



**COMPASS**  
Partnering for Mind-Body Health

# COMPASS Implementation - System Level

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# Outline

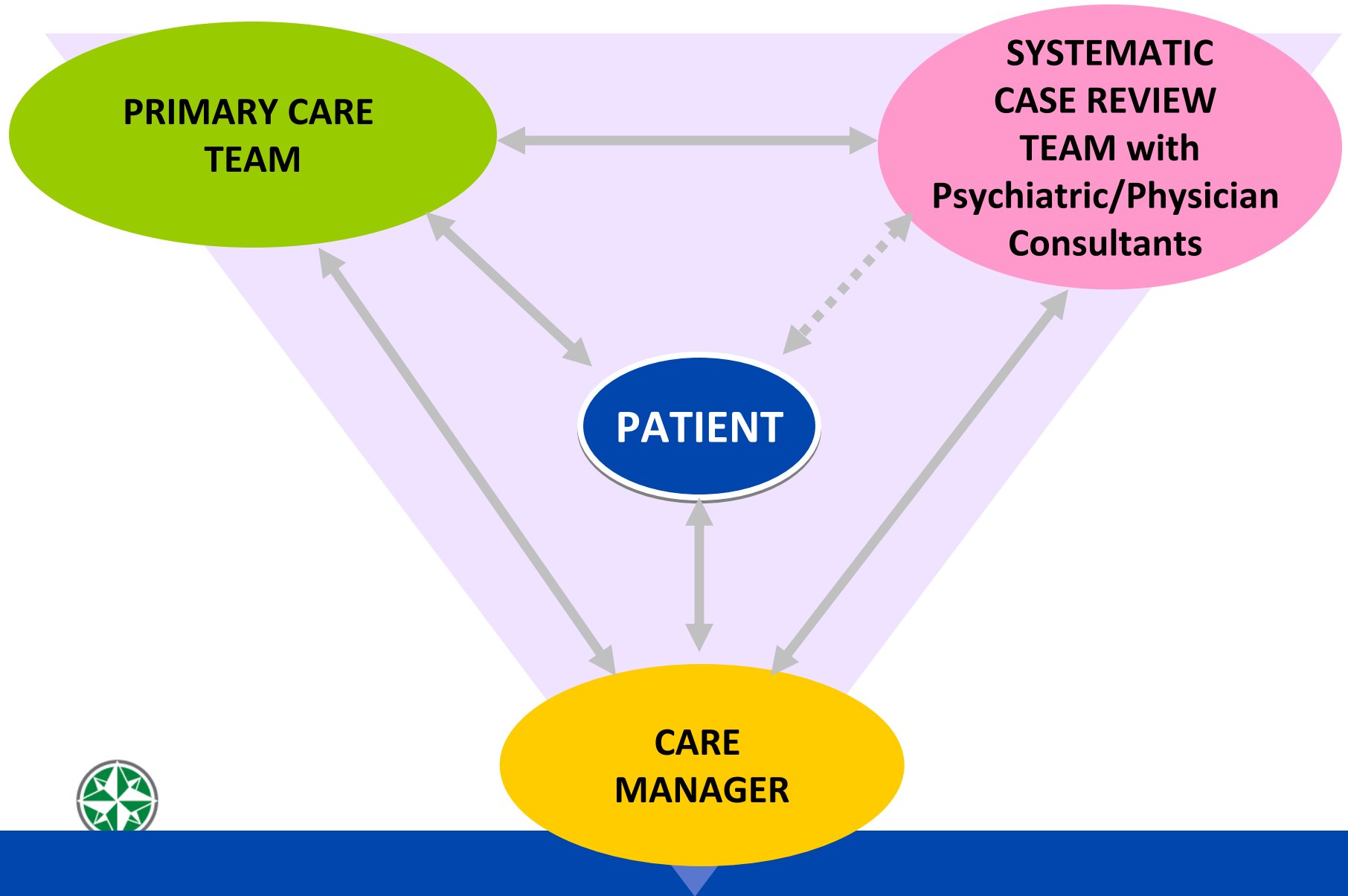
- Implementing COMPASS - challenges
- Using data for patient management - registry
- Do we really need a supervisory meeting?
- Care coordination and managing a population



## First, a patient example

- 60 year old male who saw his ability to cope with his medical issues collapse in 2005 when his back gave out – job loss.
  - Diabetes (initial HgB A1C 9.8)
  - CVD – previous MI and stent
  - HTN
  - Psychosocial
    - Depressed (PHQ-9 14 )
    - Unable to afford medications, not taking care of himself.

# COMPASS TEAM



# Challenges for implementation

- **Finding your team members**
  - What's a care coordinator and where do I find a psychiatrist?
- **Cost in a fee-for-service world**
  - How do we pay care coordinators?
  - Can we block providers time?
- **Culture**
  - PCP supervising – you mean I give feedback to my colleagues about their patients?
- **Locating patients**
  - PHQ-9 needs to be used routinely
  - Do we know which patients are not doing well?
  - Links with specialty areas/hospital



# A registry



- A tool for:
  - Tracking patients
    - Care coordinators know who needs a call
    - Providers know who needs more attention even when the patient is not in clinic
    - Primary care provider can see his/her entire patient list
  - Tracking systems
    - Are we doing our job?
    - Best practices?

# Example: Registry sorting attending to the absent patient

## Demo - Patient Stats (31)


Patient						Initial Asmnt	Contacts			Last F/U w/ PHQ-9
Clinic #	Name	Location	CM	PCP	Activation Date	PHQ	# All	# Clinic	# Phone	PHQ
-	-	Baldwin PCIM	jjm07	eet05	2013-10-09	23	2	2	0	22
-	-	Baldwin PCIM	jjm07	m08911	2013-05-30	16	16	0	16	20
-	-	Baldwin Fam Med	jjm07	gmg03	2012-12-12	14	19	1	18	18
-	-	Baldwin PCIM	jjm07	dgb04	2013-08-22	13	9	1	8	17
-	-	Baldwin Fam Med	jjm07	mrm3455	2013-05-28	20	11	1	10	16
-	-	Baldwin PCIM	jjm07	law02		15	2	1	1	15
-	-	Baldwin Fam Med	jjm07	dmk03		19	0	0	0	15
-	-	Baldwin Fam Med	jjm07	m007860		16	1	1	0	14
-	-	Baldwin Fam Med	jjm07	kjs24		14	1	1	0	14
-	-	Baldwin Fam Med	jjm07	jwf01	2013-09-04	14	10	1	9	14
-	-	Baldwin Fam Med	jjm07	m059414	2013-07-11	17	5	2	3	13
-	-	Baldwin Fam Med	jjm07	m059414	2013-06-24	22	7	2	5	12
-	-	Baldwin Fam Med	jjm07	jwb04	2013-08-07	23	8	0	8	12
-	-	Baldwin Fam Med	jjm07	mah08		12	0	0	0	12
-	-	Baldwin Fam Med	jjm07	msh01	2013-10-14	12	3	1	2	11
-	-	Baldwin PCIM	jjm07	mrn0733	2013-10-08	17	2	0	2	11
-	-	Baldwin Fam Med	jjm07	jwf01	2013-09-20	25	7	1	6	11
-	-	Baldwin Fam Med	jjm07	m106418		17	2	1	1	11
-	-	Baldwin Fam Med	jjm07	m070121		19	4	0	4	11
-	-	Baldwin Fam Med	jjm07	svs04		10	0	0	0	10
-	-	Baldwin Fam Med	jjm07	m059414	2013-09-18	13	8	4	4	10
-	-	Baldwin Fam Med	jjm07	m007860	2013-09-18	15	4	1	3	9
-	-	Baldwin Fam Med	jjm07	jwf01	2013-10-17	10	2	2	0	9
-	-	Baldwin Fam Med	jjm07	bainj	2013-08-12	16	13	1	12	8
-	-	Baldwin Fam Med	jjm07	m070121	2013-02-14	11	19	1	18	6
-	-	Baldwin Fam Med	jjm07	m059414	2012-12-17	16	14	2	12	5
-	-	Baldwin PCIM	jjm07	bja07	2013-08-19	15	6	1	5	4
-	-	Baldwin PCIM	jjm07	mri4215	2013-05-21	18	22	1	21	3
-	-	Baldwin Fam Med	jjm07	jab35	2013-07-30	10	10	1	9	3
-	-	Baldwin Fam Med	jjm07	m049546	2013-09-09	11	5	4	1	2
-	-	Baldwin Fam Med	jjm07	rds03	2013-09-25	15	3	1	2	2





















A simple column sorting tool lets the supervising physician sort by patients with (in this example) a PHQ-9 of 10 or more to make sure to review them all and make suggestions. Same concept with LDL/HgBA1C

# Example 2: Management of the practice – how're we doing?

## CASELOAD STATISTICS

Site : Mayo (Aggregated by Clinic)   
 Report Created on : Friday, November 1, 2013, 12:17PM

CLINIC	# OF PT. 	INITIAL CONTACT		FOLLOW UP				LAST AVAILABLE 	DECREASED 5+ POINTS	# ON MEDS 	# W/ MISSING MEDS 	# IN M/P 	PSYCHIATRY CONSULTATION 			50% IMPROVED OR < 10 AFTER > 10 WKS
		# 	MEAN PHQ 	# OF PT. 	MEAN # 	MEAN # CLINIC 	MEAN # PHONE 	MEAN PHQ 	PHQ 				# REQ'D 	# W/ P/N 	NOT IMPRV W/O P/N 	PHQ 
Albert Lea	39	39 (100%)	16.0	39 (100%)	3.9	0.4 (9%)	3.6 (91%)	11.4	22 (65%)	29 (74%)	1 (3%)	0 (0%)	0 (0%)	24 (62%)	8	15 (48%) (n=31)
Austin	56	54 (96%)	16.6	53 (98%)	7.7	0.5 (6%)	6.7 (87%)	8.9	34 (69%)	50 (94%)	1 (2%)	3 (6%)	0 (0%)	54 (96%)	4	26 (67%) (n=39)
Faribault	12	12 (100%)	13.8	11 (92%)	8.5	1.2 (14%)	5.8 (69%)	11	5 (45%)	11 (100%)	0 (0%)	1 (8%)	0 (0%)	12 (100%)	8	4 (40%) (n=10)
Mankato	69	69 (100%)	14.1	55 (80%)	7.1	1.8 (25%)	5.2 (73%)	10.2	30 (59%)	25 (45%)	40 (58%)	4 (6%)	0 (0%)	66 (96%)	0	18 (69%) (n=26)
Owatonna	16	16 (100%)	15.9	13 (81%)	4.5	1.3 (29%)	1.9 (43%)	8.3	8 (67%)	12 (92%)	1 (6%)	0 (0%)	0 (0%)	15 (94%)	7	8 (73%) (n=11)
Red Wing	32	32 (100%)	15.5	31 (97%)	9.9	1.2 (12%)	8.6 (87%)	10.3	19 (66%)	31 (100%)	0 (0%)	0 (0%)	0 (0%)	32 (100%)	0	9 (50%) (n=18)
All	224	222 (99%)	15.4	202 (91%)	7.0	1.0 (15%)	5.6 (80%)	10.0	118 (63%)	158 (78%)	43 (19%)	8 (4%)	0 (0%)	203 (91%)	27	80 (59%) (n=135)

Population(s) included :  COMPASS





# Example 3: Managing the managers

## CASELOAD STATISTICS

Site : Mayo (Aggregated by Care Manager   
 Report Created on : Friday, November 1, 2013, 12:28PM

CARE MANAGER	# OF PT. <input type="text"/>	INITIAL CONTACT		FOLLOW UP			LAST AVAILABLE <input type="text"/>	DECREASED 5+ POINTS		# ON MEDS <input type="text"/>	# W/ MISSING MEDS <input type="text"/>	# IN M/P <input type="text"/>	PSYCHIATRY CONSULTATION <input type="text"/>			50% IMPROVED OR < 10 AFTER > 10 WKS
		# <input type="text"/>	MEAN PHQ <input type="text"/>	# OF PT. <input type="text"/>	MEAN # <input type="text"/>	MEAN # CLINIC <input type="text"/>	MEAN # PHONE <input type="text"/>	MEAN PHQ <input type="text"/>	PHQ <input type="text"/>				# REQ'D <input type="text"/>	# W/ P/N <input type="text"/>	NOT IMPRV W/O P/N <input type="text"/>	PHQ <input type="text"/>
Andrea	56	54 (96%)	16.6	53 (98%)	7.7	0.5 (6%)	6.7 (87%)	8.9	34 (69%)	50 (94%)	1 (2%)	3 (6%)	0 (0%)	54 (96%)	4	26 (67%) (n=39)
Betty	36	36 (100%)	16.3	36 (100%)	4.2	0.3 (8%)	3.8 (92%)	11.6	22 (69%)	26 (72%)	1 (3%)	0 (0%)	0 (0%)	22 (61%)	8	15 (48%) (n=31)
Chad	28	28 (100%)	15	24 (86%)	6.3	1.3 (20%)	3.7 (59%)	9.8	13 (57%)	23 (96%)	1 (4%)	1 (4%)	0 (0%)	27 (96%)	15	12 (57%) (n=21)
David	0	- (-%)	-	- (-%)	-	- (-%)	- (-%)	-	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	0	- (-%) (n=0)
Elizabeth	36	36 (100%)	14.4	26 (72%)	5.2	2.8 (54%)	2.2 (43%)	12.7	11 (48%)	10 (38%)	26 (72%)	4 (11%)	0 (0%)	33 (92%)	0	5 (56%) (n=9)
Francis	0	- (-%)	-	- (-%)	-	- (-%)	- (-%)	-	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	0	- (-%) (n=0)
Geoff	0	- (-%)	-	- (-%)	-	- (-%)	- (-%)	-	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	0	- (-%) (n=0)
Holly	0	- (-%)	-	- (-%)	-	- (-%)	- (-%)	-	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	- (-%)	0	- (-%) (n=0)
Immanuel	33	33 (100%)	13.8	29 (88%)	8.9	0.9 (10%)	7.9 (88%)	8.4	19 (68%)	15 (52%)	14 (42%)	0 (0%)	0 (0%)	33 (100%)	0	13 (76%) (n=17)

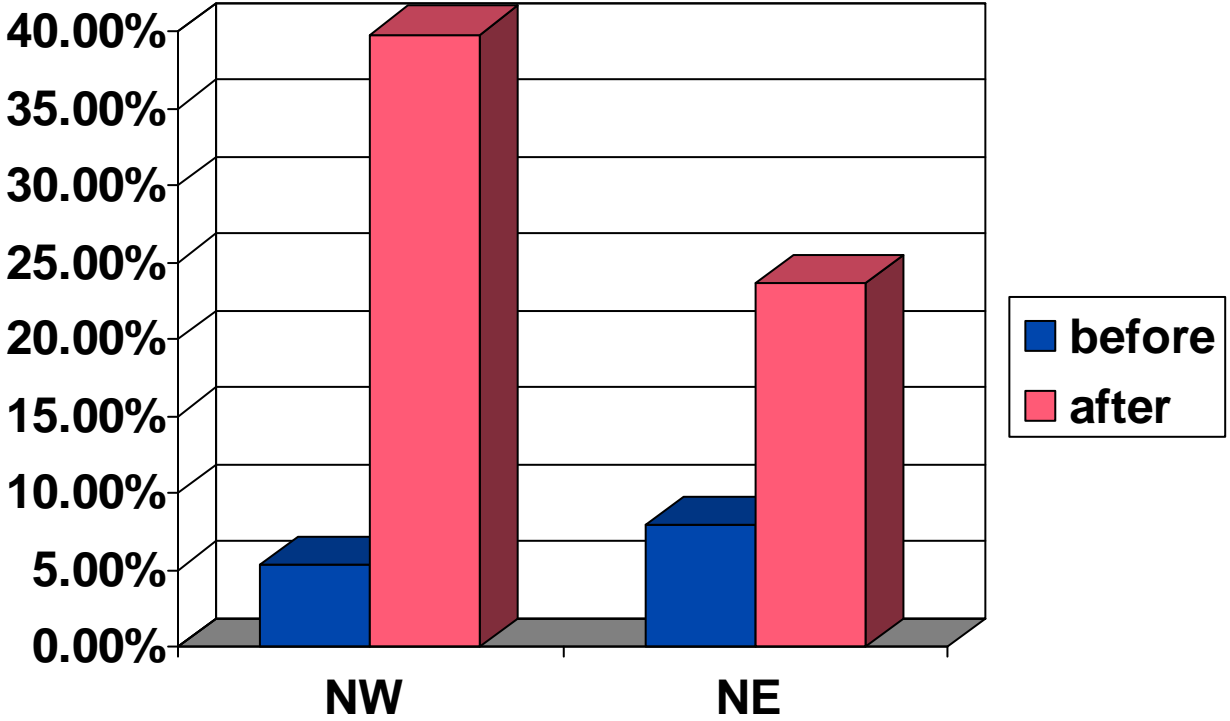


# Models of care coordination at Mayo

- DIAMOND (2008)
  - Care coordination for adult depression
    - Supervision with a psychiatrist weekly
    - Admission/discharge criteria clear
    - Time limited
    - Bundled reimbursement
  - Challenges
    - Patient comorbidities
    - Designed around symptom reduction, not specifically around cost



# Six month remission rate (intent to treat) at two primary care clinics before and after introduction of care coordination

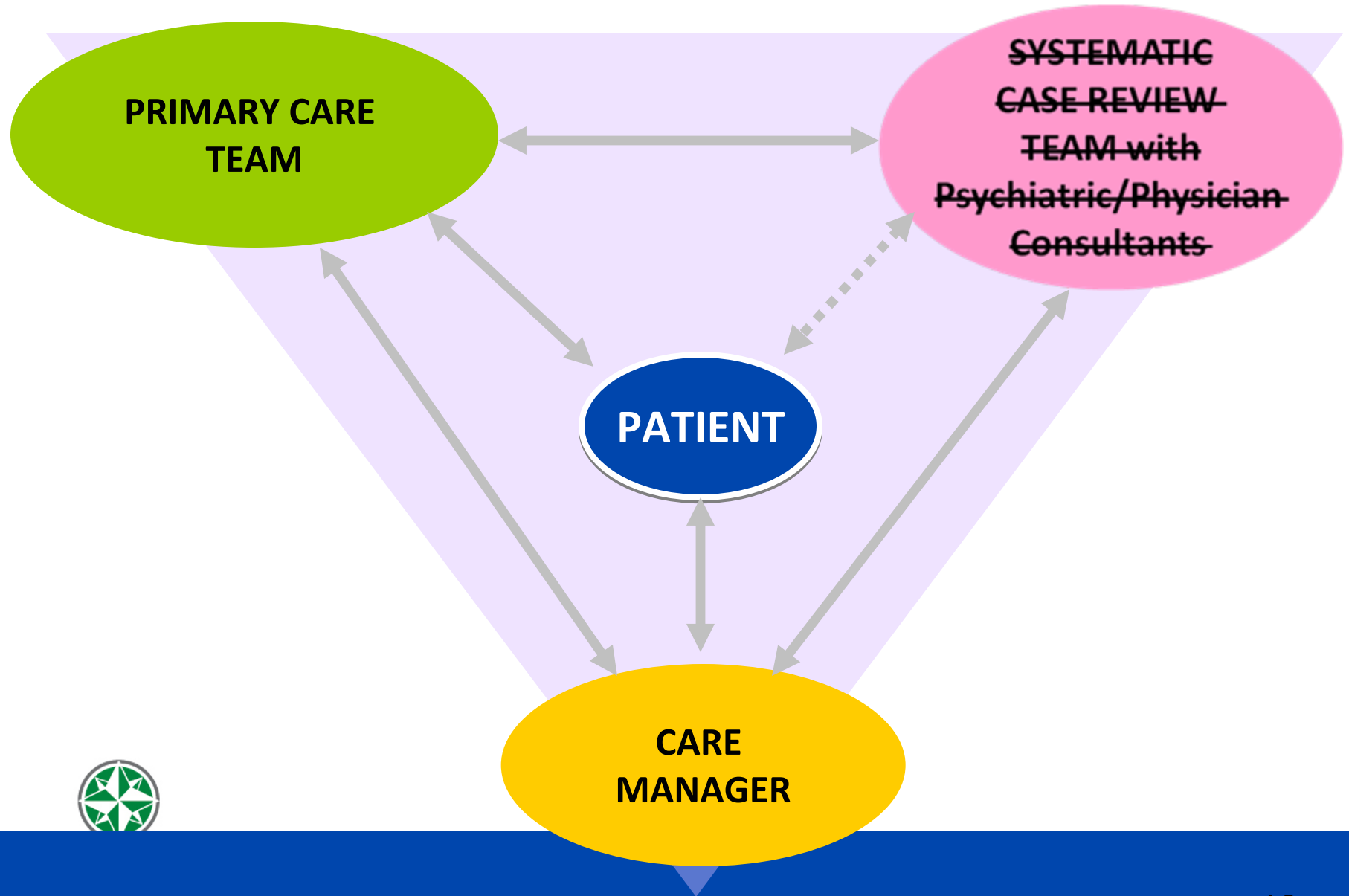


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# Medical adult care coordination (2010) (healthcare home)

- Diabetes and Asthma – disease management – good clinical results
- New research data on cost and tiering
  - Switch to adult patients with highest comorbidities and cost
  - Healthcare home certification

# Team – Healthcare Home Care Coordination



# What happens without supervisory sessions?

- Entry of patients
  - PCP could pressure care coordinators into taking patients
- Interventions
  - Depended on finding time with each PCP to discuss their patients – burnout of care coordinators, takes longer to treat to target...
    - No peer review, harder to standardize approach
- Discharge
  - Providers advocate to keep patients in care coordination (some over 3 years).

# Adult care coordination for complex patients

- Advantages
  - Focus on most costly patients
- Challenges
  - Does high cost = response to care coordination?
  - No research base to design model
  - Entry and exit criteria influenced by each PCP
  - Care coordinator burnout and case load
  - Mental health and psychosocial issues not incorporated into model and plan

# COMPASS

- Selling it to the practice
  - Advantages
    - Build a model on evidence and expand
    - Mental health issues are now addressed
    - Access to collaborative learning
  - Disadvantages
    - Narrow criteria – what about other costly conditions (bipolar, COPD, etc)?
  - Question raised
    - Is systematic case review worth the cost?



# Outcomes COMPASS- Mayo vs. Randomized Trial (preliminary data)

	<b>TEAMcare Intervention Group- 6 months (n = 214)</b>	<b>Mayo COMPASS 10 weeks (n = 130)</b>
<b>Depression Severity Percent Response</b> <small>(response = 50% reduction in PHQ score)</small>	59%	60%
<b>Change A1c</b>	0.72	0.70
<b>Change LDL</b>	14.9	17.3
<b>Change Systolic BP</b>	3.8	20.4

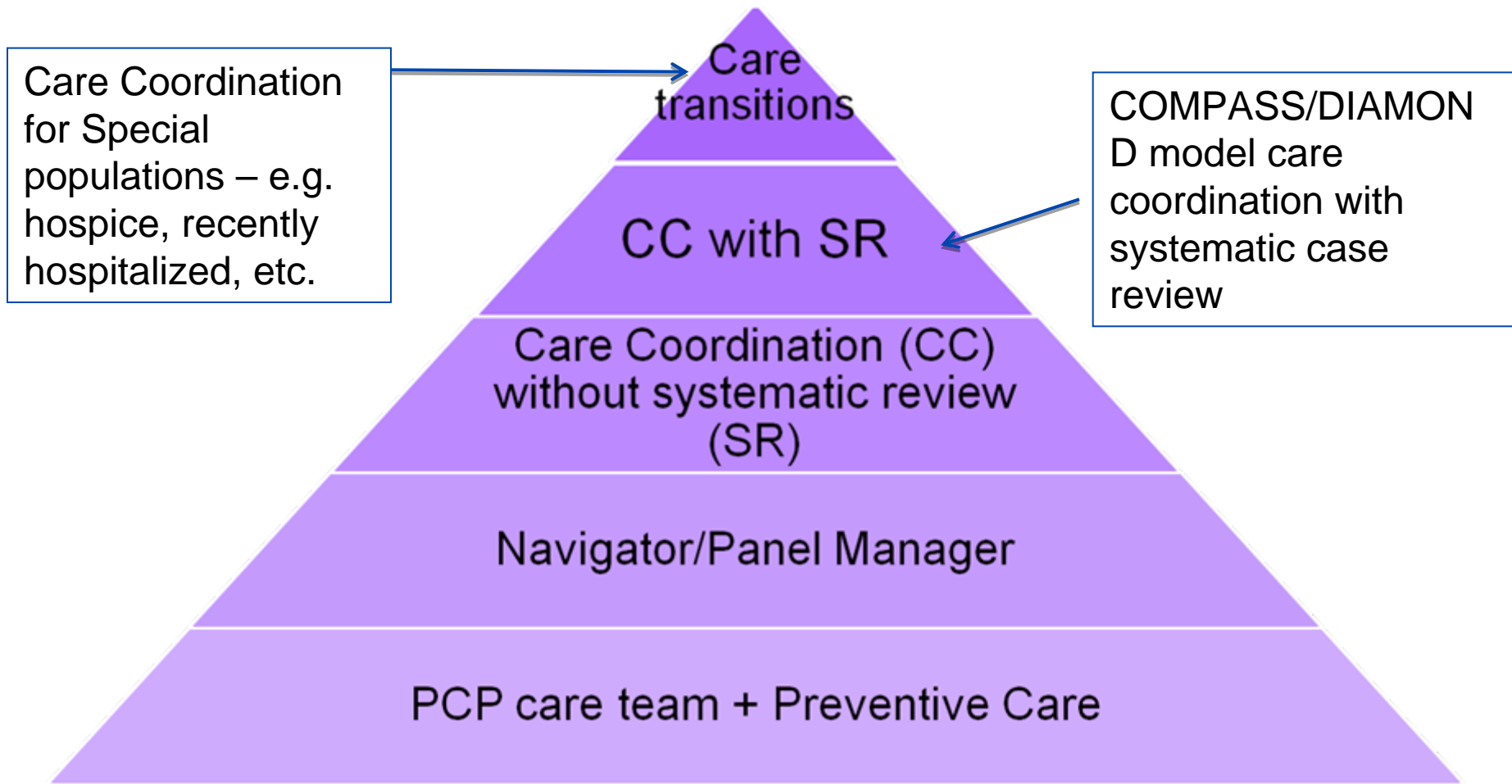
# What's next – work towards one model?

- Dual Diagnosis patients - COMPASS
  - Which conditions?
  - How do we define graduation?
- Behavioral health patients - DIAMOND
  - can we broaden to other patients with mental health conditions beyond depression?
- Medical high cost patients--Adult Care Coordination
  - Which medical conditions need supervisory sessions?
  - Can we identify outcome measures beyond cost that are meaningful.

# Decisions on the way to one model

- Base your model on published evidence?
- Will you only follow cost?
  - What about those rising cost patients?
  - Cost savings when?
  - Do clinicians know how to manage cost?
- Treat to target – who's target?
- Is there a time limit to care coordination?
- How creative are you able to be with psychosocial needs?

# Hybrid Complex Care Model



# Highlights of doing this type of work

- Team learning
  - Psychiatrist and Primary care supervisor
    - Recognize problems in care delivery system
    - Recognize resource limitations
- Better use of data for patient care
  - Registry can be a powerful tool
- Toughest patients start to get better – many patient stories

# Major challenges to this work

- Inconsistent reimbursement for care coordination
  - How do systems learn to do this?
- Social determinants of health
  - How much can the health system manage?
- Electronic resources – data registry
  - Many on the market, not generally compatible with multiple Electronic Medical record systems.
- Silos of care – specialists/hospitals/ED/primary

# Summary

- Care coordination in our future needs to both improve clinical outcomes and control costs.
- COMPASS provides outside expertise and funding to leverage change within a system like Mayo.
  - Can we get research level results?
  - With experience and tools in place to track outcomes, can we broaden the approach to include other conditions?
  - How to afford the spread of care coordination in advance of reimbursement for care coordination or shared savings?
  - Pay for performance can help if done wisely