



COMPASS

Partnering for Mind-Body Health

COMPASS:

A Team-Based Model to Treat Patients with Both
Mental and Medical Conditions in Primary Care



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The project described was supported by Grant Number 1C1CMS331048 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.



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Overview

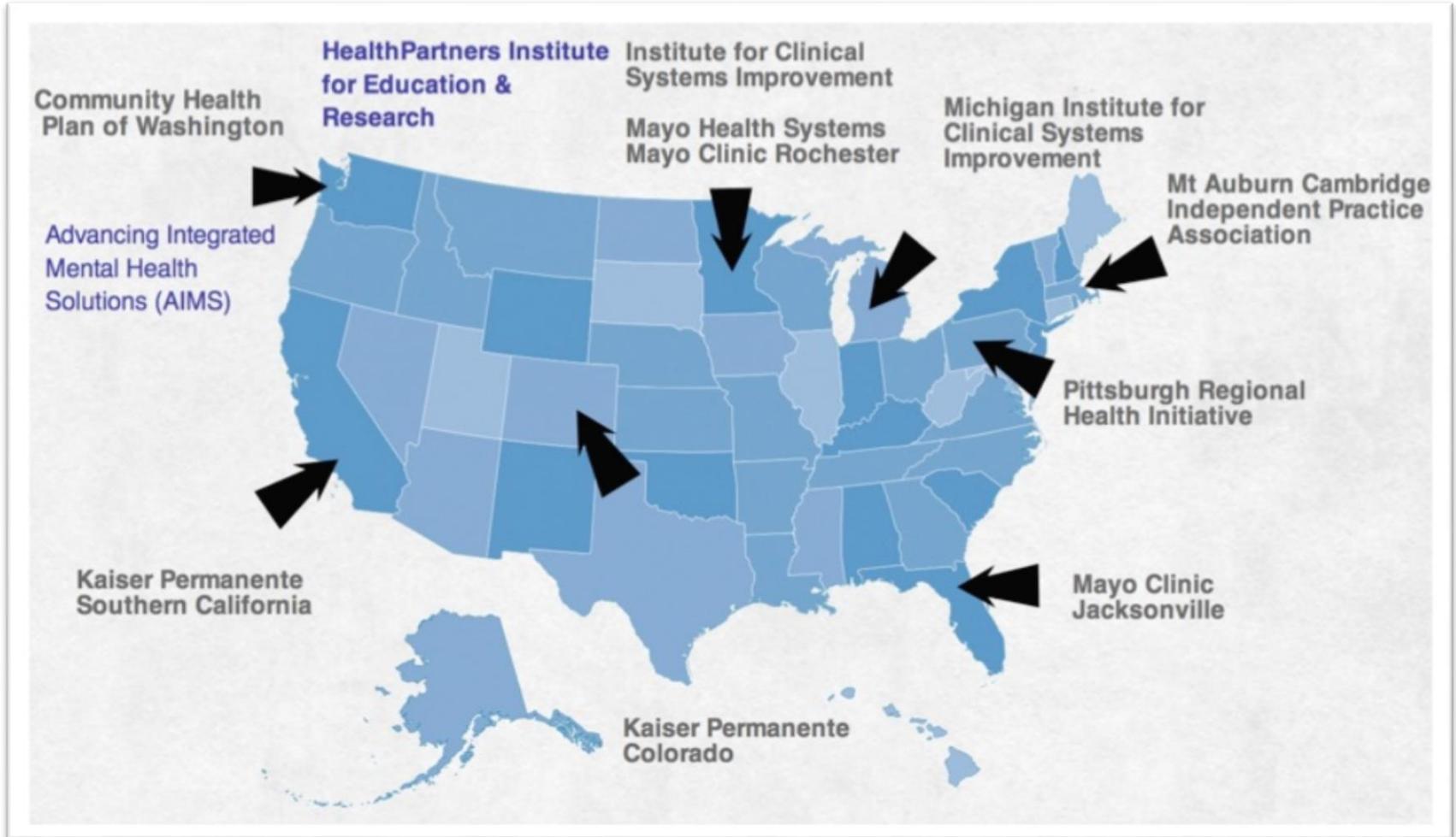
- Overview of COMPASS national project
- Lessons from Implementation
- COMPASS at Mayo Clinic Health System



Part of ICSI's work is to take well-studied, successful innovations to scale and spread new models of care in settings that differ from the original intervention.



COMPASS: A National Dissemination and Implementation Project



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**North Memorial
Health Care**



Essentia Health



**EntiraSM
FAMILY CLINICS**

Where generations thriveSM



**STILLWATER
MEDICAL GROUP**

 *HealthPartners Family of Care*

**MAYO
CLINIC**



**MAYO CLINIC
HEALTH SYSTEM**



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The Partnership

- 18 medical groups with nearly 200 participating clinics
 - urban, suburban and rural
 - integrated systems and standalone primary care
 - FQHC
- 3 organizations skilled in QI project design and evaluation, including those who have done original research in collaborative care models
- 3 regional quality improvement organizations with broad experience in implementing complex care interventions
- 1 IPA, 2 ACOs, 3 Health Plans





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The COMPASS Consortium is a collaboration of 10 partners drawing on information from clinical trials and implementation projects to spread an integrated care model across varied settings.



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Improve

- depression outcomes
- diabetes control
- hypertension control

Increase

- clinician satisfaction
- patient satisfaction

Decrease

- costs
- unnecessary hospital & ED use

Expand

- workforce roles

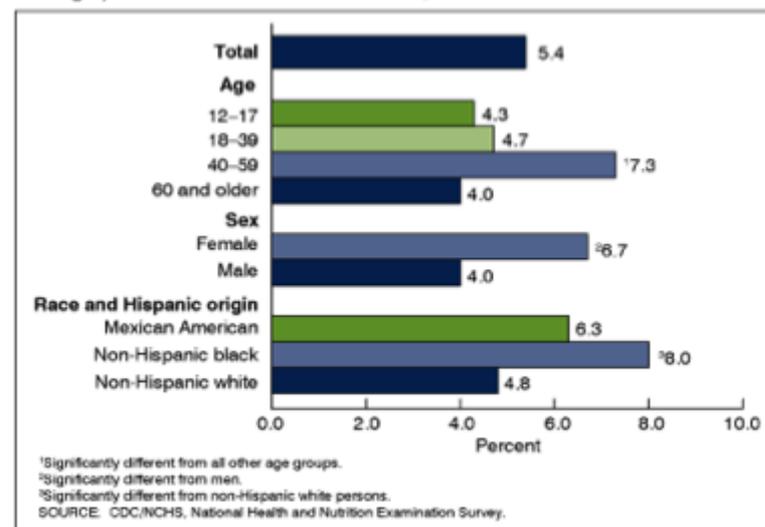


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Depression

At any given time, 8% of American adults suffer from depression. This costs \$84 billion per year in health care and lost productivity.

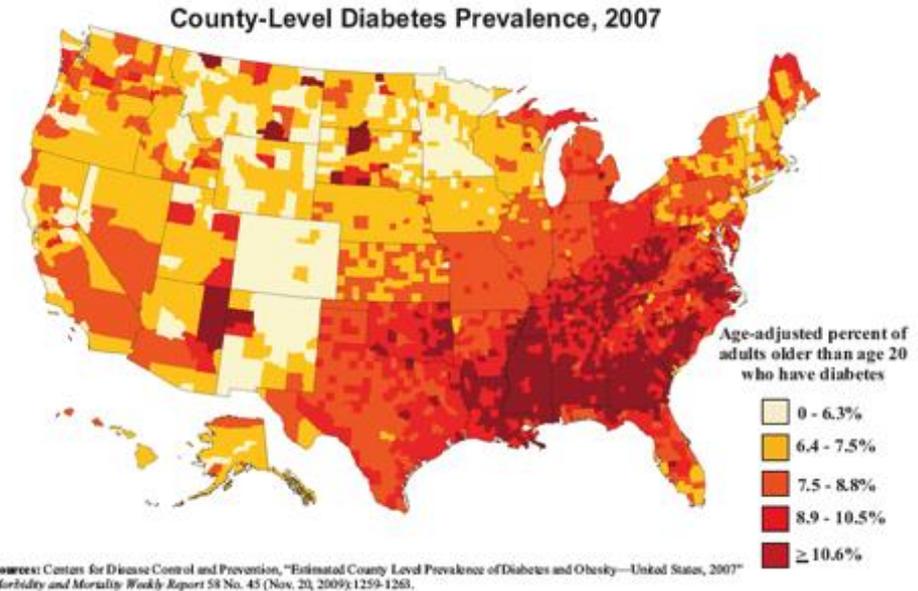


Diabetes

27% of US residents over 65 have DM.

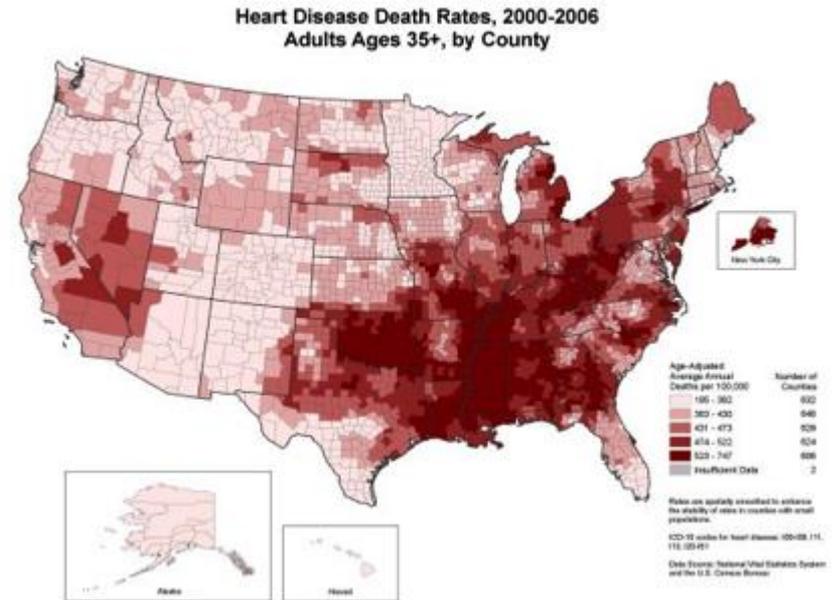
Expected increase to 85% by 2034.

Cost will increase to \$334 billion per year.



Heart Disease

33% of US adults are living with some form of cardiovascular disease. By 2040, this will have risen to 40% with a cost of \$818 billion per year.



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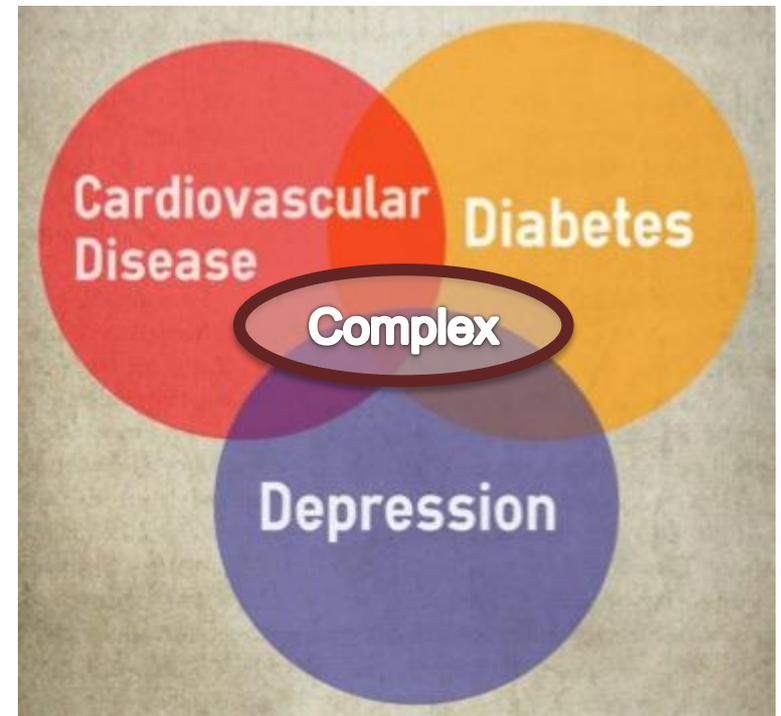
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Complex Comorbidities

15% of patients with diabetes or heart disease have depression.

When depression is present with chronic disease:

- ✓ costs are higher
- ✓ complications higher
- ✓ premature death



COMPASS Model of Care



Primary Care Teams

- Varied experience with care management
 - ¼ of the MGs had little experience with CM
 - ¼ of the MGs had extensive, but separate medical and BH CM programs
- Varied experience with “outside” recommendations
 - DIAMOND/IMPACT clinics; Standing orders/protocol-based care plans
- Varied experience with depression care in Primary Care



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Care Managers

- Most are RNs, but also have MAs, LPNs, SWs
- $\frac{3}{4}$ had some experience in care management programs, for some it was <1 yr
- The MAs and LPNs were all from BH care management programs
- Most drawn from existing staff
- $\frac{1}{3}$ were full-time COMPASS CMs
- **NEW ROLE:** Combined medical and BH care management



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Systematic Case Review Teams





Improve

- depression outcomes
- diabetes control
- hypertension control

Increase

- clinician satisfaction
- patient satisfaction

Decrease

- costs
- unnecessary hospital & ED use

Expand

- workforce roles



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Preliminary Outcomes

Enrolled: 3912

| | Outcome Goals | As of March 2015 |
|-------------------------|-------------------------------------|---|
| Depression | Improve control for 40% of patients | 63% have shown significant improvement |
| Diabetes & Hypertension | Improve control rates by 20% | 18% have HgbA1c <8 76% of those who entered with hypertension have BP in control |
| Cost Savings | | \$6,000,000 (estimated) |



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Lessons Learned

Finding patients is
challenging

*Context Lesson:
Understand the Study
Population and Usual
Care*



Lessons Learned

All teams are recognizing social complexity as a significant issue.

*Context Lesson:
Be ready for the
“unexpected”.*

THE SOCIAL DETERMINANTS OF HEALTH

Access to healthy living conditions like food, exercise, employment, health insurance, education, and a supportive family determines whether a person is healthy

| GOOD HEALTH | POOR HEALTH |
|------------------|-----------------|
| Blue person icon | Red person icon |
| Green apple | Yellow 'X' mark |
| Green bicycle | Yellow 'X' mark |
| Green briefcase | Yellow 'X' mark |
| Green bandage | Yellow 'X' mark |
| Green books | Yellow 'X' mark |
| Green heart | Yellow 'X' mark |

GOOD HEALTH **POOR HEALTH**

The Washington Center for Nursing is a nonprofit working to ensure Washington State has enough nurses now and in the future to keep our population healthy. Research behind the social determinants of health helps shape our work and who we work with. For more information, visit WaCenterforNursing.org, 3d.dgimeetings.com/about-the-summit, www.who.int/social_determinants/en/

Inclusion | Outreach
Washington Center for Nursing



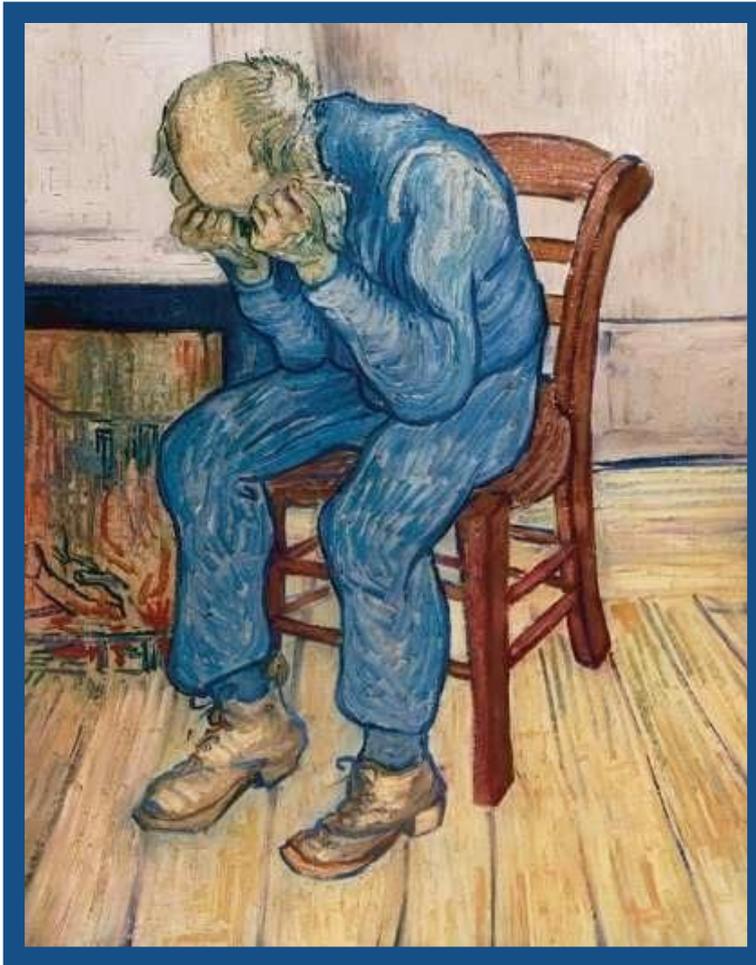
Lessons Learned

Care managers need professional and interpersonal skills to engage and support this population.

*Context Lesson:
Look beyond the
technical components*



Lessons Learned



There continues to be a stigma around depression for both patients and health care providers.

*Context Lesson:
Consider the changes in
Knowledge, Skills and
Attitudes*



Man in Sorrow, Van Gogh, Kröller-Müller Museum, Otterlo, Netherlands

Lessons Learned

Care for these complex patients requires some silo busting.

Health care systems cannot do it alone.



Lessons Learned

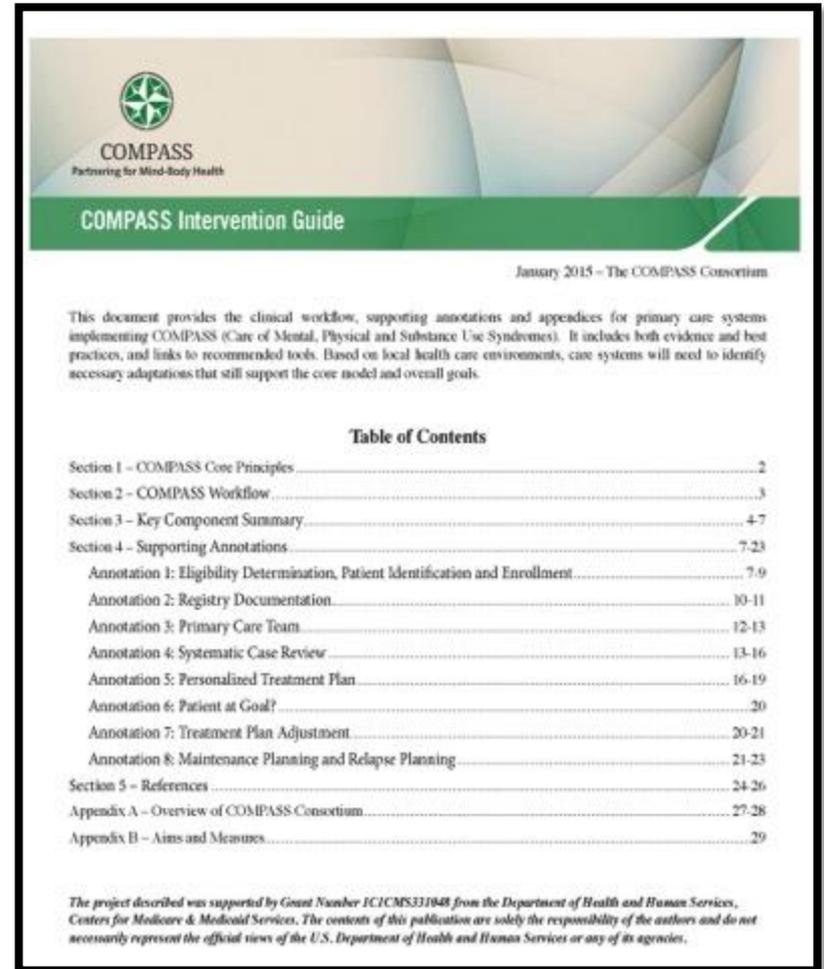
Change is hard.

*Context Lesson:
Watch the data
carefully, to avoid
getting stuck.*



COMPASS Core Elements

- Population Focus
- Patient Engagement in Care
- Care Management
- Use of a Registry
- Systematic Case Review Team
- Treatment Intensification



Includes more than 100 tools and resources





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A Team-based Model to Treat Patients with Mental and Medical Conditions in Primary Care

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Carrie Petsinger, RN

2015 Minnesota Rural Health Conference
June 29, 2015

Duluth, Minnesota

Research Disclaimer

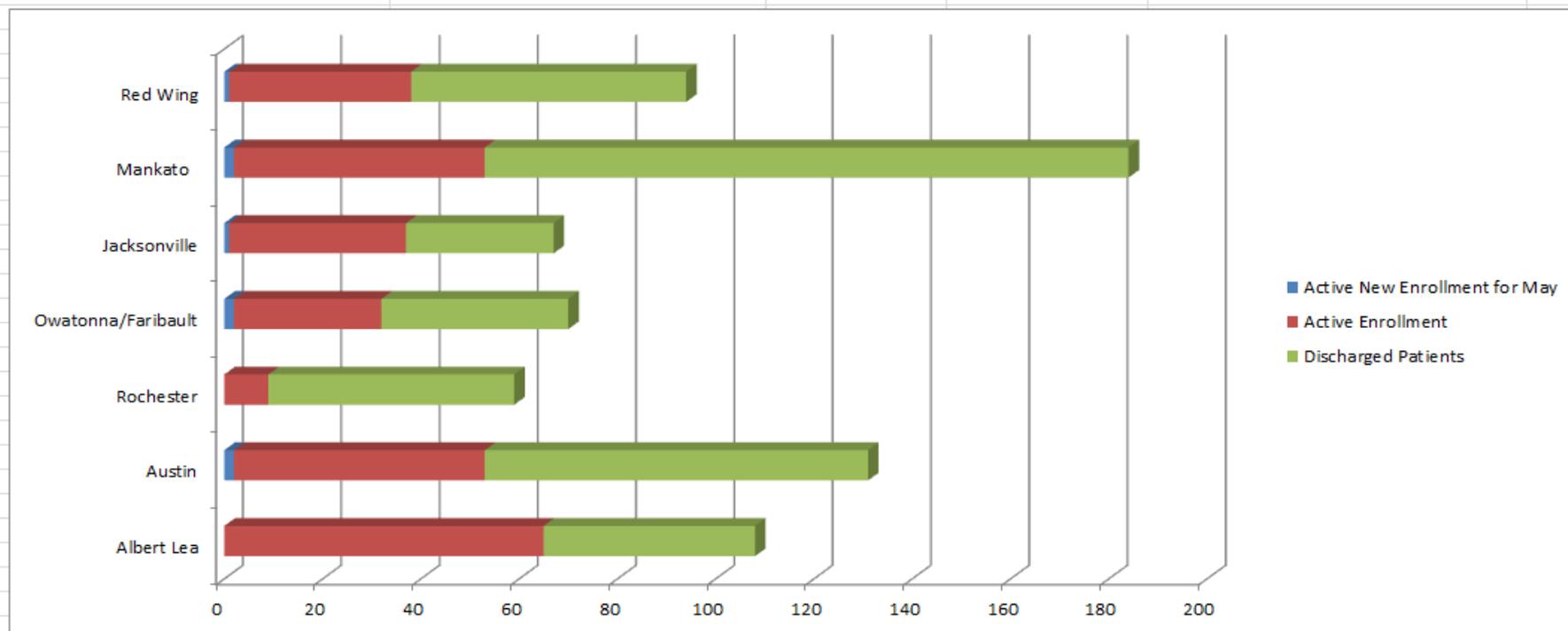
The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the independent evaluation contractor.

Mayo Clinic Locations



COMPASS Enrollment by Site

| Site | Active New Enrollment for May | Active Enrollment | Discharged Patients | Total Enrollment |
|---|-------------------------------|-------------------|---------------------|------------------|
| Albert Lea | 0 | 65 | 43 | 108 |
| Austin | 2 | 51 | 78 | 131 |
| Rochester | 0 | 9 | 50 | 59 |
| Owatonna/Faribault | 2 | 30 | 38 | 70 |
| Jacksonville | 1 | 36 | 30 | 67 |
| Mankato | 2 | 51 | 131 | 184 |
| Red Wing | 1 | 37 | 56 | 94 |
| TOTAL COMPASS ENROLLMENT ALL SITES | 8 | 279 | 426 | 713 |



Comparison of Clinical Outcomes COMPASS at Mayo and TEAMcare Randomized Trial

| | TEAMcare Intervention Group- 12 months* n=105 | Mayo COMPASS 12 months or greater n=591 |
|--|--|---|
| Depression Severity Percent Response >=50 % decrease | 60% | 53% |
| Change A1c** | -0.81 | -0.89 |
| Change LDL** | -14.9 | -10.5 |
| Change Systolic BP** | -4.7 | -4.0 |

*Katon W. [N Engl J Med.](#) 2010 Dec 30;363(27):2611-20

** Includes all patients with baseline A1C, LDL and Systolic BP.

Advantages

- Collaboration with and access to specialty physicians
 - Psychiatry consultation
 - Improved communication with primary
- Treat to Target
 - Increased frequency of contact
 - Accelerated adjustment of treatment
 - Direct correlation of contact frequency and improvement

Advantages

- Goal Setting
 - Care Coordinator able to work without time constraints of clinic schedule
 - Real life goals
- Team Based Appointments
 - Efficient communication
 - Discuss plan at visit
 - Social work, case worker, family members

Advantages

- Identification of barriers to treatment
- Team Based Care mentality
 - Interaction with colleagues
 - Change in care style
- Continuing education for Primary Care physicians
 - Questions or curbside consults

Advantages

- Single point of contact for patient
 - Able to easily contact care team
 - Patient perception of a higher level of care
 - Amount of contact with the patient correlated directly with patient improvement.
 - Care coordinator develops personal relationship with patients

Challenges

- Multiple Systems involved
 - Hospital, Community Psychiatry
 - Multiple EMRs, Registry
- Physical presence at Systemic Case Review
 - Phone versus in person discussion
- Unengaged patients
 - Lost to follow up

Challenges

- Initial Physician Engagement
 - Improved after first round of data
 - Still challenging in certain situations
- Reimbursement
 - Physicians, RN care coordinator, etc.
- Need for Social Worker

Benefits in a Rural Practice

- Care Coordination and access to care team
- Access to specialties otherwise unavailable
- Reduction of workload for busy practitioners
- Improvement in Quality Outcomes

Patient Experiences

- 36 yo female
 - DM type 2, uncontrolled with A1C of 9.5
 - Multiple appointments without progress
 - Patient on insulin pump
 - Depression, unresponsive to medication
- After in program for ~ 1 year
 - A1C 7.5, exercising daily, weight loss
 - PHQ-9: 11 → 4

Patient Experiences

- 72 yo male
 - DM 2, uncontrolled A1C of 11.0
 - max dose of metformin and glipizide
 - Resistant to insulin
 - Depression, lost contact with psychiatrist
- Goals set for exercise, diet, and adjusted psychiatric medications
 - In 6 months, A1C: 7.9, PHQ-9 of 10 → 4

Patient Experiences

- 59 yo female
 - Needing to start insulin for DM2
 - A1C: 10
 - Depression
- Frequent contact with care coordinator
 - Blood glucoses reported and adjusted in weekly manner
 - 2 ½ months: A1C: 8.1
 - Depression slowly improving PHQ9 10 → 7

Care Coordination After COMPASS

- MCHS sites that have COMPASS will transition to a care coordination program.
- Tentatively includes RN, Social worker, Primary Care Physician, and Psychiatrist.
- Enrollment criteria not clearly defined but will be more broad than COMPASS
- Continually developing

Questions & Discussion



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