



Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease[☆]



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ABSTRACT

Objective: The spread of evidence-based care is an important challenge in healthcare. We evaluated spread of an evidence-based large-scale multisite collaborative care model for patients with depression and diabetes and/or cardiovascular disease (COMPASS).

Methods: Primary care patients with depression and comorbid diabetes or cardiovascular disease were recruited. Collaborative care teams used care management tracking systems and systematic case reviews to track and intensify treatment for patients not improving. Targeted outcomes were depression remission and response (assessed with the Patient Health Questionnaire-9) and control of diabetes (assessed by HbA1c) and blood pressure. Patients and clinicians were surveyed about satisfaction with care.

Results: Eighteen care systems and 172 clinics enrolled 3609 patients across the US. Of those with uncontrolled disease at enrollment, 40% achieved depression remission or response, 23% glucose control and 58% blood pressure control during a mean follow-up of 11 months. There were large variations in outcomes across medical groups. Patients and clinicians were satisfied with COMPASS care.

Conclusions: COMPASS was successfully spread across diverse care systems and demonstrated improved outcomes for complex patients with previously uncontrolled chronic disease. Future large-scale implementation projects should create robust processes to identify and reduce expected variation in implementation to consistently provide improved care.

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1. Introduction

There is ample evidence of large gaps between usual and evidence-based care for patients with comorbid chronic conditions, yet few examples of successful implementation of innovative care models are able to narrow this gap [1]. Evidence-driven collaborative care for patients with multiple conditions could be used as a model for the implementation of care for complex patients. To date, despite strong evidence demonstrating that the collaborative care model is effective for depression [2–4] and a growing body of evidence that it is also effective for

other chronic diseases [4,5], collaborative care based on research outcomes is not routinely implemented outside of clinical trials.

For depression, the evidence supporting the effectiveness of collaborative care is robust, with over 80 randomized clinic trials demonstrating its value [6]. Collaborative care has been shown to increase antidepressant adherence, improve depression outcomes for 2 to 5 years, and increase patient and clinician satisfaction [2]. Some studies have also found collaborative care to be cost-saving, including Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), which demonstrated a reduction of 10% in total healthcare costs over 4 years, despite the intervention lasting only 1 year [7].

For management of chronic diseases other than depression, the evidence supporting the effectiveness of collaborative care is growing. Most notably, TEAMcare demonstrated the feasibility and effectiveness of collaborative care for patients with either diabetes or heart disease in addition to depression [4]. In TEAMcare, collaborative care reduced glycolated hemoglobin (HbA1c), systolic blood pressure (SBP), low-density lipoprotein (LDL) and depression scores and disability levels while improving quality of life measures. Additional studies further support the effectiveness of collaborative care in improving diabetes [8,9] and heart disease outcomes [10].

Despite this evidence, collaborative care for multiple chronic conditions is seldom employed outside of clinical trials, in part because key components of this care are not reimbursable. Consequently, the ability to successfully implement collaborative care in a variety of healthcare systems and improve outcomes among diverse patient populations is largely unknown. To address this knowledge gap, 10 organizations across the US collaborated in a Center for Medicare and Medicaid Health Care Innovation Award-funded project to determine if collaborative care for patients with active depression plus comorbid diabetes and/or cardiovascular disease could be spread across diverse states, healthcare systems and patient populations. The Care of Mental, Physical and Substance use Syndromes (COMPASS) initiative implemented the collaborative care model in 172 clinics representing 18 healthcare systems across eight states. The goals of COMPASS were to improve clinical outcomes (namely depression as measured by the PHQ9, diabetes as measured by HbA1c and hypertension), as well as patient and clinician satisfaction. This paper reports the main findings of the COMPASS initiative.

2. Methods

2.1. Partner organizations

Partner organizations included the Community Health Plan of Washington, Kaiser Permanente Colorado, Kaiser Permanente Southern California, Mayo Clinic Health System (Minnesota, Florida), the Michigan Center for Clinical Systems Improvement, Mount Auburn Cambridge Independent Practice Association (Massachusetts), Pittsburgh Regional Health Initiative and the Institute for Clinical Systems Improvement (ICSI; Minnesota). Each partner organization was responsible for recruiting associated care systems and clinics into COMPASS, and 18 care systems and 172 primary care clinics in rural, urban and suburban settings participated. Care systems included integrated health systems, federally qualified health centers, multisite physician practices and individual practice associations. Institutional review boards for all partner organizations approved this study.

ICSI led the overall initiative and facilitated partner organization collaboration, administration of the grant award, and implementation of the COMPASS care model. Participants from each partner organization attended a 2-day train-the-trainer session, followed by customized onsite 3-day trainings at each site. Following these trainings, partner organizations provided different levels of coaching and booster trainings. The content and frequency of these sessions were determined by each partner, with input from ICSI and other partners, taking into account outcomes and fidelity measures, regular inperson or phone observation of systematic case reviews by ICSI staff, coaching and networking calls

and requests from sites themselves. In addition, ICSI facilitated monthly Webinars with the care managers and later hosted a second train-the-trainer event. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington helped develop the COMPASS model and provided technical assistance for its implementation, including making its care management tracking system (CMTS) available for use. HealthPartners Institute led the monitoring, performance reporting and assessment of the initiative's implementation and outcomes.

2.2. Patients

Potential participants with active depression and diabetes and/or cardiovascular disease were enrolled in COMPASS between February 2013 and March 2015. Patients were identified in varying ways across clinics and medical groups, including recruitment of patients during primary care appointments, clinician referrals and electronic medical record queries. Patients who were recruited into COMPASS were typically not adequately responding to usual care.

Patients were eligible for COMPASS if they had active depression (PHQ9>9) and poorly controlled diabetes or cardiovascular disease. Initially, an additional eligibility criterion was having Medicare or Medicaid insurance; however, due to challenges with enrollment of sufficient patients and implementation in clinics with multiple payers, all insurance types were later accepted, which ultimately improved COMPASS's generalizability.

A total of 3854 patients were enrolled in COMPASS. For purposes of analysis, the following exclusion criteria were applied to ensure that patients actually received COMPASS care: 89 patients were excluded because they had no documented contact with COMPASS care managers after enrollment, 143 because less than a month elapsed between first contact and discharge from COMPASS and 13 because they were enrolled less than a month before COMPASS ended. The final analytic sample included 3609 patients.

2.3. Intervention

The COMPASS care model is described in detail in a related publication [11]. Briefly, COMPASS care was based broadly on the chronic care model [12,13] and more specifically on the collaborative care management model [2,14] as refined by the IMPACT [3] and TEAMcare [4] trials and the DIAMOND (Depression Improvement Across Minnesota—Offering a New Direction) [15] project. The key components of this model are intensive case management using rigorous treat-to-target guidelines for depression, diabetes and cardiovascular disease delivered by a care management team. Each team consisted of a care manager who had direct contact with the patient, as well as a consulting primary care physician and psychiatrist. Teams were expected to meet weekly for systematic case reviews, where they were tasked with (a) reviewing the initial care plan for all patients; (b) reviewing all patients not improving and making treatment adjustments as indicated; and (c) agreeing on discharge and follow-up plans for patients who achieved disease goals and were ready to transition out of COMPASS. Processes of care and patients outcomes were monitored using an electronic CMTS, and aggregated and site-specific quality improvement reports were routinely reported to each site. Laboratory, vital signs and healthcare services utilization information were abstracted from the CMTS.

2.4. Patient and clinician surveys

Patients who agreed to have their personal information sent to a central evaluation center were contacted to participate in a phone survey about their satisfaction with care before beginning COMPASS care and again 1 year after enrollment. Of the 3854 patients enrolled in COMPASS, contact information for 1762 (46%) patients was provided to the central survey center. Of these 1762 patients, 1133 were able to be contacted, 751 were screened and 663 (38% of 1762) were eligible

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