

COMPASS Systematic Case Review

David Katzelnick MD Mayo Clinic Rochester, MN May 8th, 2013

Case of Mr T

- •70 year old retired married factory worker
- •Chief complaints small wound right foot, difficulty sleeping, trouble with glucose readings
- •Followed by PCP in your clinic, past seen in endocrine, sleep and psychiatry clinics.
- •Type II diabetes, insulin dependent since 2003, asthma, hypertension, sleep apnea, restless leg syndrome, history depression, history alcohol dependance (sober since 1978)
- •Current Meds: Albuterol, Actos, Bupropion XL, Lantos, HCTZ, Novolog, Requip, Prozac and Zocor
- •Recent labs: HgB A1C=8.2, cholesterol 87, LDL=39, PHQ-9=23, item #9 positive (has gun at home, no plan or intent)
- •Recent stressors: wife has Alzheimer's and had to move to skilled nursing facility



How it works: collaborative care for patients with multiple conditions

➤ Identify Target Populations

➤ Registries for Multi-conditions

1 Set Goals and Plan

Patient, primary care doctor, and care manager make Care Plan with realistic, specific, measurable, step-by-step goals:

- · increase physical activity
- lower depression and blood sugar, pressure, and cholesterol levels

5 Treat to Goal

Primary care doctor:

- makes step-by-step changes in medicines for depression, blood sugar, pressure, or cholesterol
- · makes referrals as needed
- works with patient and care manager to set new goals
- transitions back to standard care when ready

Patient-Centered Coordinated Care

Primary care doctor



2 Support Self-Care

Care manager:

 motivates and supports problemsolving

Patien^{*}

- tracks blood sugar and blood pressure
- follows healthy lifestyle
- sticks to medicines

4 Review Cases

Multi-disciplinary team:

 medical and behavioral health consultants, primary care doctor, and care manager

MEASURES

- meets weekly to review cases in population
- recommends individualized treatment adjustments
 based on evidence based

based on evidence-based guidelines

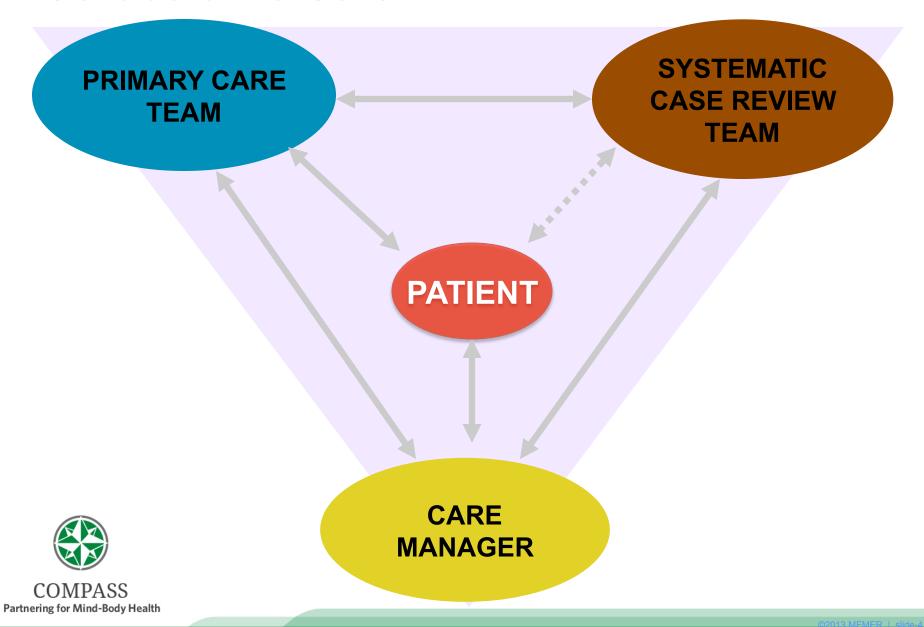
3 Track Progress

Care manager:

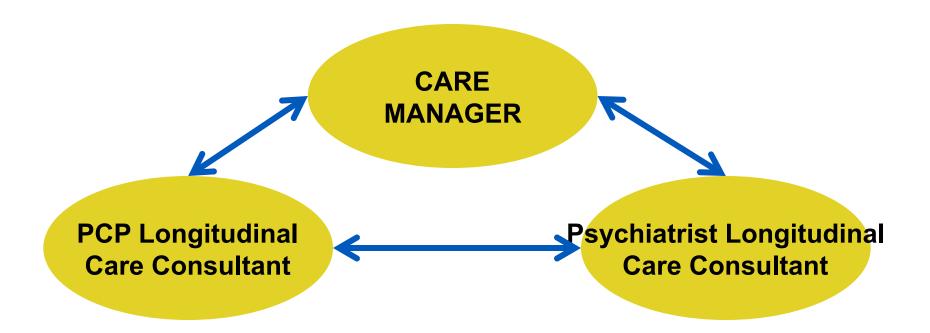
- regularly tracks patient's mental and physical health
- does systematic follow-up, including outreach



Collaborative Care



SYSTEMATIC CASE REVIEW TEAM





Systematic Case Review Content

- New cases
- Ongoing cases that haven't reached targeted goals
 - (e.g., PHQ-9 <5, HbA1c <7.0%, SBP <130, LDL <100)
- Difficult nurse-patient relationships
- Patients out of contact



Systematic Case Review Procedures: Case Presentation

- Who is this patient?
 - e.g., age, psychosocial background, unique personality constructs
- Depression and diabetes/CHD history
- Treatment targets
- Current treatment and past treatment experience



Case Review Priorities

New Patient

- Who is this patient
 - Age, psychosocial background, unique personality constructs, potential key motivators, daily functioning
 - Depression and diabetes/CHD history
 - Treatment targets
 - Patient and physician perspectives
 - Current treatment and past treatment experiences
 - Food intake, activity
 - Medications- how they are or are not taking
 - Attitudes and preferences about treatment options

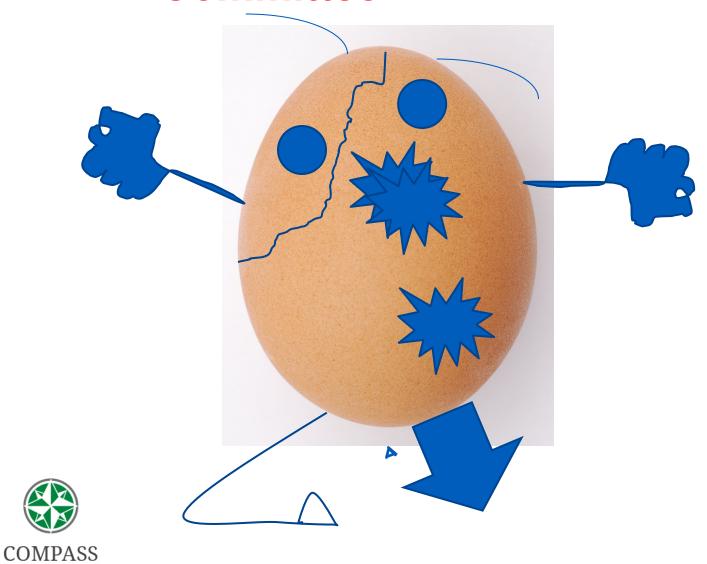


Case Review Procedures

- Ongoing Cases
- Patients flagged in the registry
- Ongoing cases who are not reaching target (PHQ-9, BP, A1C, LDL)
- Hard to reach patients
- Difficult team member-patient relationships
- Patients successfully achieving target



Egg Designed by Committee



Partnering for Mind-Body Health

Questions for Case Reviews

- 1) What are the current outcomes vs. targets:
- A1C, BP, LDL, PHQ-9,
- 2) What self-care activity is the patient doing?
- Taking medicines- name, dose, frequency
- Self-monitoring BP, glucose, weight
- Physical activity or nutrition
- Enjoyable moments, especially for depressed patients
- 3) Treat-to-Target (TTT)?
- Adjust treatment-relentless and individualized
- If no adjustment planned, document why not
- 4) Next follow-up?

Date, mode (phone, in person), labs

Successful Meetings (How to avoid egg designed by committee)

- Agreed-upon format
- Mutually agreed to scheduled time and location
- Use shared data sheets/screens
- Structured input/structured output need both
- Alternate as scribes for each other



Keys for MD Consultants/Champions

- Be supportive, but clear on goals and accountability
- Don't lower self-esteem!
- Set clear goals and action plan for following week
- Be curious and problem-solve solutions
- Be available between supervision sessions via pager, e-mail, phone



Questions and discussion?



