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Systematic case review

Improving treatment for complex mental and medical conditions

By Jim Trevis

Can a collaborative care management model implemented in primary care improve the outcomes and lower the cost of care for patients with multiple mental and medical chronic diseases? That is what the COMPASS (Care Of Mental, Physical And Substance-use Syndromes) model is striving to discover.

Funded by a three-year Center for Medicare & Medicaid Innovation grant, and led by the Institute for Clinical Systems Improvement (ICSI), the initiative is being implemented by 18 medical groups through 187 clinics in eight states. Entira Family Clinics, Essentia Health, Mayo Clinic Health System, North Memorial Health Care, and Stillwater Medical Group are implementing the model in Minnesota.

The COMPASS model includes the following components:

1. An initial evaluation to measure condition severity and assess the patient's readiness for self-management
2. A computerized registry to track and monitor the patient's progress
3. A care manager to provide patient education and self-management support, coordinate care with the primary care physician and consultants, and provide active follow-up
4. A consulting psychiatrist and consulting medical physician

to review cases with the care manager and recommend changes in treatment to the primary care physician

5. Treatment intensification when there is a lack of improvement
6. Relapse and exacerbation prevention

Complex patients

Patients eligible for COMPASS have suboptimally managed depression (PHQ-9 >9), and treatable suboptimally managed diabetes or cardiovascular disease (including patients over age 65 with uncontrolled hypertension), with an option to include substance misuse based on AUDIT ≥ 7 for females or ≥ 8 for males, and/or DAST-10 ≥ 2 .

The medical groups implementing COMPASS have found it more complicated and challenging than anticipated to find appropriate high-risk patients. "The biggest surprise for me was discovering how complex these patients are and how many issues they have," says Faris Keeling, MD, medical director, Integrated Behavioral Health, Division of Community Clinics, Essentia Health, and COMPASS consulting psychiatrist. "These patients are fewer in number but are our most expensive to treat." Adds Emilie Hedlund, MHA, outpatient care coordination manager, North Memorial, "These patients typically are not served well in the fast-paced, visit-oriented primary care system."

Systematic case reviews

The COMPASS model addresses the complexity of these chronically ill patients through its Systematic Case Review (SCR). The core SCR team is composed of a care manager, consulting psychiatrist, and consulting physician. This team meets weekly for two hours to review the registry of COMPASS patients, focusing on creating care plans for new patients and recommending treatment changes to the primary care physician (who makes the final decisions) for patients not progressing.

Minnesota medical groups designed their SCR teams differently. Stillwater assigned a single doctor to the physician consulting role, believing regular involvement in the SCR would improve patient outcomes faster. The team also includes a diabetes educator and medical home care managers.

Entira initially rotated many physicians into the consulting role to expose more providers to the model for eventual spread across their clinics, according to Ruth Herman, MBA-H, director of clinical practice. Entira now is rotating fewer physicians onto the SCR team to address the importance of having ongoing knowledge of the patient's condition to achieve results.

North Memorial brings in its care managers from 13 clinics to attend the SCR team meeting. They do extensive prep on their patients to efficiently use the SCR team's two-hour window. Representatives from pharmacy, plus a diabetic program director and vascular consultant, join the discussions.

In addition to core players, Essentia Health involves clinic management on its SCR team. An Essentia psychiatrist now devotes part of their time to COMPASS patients who need face-to-face time not provided by the SCR consulting psychiatrist.

Collaborative care models

Some of the clinics offering COMPASS were familiar with team-based care through programs like DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction). Most primary care physicians liked the input of the consulting psychiatrist in this model because many patients with depression present with much complexity.

The COMPASS model added a consulting medical physician, usually a family practitioner or internal medicine physician. For clinics less familiar with team-based care, this addition required cultural changes. Primary care physicians with long-term relationships with COMPASS patients sometimes did not agree with the SCR medical physician's recommendations because he or she was not aware of the context for the proposed change in care. This highlighted the importance of having good, strong care managers, as they are the communications conduit between the primary care physician and the SCR team.

Many clinics report that they are seeing the value of the SCR process. The consulting physicians often have more expertise in addressing depression, diabetes, and/or cardiovascular disease and can focus on a "treat-to-target" strategy for nonprogressing patients. As SCR teams better understand this patient population, some have added diabetic educators, pharmacists, and endocrinologists. The results: Primary care physicians are seeing improvements in long-term, high-utilizer patients.

"The patient benefits by getting expert input that focuses on a particular condition, such as diabetes, whereas in usual care, the primary care physician might be faced with a half a dozen issues at once, making it nearly impossible to concentrate and improve just one ailment," says Dr. Keeling.

SCR roles

Clinicians consulting in SCRs report that the team approach provides a deeper dive to uncover health and social issues of complex patients that are real barriers to patient improvement. Many express their satisfaction with their role on the SCR team.

Says Martha Sanford, MD, medical

director of quality at Stillwater, "I was hesitant to serve as the consulting medical provider. Now it is one of my favorite parts of the week. Hearing about patients who had been receiving 'usual care' and not getting better was an eye-opener in terms of understanding these patients' struggles. Now we all work together and these patients are benefitting from the model."

Dr. Keeling says that the SCR meeting is the most rewarding part of his week. "I can very efficiently give input on five to 10 cases that make a positive impact on the patients' health."

Leveraging data

Patient outcome data now is being supplied to participating medical groups. Clinics are seeing how the model and the SCR component are impacting care. If they are missing the initiative's target goals, they can focus on "treating to target" with their care plans. The data also help care managers to uncover patient barriers to improvement, and then use motivational interviewing to address patient desires for self-management.

Through July 2014, 3,239 patients nationally were enrolled in COMPASS. Among those enrolled for more than four months (2,316), very preliminary results are as follows:

- Sixty percent have seen their depressive symptoms improve (PHQ-9 improved by at least five points or now are under 10), compared to the initiative's goal of 40 percent.
- Only 28 percent of diabetes patients had their HbA1c in control (<8.0) at baseline. That percentage improved to 42 percent (an absolute improvement of 14 percent, compared to the initiative's goal of 20 percent).
- Of the 450 patients identified with uncontrolled blood pressure at baseline, 237 have achieved control, an improvement of 53 percent compared to the initiative's goal of 20 percent.

While improving, their complex conditions make it difficult to graduate patients out of COMPASS, resulting in care manager capacity issues. Clinics now are moving toward less frequency and length of contact for improving patients, implementing relapse programs, and

determining patient follow-up post-graduation.

Integration and sustainability

Medical groups currently are exploring how to integrate the model into their workflows, and how to sustain it once payment through the CMS grant ends.

Medical groups report that the model is most beneficial and definitely needed for the very complex patient at the top strata of their health care homes, but possibly unnecessary for other patients. So, they are exploring stratification. At Stillwater, if a patient is severely depressed but doesn't quite meet COMPASS eligibility criteria for diabetes or cardiovascular disease, he or she enters the clinic's DIAMOND program. According to Hedlund at North Memorial, "As health care moves to Total Cost of Care and accountable care organizations, we need a way to holistically care for these complex patients without compromising the entire workflow in a clinic. We're looking at what elements of COMPASS can be applied on a broad scale to serve this population."

Participating medical groups continue to see the COMPASS vision and its implementation as essential for building better health care systems going forward.

"The model requires more FTE [full-time employee] hours, maybe a social worker, and more robust patient registries to monitor and treat this population," notes Dr. Sanford. "But as payment shifts to outcomes, COMPASS is showing its potential to improve the health of our sickest patients who do not reach care goals in the current visit-based model."

"Our survival will be based on getting better outcomes, lower costs, building for the future. If this type of care can't achieve those goals, I don't know what will," says Dr. Keeling. ■

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