COMPASS

Care Management Phases & Follow-up Guide

This tool provides recommended guidance for the COMPASS team assisting a patient through the phases of care. Each system has to determine the tailoring needed within their own processes to operationalize this guide to its fullest. Above all, remember the patient is fluid and not a referral to be "handed off" to any one team member and then "given back". Communication leading up to and following each transition is critical to ensure all members of the team including the patient are aligned with the same goals. Stages of change and readiness are parallel aspects of this flow and may resonate with some users in applicability.

Active Engagement Phase

1st & 2nd contacts

- Determine eligibility & appropriateness
- Introduce COMPASS & set the roadmap for care
- Start building relationship with patient to identify preferences, strengths and challenges
- Establish primary care team communication strategy, engagement plans, caseload impact & understanding of patient care needs

Active Management Phase

Weekly contacts in the first month
Every other week over the next 2-3 months

- Clinical prioritization, assessment of red flag risks and identify patient preferences
- Establish care plan including both short & long term goals for optimal improvement
- Purposeful care management using Motivational Interviewing, Behavioral Activation & goal setting that links treat-to-target clinical plan including med intensification with personal health goals by developing strategies for self-monitoring, treatment (including medications) adherence and problem solving skills
- Shared understanding of working toward optimal maintenance of the chronic conditions and the organic but intentional process of outcome oriented care management

Active Transition Phase

Frequency gradually extended
Average duration 5-18 weeks

- Based on pt's progress with clinical and personal goals and agreement that significant improvement has been made.
- Less frequent contacts as an opportunity for pt to practice identifying triggers, problem solve and self-monitor.
- Duration may need to be variable based on pt readiness, unanticipated pitfalls and ongoing coaching needs but overall becomes longer periods of self-management success.
- Starting to build maintenance plan using pts own words for what has contributed to improvement & problem solve obstacles

Maintenance Phase

Monthly to every 3 mo
Average duration 6-12 months

- Patient has been practicing and more consistently demonstrating self-management including ability to identify triggers, setbacks and opportunities
- Maintenance Plan has been developing along the way and patient can now articulate and complete own written plan for sustainment (example: own personal "yellow zone" and when to contact clinic when things come up and assistance is needed)
- Schedule established for PCP follow-up and lab/clinical monitoring intervals
- Primary care team understanding of maintenance plan including support role and and routine follow up expectations