COMPASS
Partnering for Mind-Body Health

Value Based Integrative Behavioral Health: COMPASS

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Institute for Clinical Systems Improvement

Institute for Clinical Systems Improvement

A healthcare quality improvement collaborative in Minnesota focused on achieving the Triple Aim of improving the health of the population, the patient care experience, including quality, and the affordability of care.

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Part of ICSI's work is to take well-studied, successful innovations to scale and to spread further to settings that differ from where the original intervention was proven.

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Care of Mental, Physical, and Substance-use Syndromes

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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.

DIAMOND

IMPACT Evidence-based depression care

Partners in Integrated Care
Patients, Payers, Providers, Primary Care, Purchasers

project BOOST
Better Outcomes for Older adults through Safe Transitions

MiPCT
Michigan Primary Care Transformation

SBIRT

So we all sleep more peacefully

RARE Reducing Avoidable Readmissions Effectively

TEAMcare™

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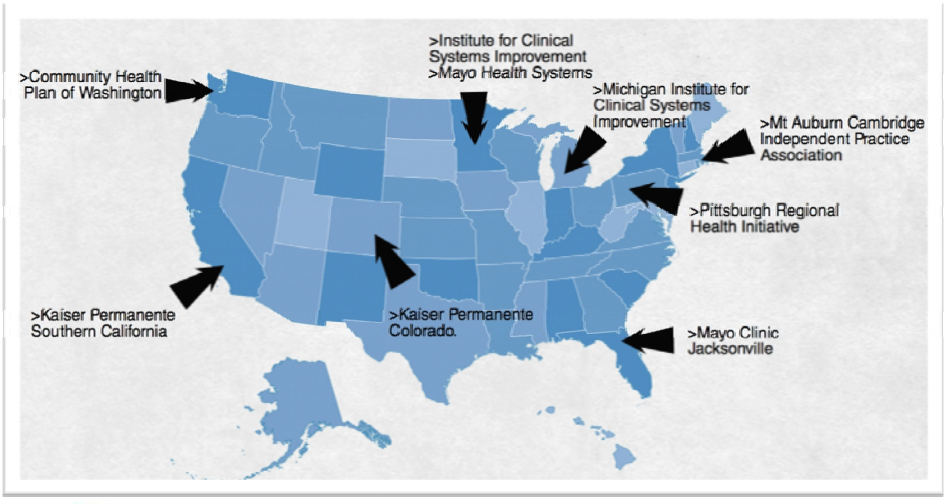

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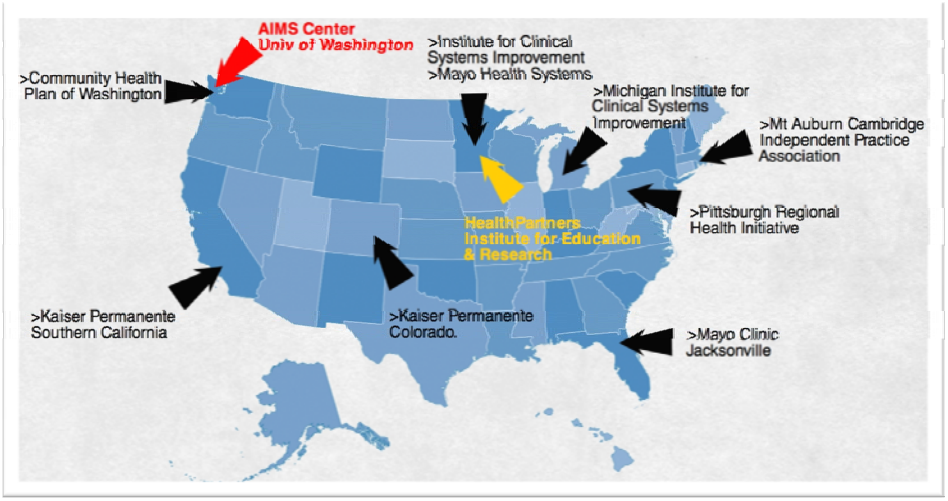

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Improve
- depression outcomes
- diabetes control
- hypertension control

Increase
- clinician satisfaction
- patient satisfaction

Decrease
- costs
- unnecessary hospital & ED use

Expand
- workforce roles

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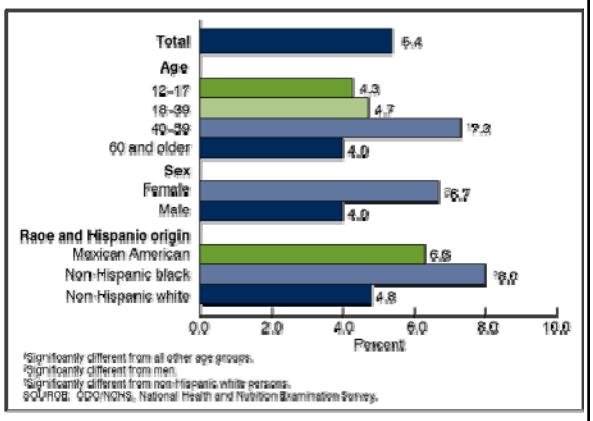
Depression

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



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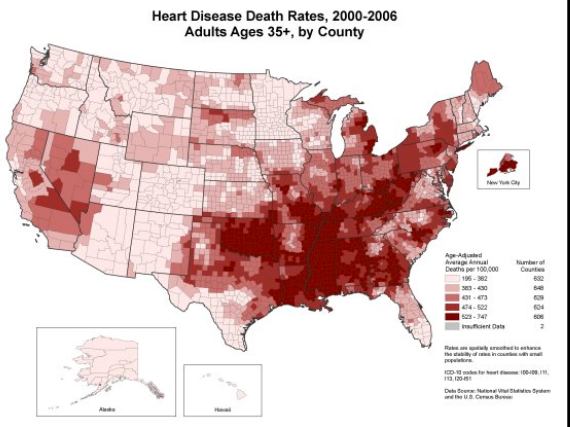
Heart Disease

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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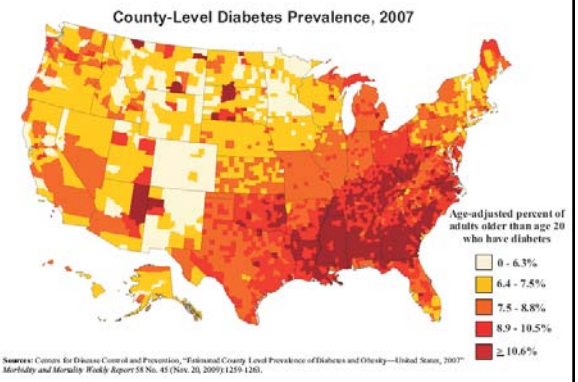
Diabetes

27% of US residents over 65 have DM, with an expected increase to 85% by 2034 increasing cost to $334 billion per year.



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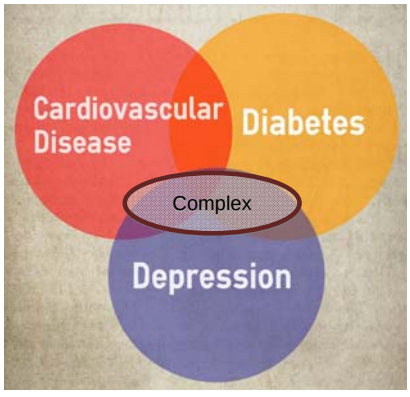
15% of patients with diabetes or heart disease have depression.

When depression is present with chronic disease:

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



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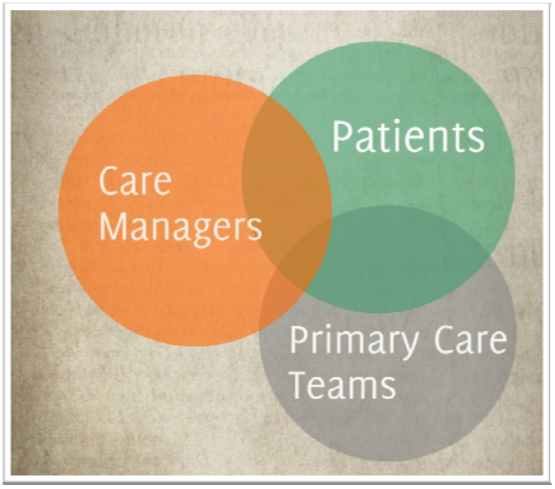

Patient-centered medical home adds care managers to assist primary care teams.

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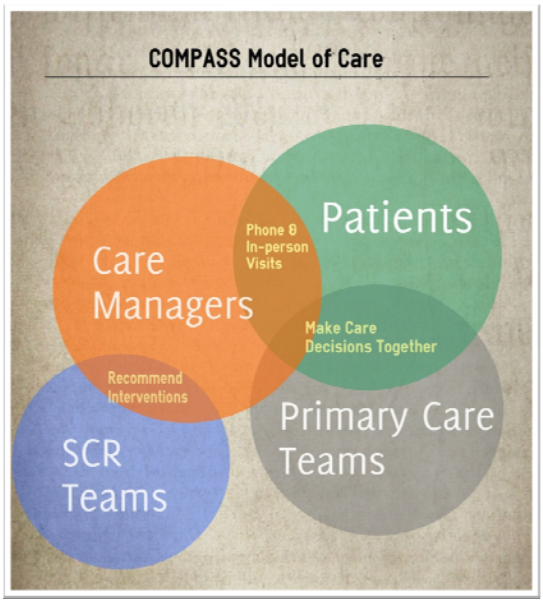
Systematic Case Review Teams



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A Systematic Case Review Team can review 40+ cases during their 2 hour, weekly, meeting.

There are 27 SCR Teams participating in COMPASS.

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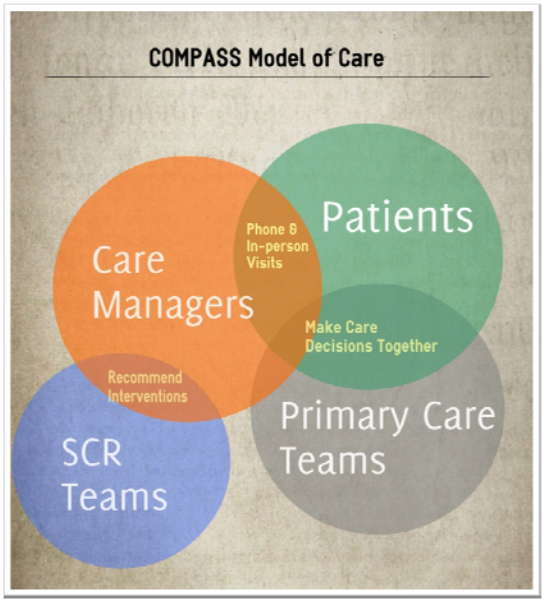

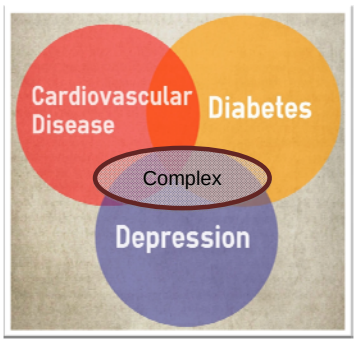

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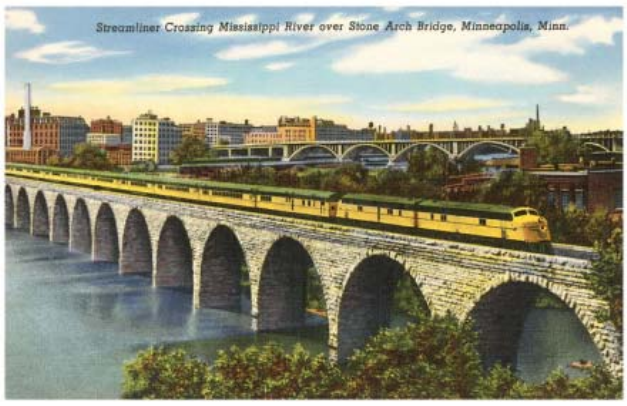

Primary care may have the knowledge to manage these patients, but is on a track that does not easily allow change.

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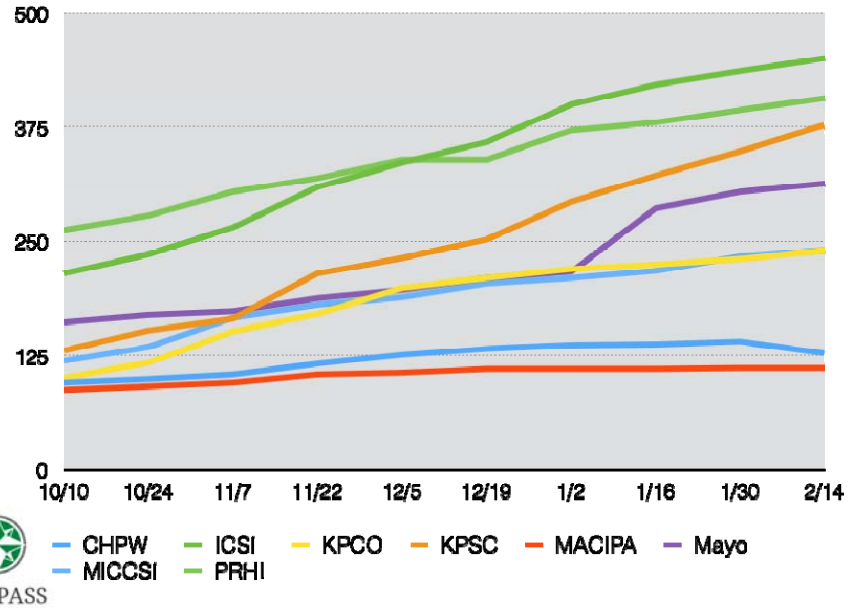
Enrollment in COMPASS



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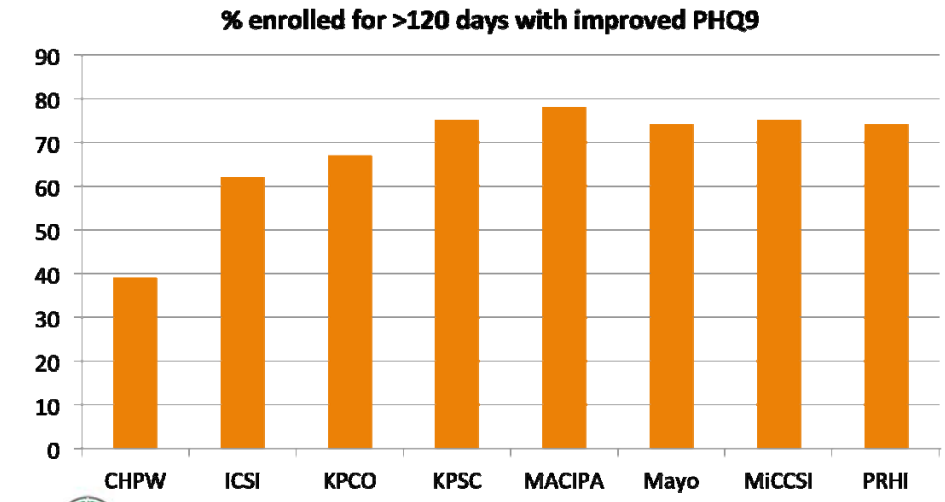
Depression



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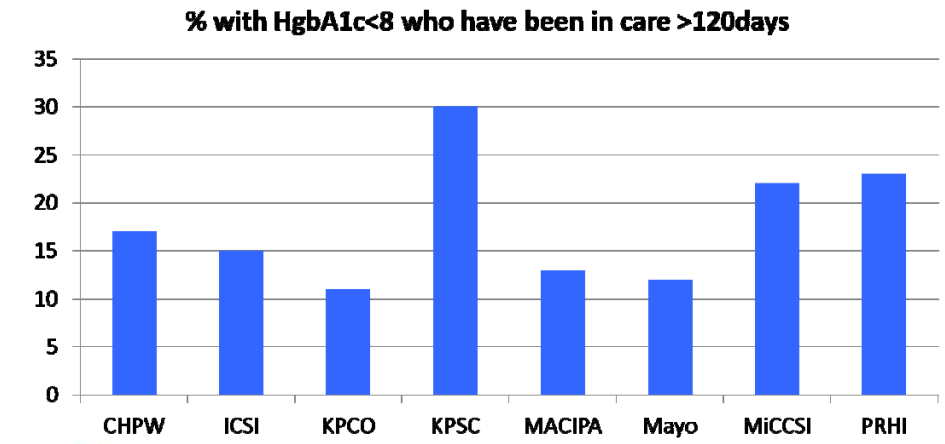
Diabetes



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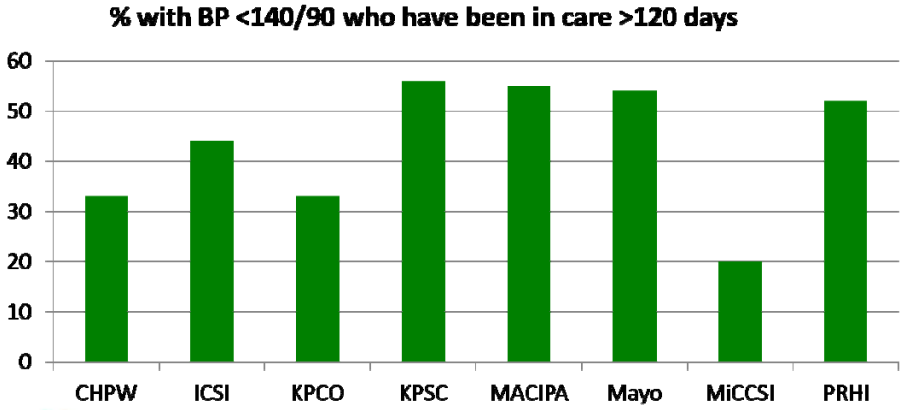
Blood Pressure



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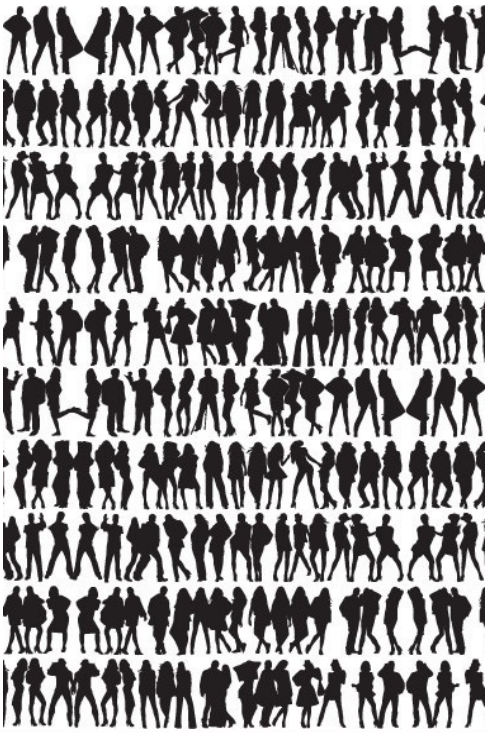
Lessons Learned



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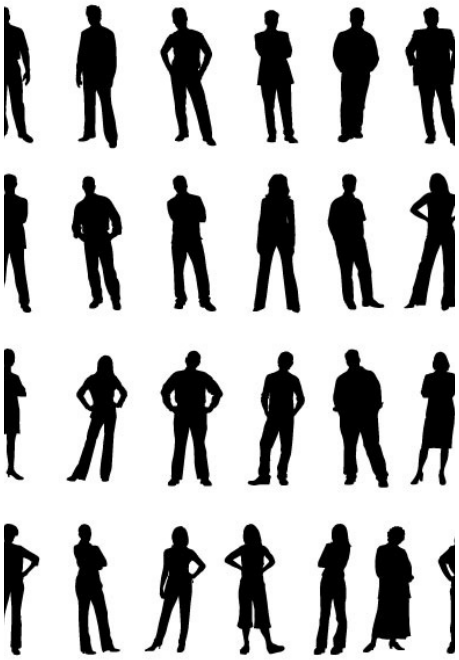
Lessons Learned

Not as many patients have enrolled as expected.

Not engaged in healthcare
Not attending primary care



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Lessons Learned

Practices have to actively search for patients and invite them into the health care system.

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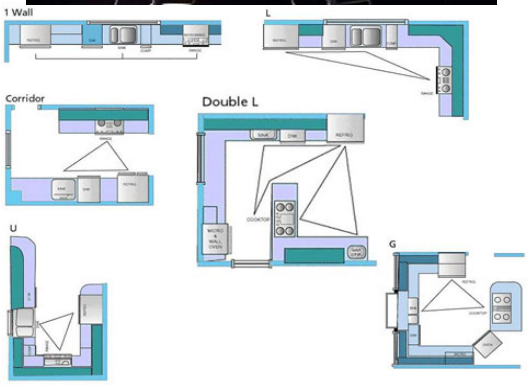
Lessons Learned

There is a dynamic balance between the need for fidelity and the need for local adaptation.



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Lessons Learned

The skills and attitudes of care managers are as important as their professional degree.

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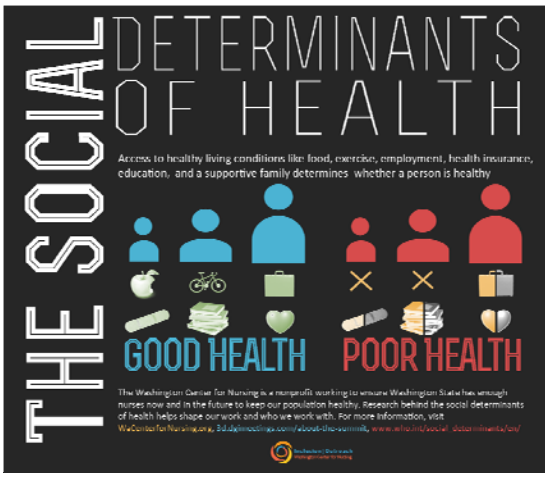
Lessons Learned

Many of the systematic case review teams are adding social workers.



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Lessons Learned

Some financial incentives help speed implementation. Some don't.

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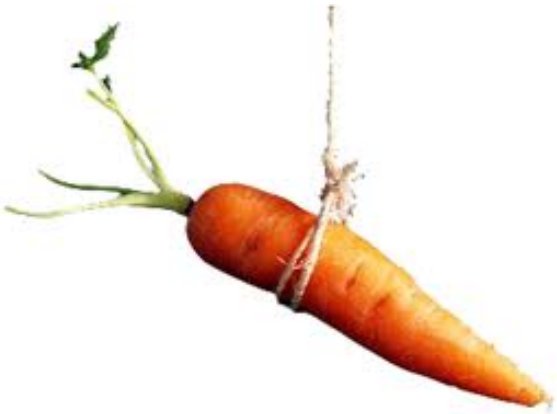

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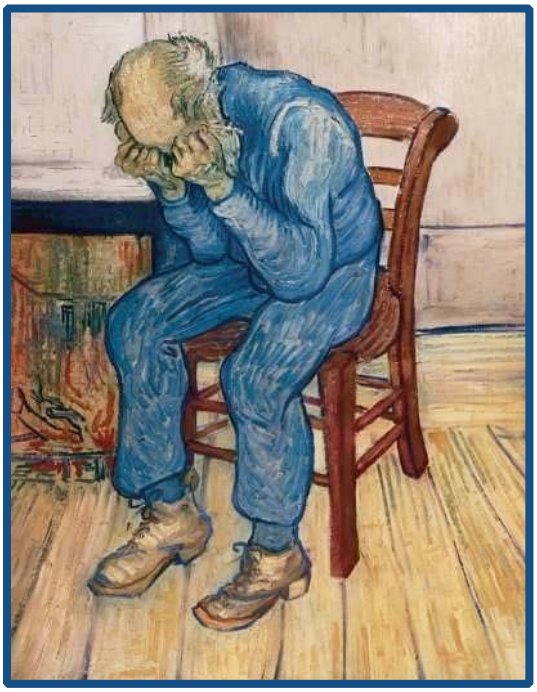
Lessons Learned

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



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THANK YOU

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