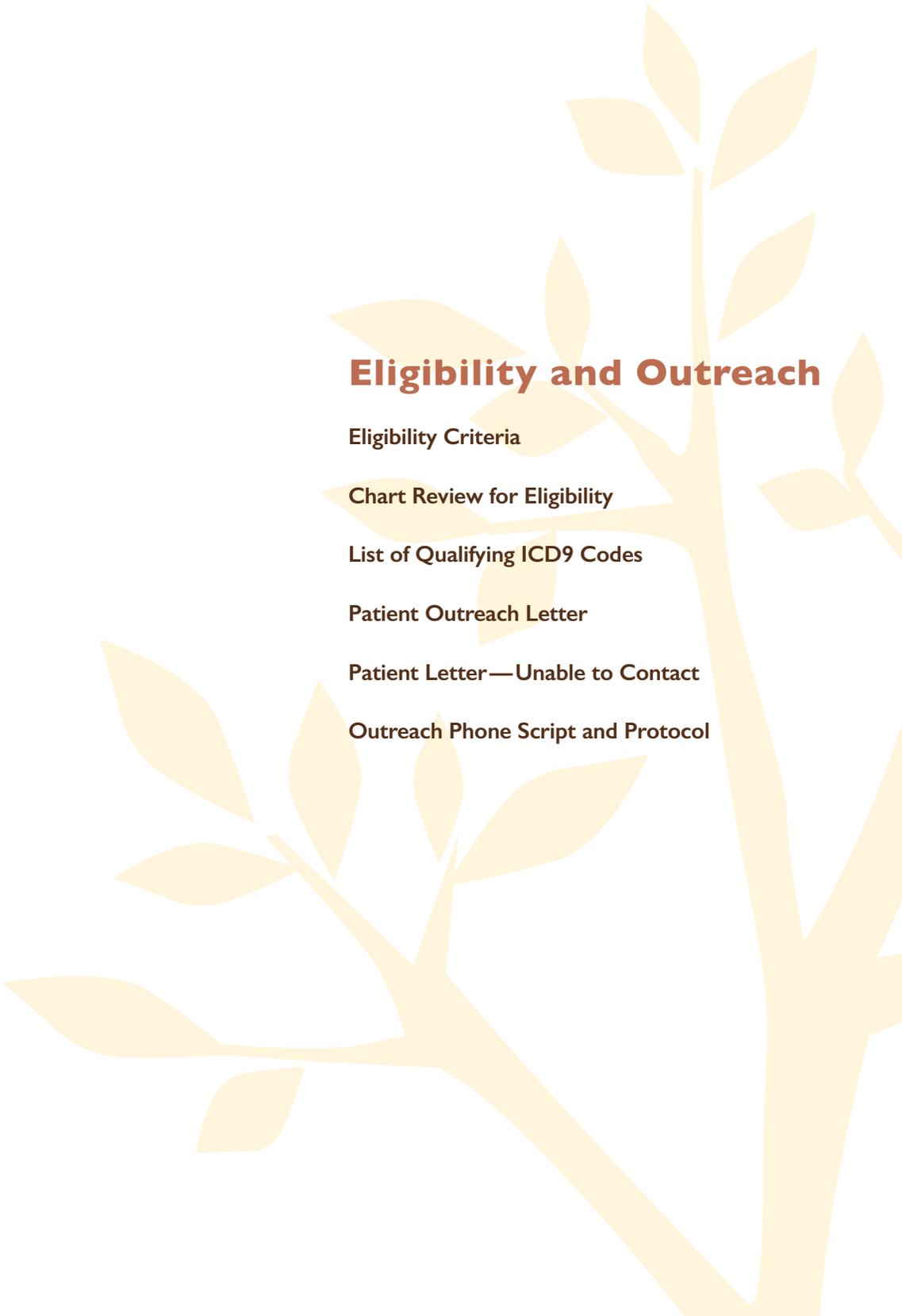
**Care Plan**

Add another problem/goal

**Additional Comments**



# APPENDIX



## **Eligibility and Outreach**

Eligibility Criteria

Chart Review for Eligibility

List of Qualifying ICD9 Codes

Patient Outreach Letter

Patient Letter—Unable to Contact

Outreach Phone Script and Protocol

## Eligibility Criteria

### A) Eligibility for COMPASS

- Adult patients with Medicare or Medicaid insurance (for Neighborcare Health, membership in a CHPW Medicaid or Medicare health plan was also required)
- **AND** sub-optimally managed depression, as defined by the criteria below
- **AND** treatable, sub-optimally managed diabetes or cardiovascular disease, as defined by the criteria below:

#### Criteria

- PHQ-9 > 9

#### AND at least 1 of the following:

- A diagnosis of DIABETES with one of the following:  
A1C ≥ **8.0%**  
OR systolic blood pressure (SBP) ≥ 145 mm Hg  
OR low density lipoprotein (LDL) ≥ 100 mg/dl
- Existing cardiovascular disease (CVD) (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 > 65 years and old with uncontrolled hypertension (SBP >160)
- Recent hospitalization related to diabetes or cardiovascular disease

### B) Ways to identify eligible CHPW Medicare or Medicaid patients

- Electronic Health Record Query
  - Depression diagnosis
  - Diabetes diagnosis
  - Diabetes and A1C > 8.0%
  - OR Diabetes and SBP > 145mmHg
  - OR Diabetes and LDL > 100ml/dl
  - Existing CVD (hx of ischemic heart disease, coronary heart disease, CHF, or stroke)
  - Existing CVD AND SBP ≥ 145 mmHg
  - Existing CVD AND LDL ≥ 100 ml/dl
- Additional referral from clinic team members
  - Diabetes educator, primary care provider team, patient representatives, nurses, medical assistants
- Registries
  - Diabetes panels
  - Cardiovascular disease panels
  - Depression registry
- Automated Data (claims) or Notification by facility
  - Hospital discharges
  - Emergency Department visits

## Chart Review for Eligibility

**1. Check Clinical Lab Values and Diagnoses** for evidence of substantial chronic disease in poor control.

Lab Values: A1C (>8), BP (SBP >160, DBP>100), LDL (>100 for CVD or >130 for DM).

If CAD (aka ischemic, aka atherosclerosis if related to coronary arteries), view patient's most recent cardiology consult and look for the following: cardiac catheterization, stent, CABG, h/o STEMI (ST segment Elevation Myocardial Infarction) or Non-STEMI. If you find any of this language, YES (patient qualifies)- if not present, you may need to send a communication to PCP to request clarification of diagnosis. If unable to obtain cardiac consult, NO (patient does not qualify).

If CHF (aka cardiomyopathy), view patient's most recent cardiology consult and look for the following: 2D echocardiogram, CHF, and/or heart failure or ejection fraction, If ejection fraction <50% then YES, if greater than 50% NO.

If CVA (aka stroke), view most recent neurology consult or MRI report and look for the following: CVA, chronic infarcts. If present, YES.

If DM, be sure that patient has one of the following to confirm: Diabetes diagnosis, A1C >8, currently on DM medications.

**2. Check most recent PHQ-9 results (if applicable)**

If >9, YES. If <9, NO. If there are no PHQ-9 results for the patient in EMR, mail a questionnaire to the patient or complete one over the phone with them to see if they qualify.

**3. Check that patient's current insurance is eligible.**

**4. Send COMPASS introduction letter to those who qualify.**

Patients qualify based on diagnoses, lab values, PHQ-9, AND insurance.

Start calling patients around 1 week after sending letter to assess if they have questions or would like to schedule an appointment for Care Management.

**5. Schedule Initial Health Assessment (IHA) with a Care Manager.**

Send a communication to the Care Manager to inform them of the appointment and the patient's qualifying criteria.

Add the patient to the Care Manager's caseload in the Medical and Mental Health Integrated Tracking System.

If the patient would like a reminder call for IHA, call them the business day before the appt.

**6. For IHA no-shows, attempt to call the patient up to three times and send an additional letter. If still no response, remove from list.**

If there is no accurate address or phone number in the EMR, request that front desk staff update when patient comes into the clinic, and have them notify COMPASS staff if patient arrives at clinic.

## ICD-9 Codes for Relevant Conditions

For Patient Proactive Identification of Target Conditions for COMPASS

### Diabetes

250.00	DMII WO CMP NT ST UNCNTR
250.50	DMII OPHTH NT ST UNCNTRL
250.01	DMI WO CMP NT ST UNCNTRL
250.51	DMI OPHTH NT ST UNCNTRLD
250.02	DMII WO CMP UNCNTRLD
250.52	DMII OPHTH UNCNTRLD
250.03	DMI WO CMP UNCNTRLD
250.53	DMI OPHTH UNCNTRLD
250.10	DMII KETO NT ST UNCNTRLD
250.60	DMII NEURO NT ST UNCNTRL
250.11	DMI KETO NT ST UNCNTRLD
250.61	DMI NEURO NT ST UNCNTRLD
250.12	DMII KETOACD UNCONTROL
250.62	DMII NEURO UNCNTRLD
250.13	DMI KETOACD UNCONTROL
250.63	DMI NEURO UNCNTRLD
250.20	DMII HPRSM NT ST UNCNTRL
250.70	DMII CIRC NT ST UNCNTRLD
250.21	DMI HPRSM NT ST UNCNTRLD
250.71	DMI CIRC NT ST UNCNTRLD
250.22	DMII HPROSLR UNCONTROL
250.72	DMII CIRC UNCNTRLD
250.23	DMI HPROSLR UNCONTROL
250.73	DMI CIRC UNCNTRLD
250.30	DMII O CM NT ST UNCNTRLD
250.80	DMII OTH NT ST UNCNTRLD
250.31	DMI O CM NT ST UNCNTRLD
250.81	DMI OTH NT ST UNCNTRLD
250.32	DMII OTH COMA UNCONTROL
250.82	DMII OTH UNCNTRLD
250.33	DMI OTH COMA UNCONTROL
250.83	DMI OTH UNCNTRLD
250.40	DMII RENL NT ST UNCNTRLD
250.90	DMII UNSPF NT ST UNCNTRL
250.41	DMI RENL NT ST UNCNTRLD
250.91	DMI UNSPF NT ST UNCNTRLD

250.42	DMII RENAL UNCNTRLD
250.92	DMII UNSPF UNCNTRLD
250.43	DMI RENAL UNCNTRLD
250.93	DMI UNSPF UNCNTRLD

### Depression

296.2	Major Depression, single episode
296.3	Major Depression, recurrent
300.4	Dysthymia

### Hypertension

401.0, 401.1, 401.9

### LDL

410-414.9, v45.81, v45.82

### Ischemic Vascular Disease

410-410.92	Acute Myocardial Infarction (AMI)
411-411.89	Post Myocardial Infarction Syndrome
412	Old AMI
413-413.9	Angina Pectoris
414.0-414.07	Coronary Artherosclerosis
414.2	Chronic Total Occlusion of Coronary Artery
414.3	Atherosclerosis due to lipid rich plaque
414.8	Other Chronic Ischemic Heart Disease (IHD)
414.9	Chronic IHD
429.2	Cardiovascular (CV) disease, unspecified
433-433.91	Occlusion and stenosis of pre-cerebral arteries
434-434.91	Occlusion of cerebral arteries
440.1	Atherosclerosis of renal artery
440.2-440.29	Atherosclerosis of native arteries of the extremities, unspecified
440.4	Chronic Total Occlusion of Artery of the Extremities
444-444.9	Arterial embolism and thrombosis
445-445.8	Atheroembolism

## Heart Failure

428.0	CONGESTIVE HEART FAILURE UNSPECIFIED
428.1	LEFT HEART FAILURE
428.20	UNSPECIFIED SYSTOLIC HEART FAILURE
428.21	ACUTE SYSTOLIC HEART FAILURE
428.22	CHRONIC SYSTOLIC HEART FAILURE
428.23	ACUTE ON CHRONIC SYSTOLIC HEART FAILURE
428.30	UNSPECIFIED DIASTOLIC HEART FAILURE
428.31	ACUTE DIASTOLIC HEART FAILURE
428.32	CHRONIC DIASTOLIC HEART FAILURE
428.33	ACUTE ON CHRONIC DIASTOLIC HEART FAILURE
428.40	UNSPECIFIED COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
428.41	ACUTE COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
428.42	CHRONIC COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
428.43	ACUTE ON CHRONIC COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
428.9	HEART FAILURE UNSPECIFIED

<b>Cardiovascular Procedure</b>	<p>ICD procedure codes: 00.66 36.01 – 36.99</p> <p>CPT codes: 33510 – 33523, 33533-33536, 33572, 92980, 92981, 92982, 92984, 92973, 92974, 92975, 92977, 92995, 92996</p>
<b>Cerebrovascular Procedure</b>	<p>ICD procedure codes: 00.61, 00.62, 00.63, 00.64, 00.65, 39.22, 39.28</p> <p>CPT codes: 35390, 35301, 35501, 35506, 35508, 35509, 35510, 35515, 35526, 35601, 35606, 35642, 35645</p>

Date \_\_\_\_\_

Dear \_\_\_\_\_,

We are writing to tell you about a new Care Management program that you qualify for at \_\_\_\_\_. Care Management can help improve the health of patients like you who have Diabetes and/or Heart Disease. We want to offer this program to patients who might need extra help managing these health problems.

This Care Management program is completely free to you, and allows you to work closely with a Care Manager, who is a Nurse or Social Worker. The Care Manager can assist you in figuring out ways to make changes to your health, ensure that all your care providers understand your needs, and help you deal with some of the stresses that may be interfering with getting better. Your Primary Care Provider (PCP), \_\_\_\_\_, would like you to consider this program, though it is voluntary. This program is in addition to the care you receive from your PCP, who will still be your main provider.

If you have any questions about Care Management or if you are interested in scheduling your first appointment with a Care Manager, please call the program's Administrative Coordinator, at \_\_\_\_\_. They can tell you more about the program and schedule your initial interview if you are interested. If we do not hear from you, we will call you within 2 weeks to follow up and see if you would like to schedule an appointment. Thank you for considering this new program, and for choosing \_\_\_\_\_.

Sincerely,

Your \_\_\_\_\_ Primary Care Team

Date

Dear \_\_\_\_\_,

On ##/##/##, you completed a health assessment as part of our Care Management program for patients with complex medical conditions. You spoke with a Care Manager a few times to follow up, the last of which was on ##/##/##. I would like to continue working with you regarding the health concerns you and your Primary Care Provider have identified to create a personal health care plan for you.

I have tried to contact you by phone to discuss your health care plan but have not been able to reach you. Please call me at (###) ###-#### to let me know if you would like to continue receiving services through our Care Management program.

You can also call (Clinic Name) at (###) ###-#### to update your contact information.

Sincerely,

(Name), Care Manager

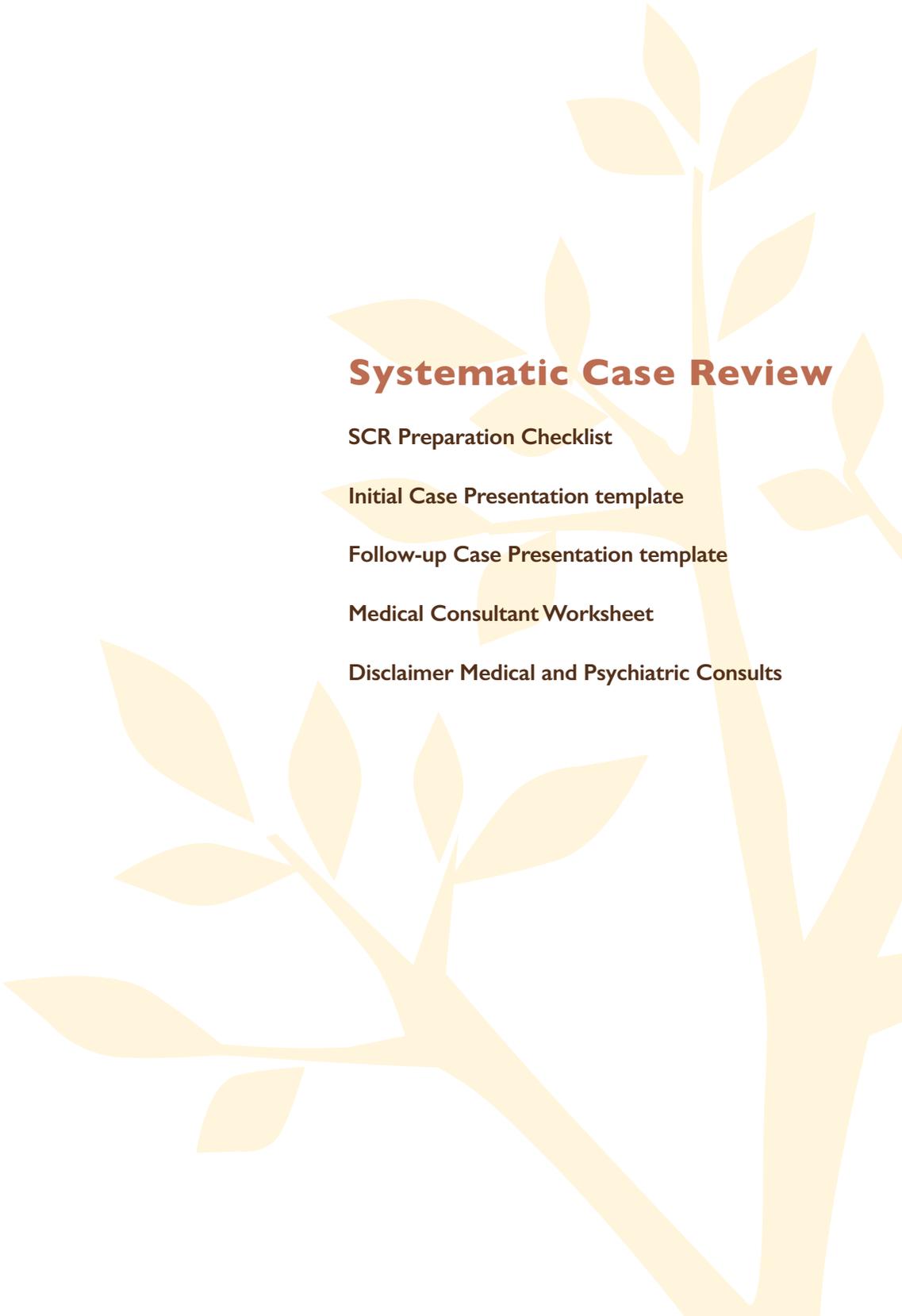
## Outreach Phone Script and Protocol

<b>Before Calling:</b>	<ul style="list-style-type: none"> <li>■ Check HIPPA document; allowed to leave voicemail?</li> </ul>			
	<ul style="list-style-type: none"> <li>■ Do they still qualify? If the month has changed over, check insurance; if they have had another appointment, double-check labs.</li> </ul>			
<b>If NO pick-up:</b>	<ul style="list-style-type: none"> <li>■ <b>If detailed message IS permitted according to HIPPA doc, leave voicemail:</b>   <b>Staff:</b> “Hi my name is _____, I am calling from _____ about the COMPASS Care Management program. We sent you a letter about the program in the mail, and I was just calling to see if you got the letter, if you were interested in participating, or if you had any questions. In any case, even if you are not interested or did not receive the letter, please give me a call back at _____.”</li> </ul>			
	<ul style="list-style-type: none"> <li>■ <b>If message IS NOT permitted according to HIPPA doc, hang up.</b>            In either case, document your call in spreadsheet &amp; EHR: “Called patient re: Care Management on (date); left voicemail asking for call back.”</li> </ul>			
<b>If pick up:</b>	<b>Staff:</b> “Hello, my name is _____ and I’m calling from _____. Is this (patient’s name)?”			
	<b>Response:</b>	If yes, proceed.  ▼ ▼ ▼ ▼	If no and HIPPA doc allows, leave message.	If not, thank the person and end the call. If they persist in asking why you are calling, just say, “I am sorry but I am only authorized to discuss with the patient.”
	<b>Staff:</b> “I am calling about the COMPASS Care Management program. We sent you a letter in the mail and I’m just calling to see if you got the letter, if you were interested, or if you had any questions. Did you get that letter?”			
	<b>Response:</b> If yes, ask if they have time for you to describe the program and see if it would be of interest to them. Discuss the letter, any questions, etc. If patient did not receive it, confirm that you have the correct address.			

	<p><b>Describing the COMPASS program:</b></p> <ul style="list-style-type: none"> <li>■ Care management program, free with your insurance, voluntary</li> <li>■ Partner with a Care Manager (who is a Nurse or Social Worker) to help you manage the care of your chronic health conditions. Care Manager provides extra support by checking in on you and giving you info and resources. You can discuss your health goals and any challenges that are affecting your health.</li> <li>■ The Care Manager regularly reviews your care and gives extra attention if your results are not improving.</li> <li>■ They will work with you and your primary care team to keep all of your healthcare providers in the loop about your health, and will also be working with a consulting primary care doctor and psychiatrist to see if they have any recommendations for your care.</li> <li>■ Eventually, ask if this seems of interest to them or if they are content with their care as is, or if they have any other questions.</li> </ul>	
	<p><b>If yes, schedule:</b></p> <ul style="list-style-type: none"> <li>■ Add appointment to Care Manager’s schedule.</li> <li>■ Document call in EHR and spreadsheet.</li> <li>■ Enter patient into MHITS or “start new episode” if they are already in MHITS and are not discharged from their current episode, and add the Care Manager to their provider list.</li> <li>■ Task Care Manager to alert them of upcoming appointment.</li> </ul>	<p><b>If no, document:</b></p> <p>Thank them and end the call. Document their decision in EHR and spreadsheet. Try to discern if you might want to try them again in a few months or if it’s a No Forever.</p>
	<p><b>Other situations:</b></p> <ul style="list-style-type: none"> <li>■ The patient may want to discuss with their PCP first. If so, check to see if they have an upcoming appointment. If not, encourage them to schedule one.</li> <li>■ If the patient is planning on moving or changing clinics, make a note but don’t put them in the “No Forever” category, as patient’s plans often change.</li> <li>■ If the patient becomes upset that we are offering them too many things, apologize and explain that it is a voluntary program offered to patients who might appreciate the support, but we are in no way pressuring them to participate.</li> <li>■ If the patient says that they would like their friend or family member to participate too, you can get their name and see if they are eligible and get back to them.</li> </ul>	



# APPENDIX

A large, stylized tree graphic in a light beige color, positioned on the right side of the page. The tree has a thick trunk and several branches with simple, rounded leaves. It is partially overlaid by the text of the 'Systematic Case Review' section.

## **Systematic Case Review**

SCR Preparation Checklist

Initial Case Presentation template

Follow-up Case Presentation template

Medical Consultant Worksheet

Disclaimer Medical and Psychiatric Consults

## SCR Preparation Checklist

### SCR Patient Prioritization:

1. New Admissions to the COMPASS program
2. ER visit or hospitalization in the last week
3. Indicators not improving (see criteria):
  - A1C >8 and not improving for 2 consecutive values.
  - PHQ-9 >15
  - SBP >160
4. Not reviewed in the last 3 months- even if doing well, adhering to care plan, and improving on indicators
5. Case manager discretion: concerns, barriers, successes, updates on recommendations
6. Ready for discharge

### Information to Present at SCR:

1. Most current lab values for A1C (also include A1C range over the last 6 months), Microalbuminuria, GFR (note race distinction), and LDL, plus most recent BP and BMI. Include dates each was obtained.
2. Most recent PHQ-9 and PHQ-9 range for last 3 values
3. Wrap around medications- Is the patient taking an Aspirin, Statin, and/or an ACE/ARB or Beta Blocker?
4. Medications and dosage the patient is prescribed for control of DM, CAD/CHF, and/or Depression or other mental health diagnoses.

### Template for Recording Data as SCR Prep

A1C= (date)		A1C range for last 6 months=		Microalbuminuria= (date)	
GFR= (date)	LDL= (date)	BP= (date)	BMI= (date)		
PHQ9= (date)		Range=			
Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No		Statin? <input type="checkbox"/> Yes <input type="checkbox"/> No		ACE/ARB or Beta Blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Meds for DM:					
Meds for CAD/CHF:					
Meds for Psych:					
Other Meds to Discuss:					

### Initial Case Presentation

ASSESSMENT DATE		IN PERSON		PHONE	
NAME			MHITS #		AGE
ETHNICITY	IMMIGRANT/REFUGEE	INSURANCE			
COMPASS DX			OTHER DX		
CARE MGR	PCP	SITE		LAST PCP VISIT	
OUTSIDE PROVIDERS/PRESCRIBER & LAST VISITS					
<b>Depression:</b>					
Current Rx	PHQ-9	GAD-7		Date of First Dx	
Past Rx Results of Tx					
HX OF DEPRESSION— PT/FAMILY • IP/OP tx hx • Hx SA • Family System					
SELF- MGMT OF DEPRESSION • Functioning • Stressors					
<b>Diabetes:</b>					
CURRENT RX/LABS	A1C	A1C Range	GFR	Creatinine	BMI
	B/G	MALB <input type="checkbox"/> Yes/No	<input type="checkbox"/> BP at Target		BP range x6mos
	LDL ___ACE or ARB <input type="checkbox"/> Yes/No		Statin <input type="checkbox"/> Yes/No		ASA <input type="checkbox"/> Yes/No
CONCERNS/ MGMT OF DIABETES • Hx of DM • Diet/exercise/ Self-Monitor					

<b>CVD/CAD/ CVA/CHF:</b> Current Rx	<input type="checkbox"/> BP at Target	BP range x6mos	LDL	BMI	
	Statin <input type="checkbox"/> Yes <input type="checkbox"/> No	ASA <input type="checkbox"/> Yes <input type="checkbox"/> No	ACE or ARB <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>HX OF DX:</b> <ul style="list-style-type: none"> <li>• Complications</li> <li>• Concerns</li> </ul>					
<b>Hx of Procedures or Diagnostics</b>	CABG	Stent	STEMI	Non-STEMI	AMI
	EF Fraction	2D Echocardiogram	Chronic Infarcts		CVA
<b>Concerns/Mgmt of CD</b>					
<b>Chemical Dependency/ Tobacco:</b> <ul style="list-style-type: none"> <li>• Drugs of choice</li> <li>• Last use</li> </ul>					
<b>IP/ER Hx:</b> <ul style="list-style-type: none"> <li>• Dates</li> <li>• Presenting Problem</li> </ul>					
<b>PT STRENGTHS:</b> <ul style="list-style-type: none"> <li>• Motivations</li> <li>• Supports</li> </ul>					
<b>RX DETAIL:</b> <ul style="list-style-type: none"> <li>• Other Rx</li> <li>• Overall Adherence Level</li> </ul>	<input type="checkbox"/> MEDI-SET    OPIOID INFO				
<b>TX PLAN:</b>	PT GOALS				
	TX GOALS:				

**Consult Recommendations:**

--	--

**TASKS FOR CM:**

--	--



### Follow-up Case Presentation

PATIENT/MHITS ID:		PCP/CLINIC:	
AGE: RACE/ETHNICITY: RELEVANT DX'S:			LAST/NEXT PCP VISIT:
<b>DEPRESSION</b>  PHQ-9:  DATE:	MEDICATIONS:	CMHC:  PROVIDER(S):	GAD-7:
<b>DIABETES</b>  A1C:  DATE:	MEDICATIONS:  ASA:                      STATIN:	GFR:  MICROALBUMINURIA:	SELF MANAGEMENT GOAL:  MED ADHERENCE:
<b>HEART DISEASE</b>  LDL:  DATE:	RECENT BP:  DATE:  BP RANGE:	MEDICATIONS:  ACE/ARB:                      BB:	BMI:
RECOMMENDATIONS:			
NEXT STEPS:			

## Medical Consultant Worksheet

Patient Name:  
DOB:  
PCP/Medical Home:  
Care Manager:  
Date History Taken:  
Last PCP Appointment:

Brief History:

Other diagnoses include:

Medications:

Specialty Care (active):

Recent Hospital Admission or ED Visit - When and Why:

Insurance Status and Source of Income:

Mental Health and Social History:

Primary Mental Health Diagnosis:  
Community-Based Mental Health Home:  
Last PHQ-9 - Result and Date:  
Last GAD-7 - Result and Date:  
Drug and Alcohol History:

Social Network:

Stressors:

Housing:

Support and Contact Info:  
Patient's Interests/Activities:



Patient Activation Measure (PAM):

Care Manager has identified the following principle barrier(s) to achieving targets for mental health and diabetes care:

- 1.
- 2.

COMPASS Focus:

Patient's Primary Health Goal:

Disease Assessment by Problem:

- 1.
- 2.
- 3.
- 4.
- 5.

**Recommendations:**

For Primary Care Provider:

- 1.
- 2.
- 3.
- 4.

For Primary Care Team:

(E.g., adding diagnoses to chronic problem list, recommended labs)

For COMPASS Care Manager:

- 1.
- 2.



**Disclaimer script for use in the Electronic Health Record to message the Primary Care Provider with recommendations from the Medical and/or Psychiatric Consultant**

The above treatment considerations and suggestions are based on consultation with the patient's care manager and a review of information available in the Medical and Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.

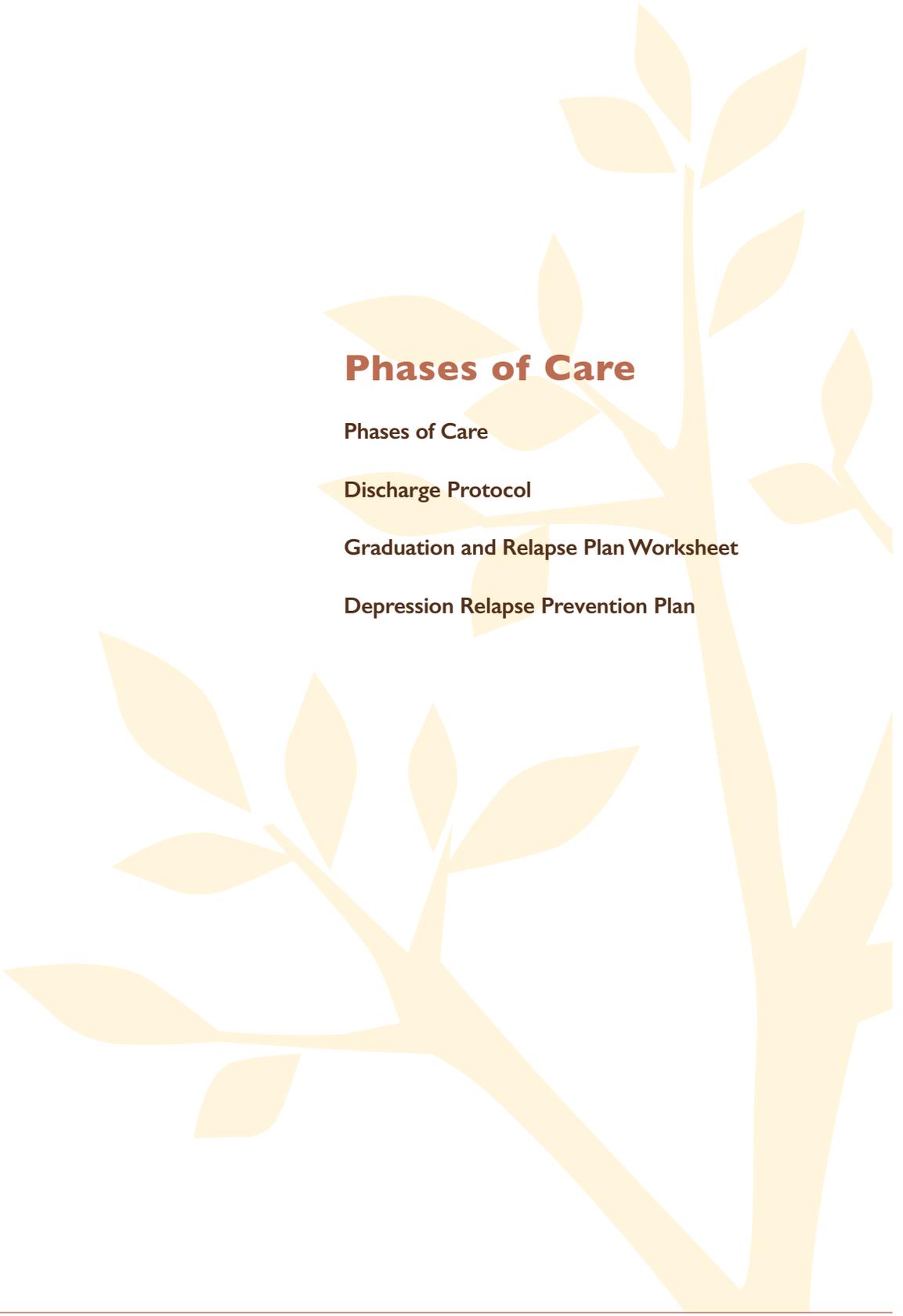
XXX XXX, Consulting Physician

Telephone:

E-mail:



# APPENDIX



## **Phases of Care**

Phases of Care

Discharge Protocol

Graduation and Relapse Plan Worksheet

Depression Relapse Prevention Plan

## COMPASS Phases of Care

### Engagement

**Goal:** To encourage patients to enroll in program, identify their health challenges related to, or in addition to, the COMPASS criteria, and commit to regular visits with the Care Manager.

**Duration:** up to 3 months of contact attempts

**Eligibility:** all COMPASS eligible patients (see **Eligibility Criteria**)

### Intensive Involvement

**Goal:** To meet at least 2 x month with Care Manager, clarify diagnoses, develop health goals, increase patient health literacy, identify and address major barriers to self-care, connect and coordinate with external providers (CMHC, specialists, home care), make intensive treatment adjustments.

**Duration:** 6 – 12 months depending on patient ability to learn and implement self-management activities

**Eligibility:** all COMPASS eligible patients who agree to engage

### Maintenance/Continuation

**Goal:** Increase patient's self-reliance and self-care, continue to identify new health goals that can be met during this phase, decrease involvement with Care Manager to 1 x every 4 to 6 weeks.

**Duration:** 3 – 6 months depending on patient ability to reliably implement self-management activities

**Eligibility:** Patient has sustained progress on clinical and personal goals. Patient has been practicing and demonstrating self-management of depression, glucose and blood pressure.

Schedule is established for PCP team follow-up and clinical monitoring intervals.

## Graduation

**Goal:** Return patient to standard chronic care with robust Relapse Prevention Plan

**Duration:** N/A

### Eligibility:

#### Depression parameters:

PHQ9 <9 for 2 months

OR PHQ9 score reduction of  $\leq 10$  with sustained reduction for at least one month AND medical targets have been reached and sustained for the appropriate amount of time

#### Diabetes parameters:

TWO A1C values of <8 in 3 months and depression is well-controlled (see above)

#### CVD parameters:

On statin as well as other evidence-based recommended medications  
AND no exacerbations (CHF, MI, CVA) for 3 months

BP at goal X 2 at least one month apart.

**If maintenance is sustained for 6 months:** Patients will graduate back to the care of their PCP team. The following elements will be recorded in the EMR, documented for the patient's use, and shared with the PCP team:

1. Chronic Disease Management plan
2. Red flags/triggers that have been identified in conjunction with the patient
3. Patient's goals
4. Patient's description of barriers that they have faced in achieving their goals
5. Explanation from patient regarding why they think they improved

See Graduation Worksheet

## Discharge

**Goal:** To either reduce unnecessary contact attempt time by Care Manager, or to return patient to usual care.

**Duration:** variable

**Eligibility:** See **Discharge Protocols**

## Discharge Protocols

### COMPASS Continued Care Plan Protocol

#### **COMPASS Discharge Protocol for Patients WITH a completed Clinical Assessment**

Before discharging the patient you need to:

- Make 3 phone calls over 1 month period (unless phone is disconnected)
- Send a letter explaining that the Care Manager was unable to contact them
- Put an alert in the EMR asking the patient to contact the Care Manager
- Send a communication to the PCP asking for support in connecting with the patient
- Make phone calls to any external providers – CMHC, Housing Case Manager, ORT provider, specialists, etc.

If all above is completed and there has been no patient contact:

- Make 1 call each month for 3 months, or send 1 letter and make 1 call to attempt to re-connect with the patient
- If there is no PCP visit scheduled within the next 3 months, discharge the patient

#### **COMPASS Discharge Protocol for Patients WITHOUT Clinical Assessment**

(Administrative Coordinator does this, as no contact with Care Manager has occurred)

- Make 3 phone calls over a 1 month period (unless phone is disconnected)
- Send 1 letter explaining COMPASS and requesting a phone call from the patient
- Put an alert in the EMR for staff to inform the patient to contact the Care Manager
- Send a communication to the PCP asking for support in contacting the patient
- Look for upcoming PCP appointments and attempt to meet with the patient while they are in the clinic.

If all of the above is completed, discontinue outreach attempts to the patient regarding Care Management.

## Patient Graduation Worksheet

STARTING VALUE	CURRENT VALUE	GOAL/TARGET
DEPRESSION SCORE: *** BP: *** HGB A1C: *** WEIGHT: *** LDL: ***	DEPRESSION SCORE: *** BP: *** HGB A1C: *** WEIGHT: *** LDL: ***	DEPRESSION SCORE: *** BP: *** HGB A1C: *** WEIGHT: *** LDL: ***

### WHAT SUCCESSES DID YOU HAVE?

- 1) \*\*\*
- 2) \*\*\*

### WHAT WILL YOU CONTINUE TO WORK ON?

- 1) \*\*\*
- 2) \*\*\*

What do you think contributed to your success?	
What are some specific challenges that affected you?	
How do you feel about your progress?	

## Your Relapse Prevention Plan

What are my warning signs to alert me that I may be relapsing?	
What are some of the things I can do to prevent a relapse?	
How will I remind myself to use these skills daily?	
When do I need to contact my health care team?	

## Patient Depression Relapse Prevention Plan

### What is Relapse?

Relapse is having depression again, after you have gotten well. Most people with depression get better within several months or even within a few weeks after they start treatment. That is the good news.

The bad news is that over half of those who get well will have depression again. To keep depression from coming back, practice good self care every day, even after you are well.

Depression is easier to treat before it gets so bad that you can't function. Understand and be on guard for your early warning signs of depression. If you see signs of depression again, take action right away.

### What are early warning signs of depression?

Early warning signs of depression are the first symptoms you feel when you start the spiral of depression.

Some early warning signs might be:

- You don't want to answer the phone.
- You say no when your friends want to do things with you.
- You feel sad or tearful.
- You exercise less.

### Diabetes and Heart Disease can also relapse after a period of good control

The Graduation Worksheet is designed to help you identify those early warning signs that are unique to you and self-care activities that have worked well for you in the past. Please take a few moments to work with the Care Manager to complete it, and keep it in a place where you can see it every day.

# APPENDIX



## **Care Manager Tools**

Initial Clinical Assessment

Care Manager Visit Summary and Patient Plan

Letter to Mental Health Provider

Patient Blood Glucose Tracking Worksheet

Morisky 8-Item Medication Adherence Questionnaire

## Initial Clinical Assessment

<b>Patient Concerns:</b>				
Tell me about your health. How would you describe your health, overall?				
How do you take care of your [chronic health condition]? How does it affect you from day to day?				
What do you do for fun? What kind of physical activity do you do? What is your diet like?				
<b>Significant Medical Problems and History:</b>				
List of patient's Chronic Problems:				
When did the patient last go to the hospital? What was it for?				
Where else has the patient been getting medical care?				
<b>Current Medications and Adherence Profile:</b>				[Review medication list with patient; refer to medications by name.]
What do you take this for? How many times per day? What is the dose?				
You're taking several different medications. How do you organize and keep track of them?				
0 = N/A, not complicated	1 = Reliable system	2 = Somewhat reliable system	3 = Poor System	4 = No system
Taking medicine every day is a real inconvenience for some people. How often in the last week did you forget to take all your medications?				
0 = Never	1 = Rarely	2 = Sometimes	3 = Usually	4 = All the time
Have you ever cut back or stopped taking your medicine without telling your doctor for any reason?				
0 = Never	1 = Rarely	2 = Sometimes	3 = Usually	4 = All the time
<b>TOTAL MED ADHERENCE SCORE =</b>				
What other concerns do you have about your medications?				
Aside from your PCP, who else prescribes medications for you?				

<b>Prior Mental Health Treatment:</b>
Have you ever received mental health services like counseling or therapy?
[If yes,] Who do you see for mental health services?
[Record name and contact information for prescriber and case manager. Obtain ROI.]
Complete <b>Social History, Income, Housing, Transportation</b> as appropriate, noting any patient concerns.
<b>Screening Questionnaires (PHQ-9, GAD-7, GAIN-SS):</b>
We know that feeling down or anxious can have an effect on your health. Would you be willing to answer a few questions about your mood and stress level to help us better understand how these things could be affecting your health? [Complete the questionnaires.]
<b>Summary of Problems/Care Plan:</b>
We've covered a lot of information, so I'd like to summarize... What would you say is your most important health concern?
What are you working on for your health? What goals do you have?
Record any Care Manager interventions (education, referrals, materials, etc.) in <b>Additional Information</b> .



## Care Manager Visit Summary and Patient Plan

PATIENT NAME		VISIT DATE	CARE MANAGER
<b>Brief Visit Summary</b>			
ACTION ITEMS COMPLETED FROM LAST VISIT? <input type="checkbox"/> Y <input type="checkbox"/> N			
<b>Long Term Goals</b>			
1.			
2.			
3.			
<b>Immediate Action Items</b>			
1.			
2.			
3.			
4.			
<b>Next Appointment:</b>			
DATE	TIME	PLACE	PROVIDER
NOTES:			

Dear

I am writing to let you know that I am working with \_\_\_\_\_ DOB \_\_\_\_\_ in an intensive primary care support program called COMPASS. The program is for patients with diabetes and/or heart disease, who also have depression.

The COMPASS care team is comprised of the patient's primary care physician and team, a care manager who coordinates the patient's care and educates/motivates them to self-management (my role), a consulting physician to review their progress with diabetes and/or heart disease, and a consulting psychiatrist to review the patient's progress with their depression. For background on COMPASS, go to [https://www.icsi.org/health\\_initiatives/compass\\_mind\\_and\\_body\\_health/](https://www.icsi.org/health_initiatives/compass_mind_and_body_health/)

Some of the patients in this program are receiving Mental Health services from an RSN Mental Health Center. In order to include information about the care your patient is getting at \_\_\_\_\_ I will communicate with your patient's case manager. I will be asking for recent psychiatric visit notes and medication lists and I will stay in touch regarding progress and barriers. I will include as much information from the patient's CMHC treatment as possible when presenting my cases for review and consultation. Please let me know if you have particular concerns about your patient's health that would benefit from this review.

I am happy to share information with you as well. Please let me know if you would like to receive notes and recommendations from the team regarding your patient's medical conditions and/or their mental health treatment.

If I DO NOT hear from you, I will assume you are not interested in receiving information from the COMPASS team, but please feel free to contact me any time if you have questions about the program or your patient's primary care. Thank you for your time.

Sincerely,

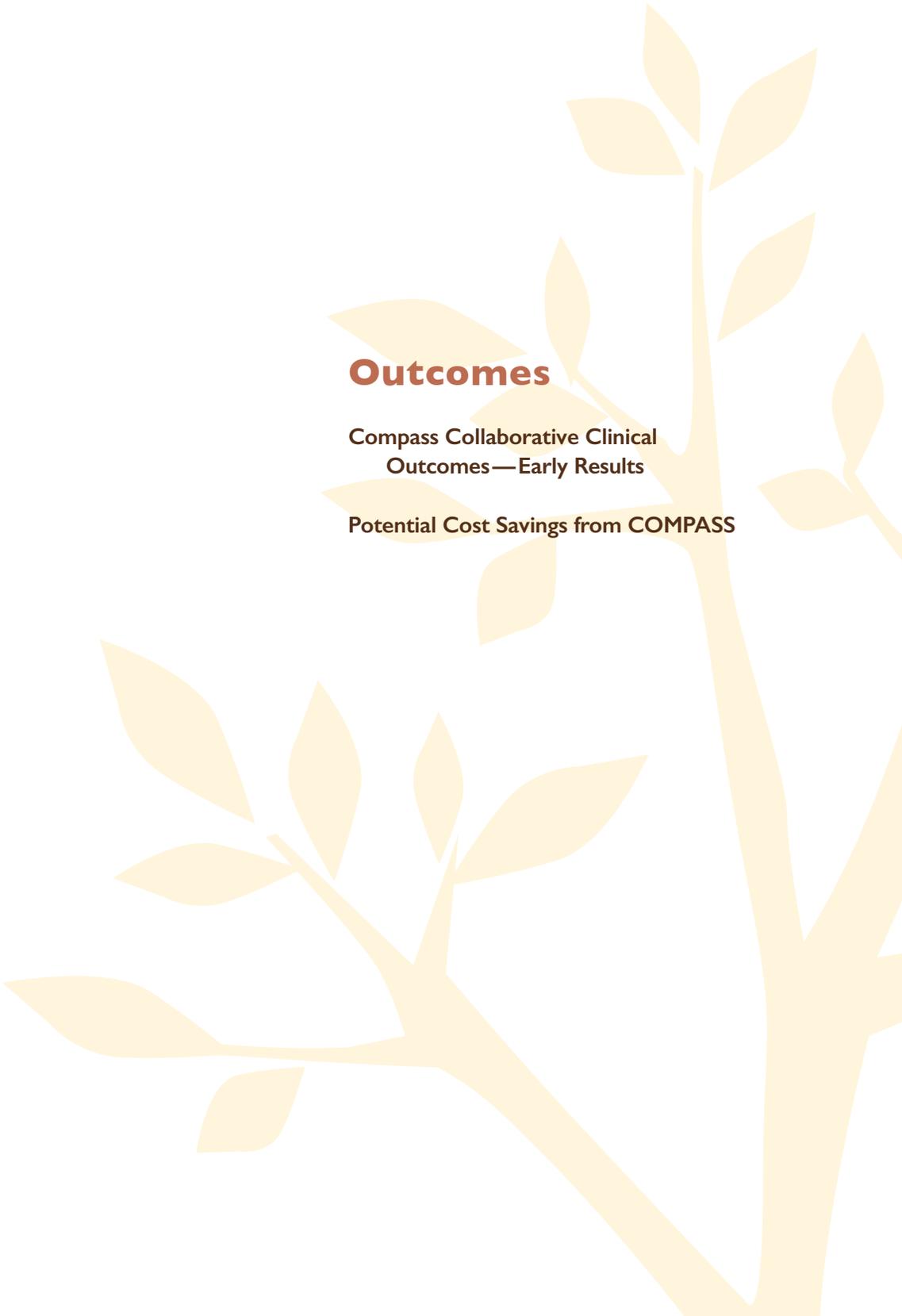
COMPASS Care Manager, Neighborcare Health



## Morisky 8-Item Medication Adherence Questionnaire

Question	Patient Answer (Yes/No)	Score Y=1; N=0
Do you sometimes forget to take your medicine?		
People sometimes miss taking their medicines for reasons other than forgetting. Thinking over the past 2 weeks, were there any days when you did not take your medicine?		
Have you ever cut back or stopped taking your medicine without telling your doctor because you felt worse when you took it?		
When you travel or leave home, do you sometimes forget to bring along your medicine?		
Did you take all your medicines yesterday?		
When you feel like your symptoms are under control, do you sometimes stop taking your medicine?		
Taking medicine every day is a real inconvenience for some people. Do you ever feel hassled about sticking to your treatment plan?		
<p>How often do you have difficulty remembering to take all your medicine?</p> <p><input type="checkbox"/> A. Never/rarely</p> <p><input type="checkbox"/> B. Once in a while</p> <p><input type="checkbox"/> C. Sometimes</p> <p><input type="checkbox"/> D. Usually</p> <p><input type="checkbox"/> E. All the time</p>		<p>A = 0; B-E = 1</p>
Total score		
<p><b>Scores: &gt;2 = low adherence</b>  <b>1 or 2 = medium adherence</b>  <b>0 = high adherence</b></p> <p>Morisky DE, Green LW, Levine DM. Concurrent and predictive validity of a self-reported measure of medication adherence. <i>Med Care.</i> 1986;24:67-74.</p>		

# APPENDIX

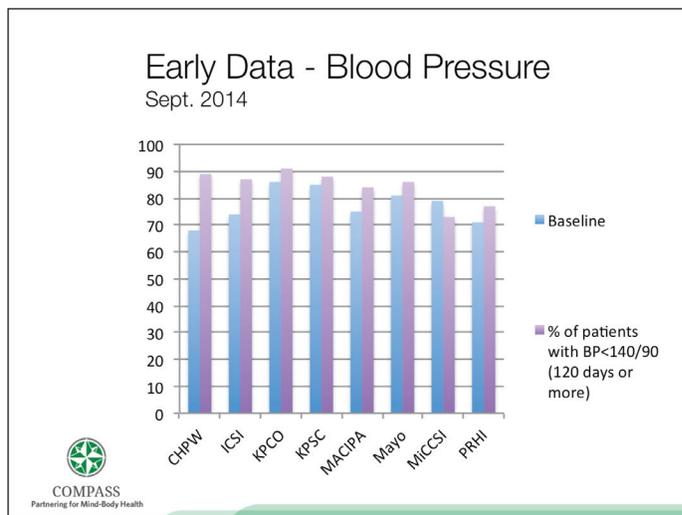
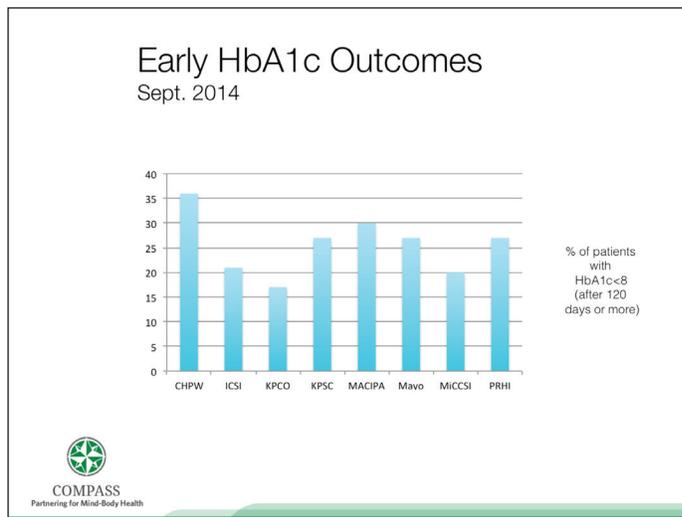
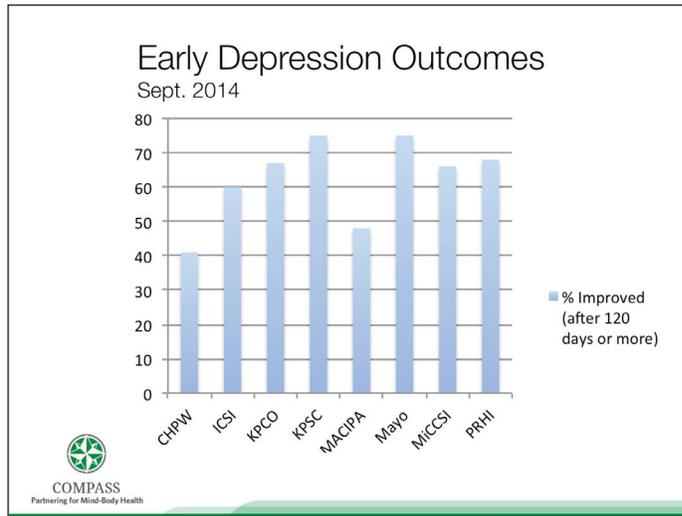


## **Outcomes**

Compass Collaborative Clinical  
Outcomes—Early Results

Potential Cost Savings from COMPASS

## COMPASS COLLABORATIVE CLINICAL OUTCOMES—Early Results





COMPASS

Partnering for Mind-Body Health

## Potential Cost Savings From Implementing COMPASS

The COMPASS Consortium is spreading the COMPASS collaborative care management model as part of its **Innovation Cooperative Agreement** with the Centers for Medicare and Medicaid Services (CMS). COMPASS combines the evidence-based elements and best practices learned in implementing several collaborative care management models, including IMPACT and DIAMOND for depression, TEAMCare for diabetes, cardiovascular care and depression, and SBIRT for risky substance use.

This document shows the costs savings that have been achieved with the models that have been incorporated into COMPASS to improve depression care, risky substance use, depression/diabetes and depression/cardiovascular disease management. The consortium estimates the three-year effort will reduce the total cost of care for treating the targeted patient population by 7%. Savings are expected since most patients with depression have other chronic problems. One third of Medicare patients have diabetes and another 30% have coronary artery disease; when depression is present, as it is 15% of the time, health care costs are 65% higher.

### IMPACT ON DEPRESSION CARE

- A robust review of 12 economic evaluations covering 10 collaborative care trials to improve depression treatment in primary care has consistently shown high value (several of the studies are referenced below).<sup>1-5</sup> Cost-effectiveness has tended to improve over time due to greater use of nursing or other less expensive medical professionals in the care programs, the introduction of 'stepped-care' which attempts high-value treatment options first, a focus on higher-cost patients with depression, and reduced emergency room visits and hospitalizations.
- The IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) model, a collaborative care management model for treating patients with depression, showed a savings of \$3,365 per patient (n = 272) over patients receiving usual primary care over a four-year period, even though the intervention ended after one year.<sup>4</sup>
- A study that implemented an adapted version of IMPACT for all adults found that the post-study group (n=172) had lower annualized total healthcare costs (\$7,471) per patient (excluding pharmacy) than the usual care and intervention groups in the original IMPACT trial.<sup>5</sup>

### References:

1. Simon GE, Katon WJ, VonKorff M, et al. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. *Am J Psychiatry*. Oct 2001; 158(10): 1638-1644.
2. Schoenbaum M, Unutzer J, Sherbourne C, et al. Cost-effectiveness of practice-initiated quality improvement for depression: results of a randomized controlled trial. *JAMA*. Sep 19 2001; 286(11): 1325-1330.

3. Pyne JM, Rost KM, Zhang M, Williams DK, Smith J, Fortney J. Cost-effectiveness of a primary care depression intervention. *J Gen Intern Med.* Jun 2003; 18(6): 432-441.
4. Unutzer J, Katon WJ, Fan MY, et al. Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care.* Feb 2008; 14(2): 95-100.
5. Grypma I, Haverkamp R, Little S, Unutzer J. Taking an evidence-based model of depression care from research to practice: making lemonade out of depression. *General Hospital Psychiatry.* 2006; 28: 101-107.

### IMPACT ON DEPRESSION AND DIABETES CARE

- Recent reports<sup>1-5</sup> have demonstrated medical cost-savings in excess of program costs for all or a portion of the targeted population when they include inpatient costs in the estimates. For example, in the PATHWAYS study of collaborative care for patients with depression concurrent diabetes, Katon et al.<sup>1</sup> observed \$4,800 in net savings over five years when including inpatient cost offsets that totaled \$4, 510. An earlier report of the same study, found positive net costs of \$35 per patient in year 1 and savings of \$1,800 in year 2, even while excluding savings from inpatient care.<sup>2</sup> When incorporating inpatient costs into the analysis Katon et al found cost-savings in each of five years.<sup>1</sup>
- A study of older adults with diabetes and depression found that in the first year of IMPACT, there was a \$655 increase in total outpatient costs; however, in the second year, when no intervention services were provided, there was a cost-savings of \$639 in total outpatient costs. Over the 24-month period, the total medical costs (inpatient and outpatient) were \$896 lower in the intervention group.<sup>3</sup>
- Among IMPACT participants who had both depression and diabetes, \$1,370 were saved over the first 24 months, driven by \$1,430 in savings from inpatient stays.<sup>4</sup>

### References:

1. Katon WJ, Russo JE, Von Korff M, Lin EH, Ludman E, Ciechanowski PS. Long-term effects on medical costs of improving depression outcomes in patients with depression and diabetes. *Diabetes Care.* Jun 2008; 31(6): 1155-1159.
2. Simon GE, Katon WJ, Lin EH, et al. Cost-effectiveness of systematic depression treatment among people with diabetes mellitus. *Arch Gen Psychiatry.* Jan 2007; 64(1): 65-72.
3. Katon WJ, Unutzer J, Fan MY, et al. Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. *Diabetes Care.* Feb 2006; 29(2): 265-270.
4. Katon WJ, Schoenbaum M, Fan MY, et al. Cost-effectiveness of improving primary care treatment of late-life depression. *Arch Gen Psychiatry.* Dec. 2005; 62(12): 1313-1320.

### IMPACT ON DEPRESSION AND CARDIOVASCULAR DISEASES

- Studies have consistently shown that patients with diabetes, coronary artery disease (CAD), and congestive heart failure (CHF) have anywhere from a 10% to 100% greater risk of hospitalization if they also have depression.<sup>1-4</sup> The probability of at least one inpatient stay during a year for those with depression and either diabetes, CAD or CHF are about 48%, 54%, and 74%, respectively, based on averages calculated across studies. Himelhoch et al.<sup>1</sup> found that 1/3 of patients with depression and either diabetes or heart disease, who have a hospitalization during a year, have a hospitalization for an ambulatory care sensitive condition.



## References:

1. Himelhoch S, Weller WE, Wu AW, Anderson GF, Cooper LA. Chronic medical illness, depression and use of acute medical services among Medicare beneficiaries. *Med Care*. June 2004; 42(6): 512-521.
2. Priest JL, Cantrell CR, Fincham J, Cook CL, Burch SP. Quality of care associated with common chronic diseases in a nine-state Medicaid population using claims data: an evaluation of medication and health care use and costs. *Popul Health Manag*. Feb 2011; 14(1): 43-54.
3. Nichols GA, Bell TJ, Pedula KL, O’Keeffe-Rosetti M. Medical care costs among patients with established cardiovascular disease. *Am J Manag Care*. Mar 2010; 16(3): e86-e93.
4. Tully PJ, Baker RA, Turnbull D, Winefield H. The role of depression and anxiety symptoms in hospital readmissions after cardiac surgery. *J Behav Med*. Aug 2008; 31(4): 281-290.

## IMPACT ON RISKY SUBSTANCE USE

- A review of literature (1992-2004) found that primary care screening and brief interventions for alcohol misuse represent one of the most effective and cost-effective preventive services. The authors reported a cost-effectiveness ratio of \$1,755 per quality-adjusted life years saved from the health system perspective (excluding patient time costs and non-medical cost offsets).<sup>1</sup>
- A 30-month study of the SBIRT model (Screening, Brief Intervention and Referral to Treatment) in nine emergency departments (EDs) for disabled Medicaid patients reported an estimated reduction in Medicaid costs of \$366 per member per month (PMPM) (P = 0.05) for all patients and \$542 PMPM for patients who received a brief intervention only and had no chemical dependency treatment in the year before or the year after the ED visit.<sup>2</sup>
- A 12-month study with 17 primary care practices found that brief physician advice for problem drinking resulted in cost-savings of \$523 per patient from reduced utilization of EDs and hospital (MCO cost) and \$1,151 per patient from reduced ED utilization, hospital utilization, crime, and motor vehicle accidents (total economic costs).<sup>3</sup>
- A 48-month study of brief physician advice for problem drinkers in primary care with two physician visits and two nurse follow-up phone calls found 20% fewer ED visits and 37% fewer days of hospitalization in the intervention group compared to the control group. Reductions in ER and hospital utilization resulted in net-savings of \$546 per patient, with a benefit-cost ratio of 4.3:1.<sup>4</sup>

## References:

1. Solberg L, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse ranking: its health impact and cost effectiveness. *American Journal of Preventative Medicine*. 2008; 34(2): 143-152.
2. Estee S, Wickizer T, He L, Shah MF, Mancuso D. Evaluation of the Washington state screening, brief intervention, and referral to treatment project: cost outcomes for Medicaid patients screened in hospital emergency departments. *Med Care*. 2010; 48(1): 18-24.
3. Fleming MF, Mundt MP, French MT, et al. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Med Care*. 2000; 38(1): 7-18.
4. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcohol Clin Exp Res*. 2002; 26(1): 36-43.



## CREATING COMPASS FROM PROVEN COLLABORATIVE CARE MANAGEMENT MODELS

The cost savings cited above come from leading collaborative care management models around the country for improving mental and physical chronic diseases: IMPACT, from which DIAMOND was developed, for depression; TEAMCare for diabetes; cardiovascular disease care and depression; and SBIRT for risky substance use.

The COMPASS model includes the evidence-based elements from these models and other best practice implementation strategies learned by the 10 partner organizations in the COMPASS Consortium. The purpose of creating the all-embracing COMPASS is to develop the best and sustainable collaborative care management model for improving mental, behavioral and physical conditions, as well as achieving the Triple Aim of improving the health of the population, the patient experience, including the quality of care, and the affordability of care.

### COMPASS CONSORTIUM

**The consortium consists of the Institute for Clinical Systems Improvement (ICSI) as the lead organization; Community Health Plan of Washington; Kaiser Permanente Colorado; Kaiser Permanente Southern California; Mayo Clinic Health System; Michigan Center for Clinical Systems Improvement; Mount Auburn Cambridge Independent Practice Association; Pittsburgh Regional Health Initiative; AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington and HealthPartners Institute for Education and Research.**

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**COMPASS**  
Partnering for Mind-Body Health