COMPASS-PH/BH™

Developing Integrated Physical Health/Behavioral Health Capability in Treatment Settings

Version 1.1

A Self-assessment Tool for Behavioral Health and Primary Health Clinics and Programs

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COMPASS-PH/BH™
User's Guide

Welcome!

We are delighted that your team has an opportunity to use the COMPASS-PH/BH™ to help develop integrated physical health/ behavioral health capability in your treatment setting.

One of the most significant advances in recent years in the delivery of health and human services to people and families is the concept of "whole person" care. This advance reflects an appreciation that, more often than not, people and families struggle with multiple physical health, behavioral health and social wellness concerns. The issues are varied—acute and chronic physical illnesses, substance use disorders and prevention needs, a variety of mental and emotional concerns that range from mild to severe, exposures and experiences with trauma and violence, social risk factors such as homelessness and loss of housing, involvement with courts and being incarcerated, problems in school or in the job, or finding oneself unemployed and in need, and unfortunately many more. The issues people face collectively create complexity that requires integrated approaches to improve health and wellness outcomes. This complexity of need is an expectation, not the exception. In response, both primary health and behavioral health settings are increasingly becoming "integrated health homes" for people with all types of complex issues, conditions, and disorders. With the advent of health care reform, much more movement in this direction is likely to occur.

Many behavioral health programs and primary health clinics are working to develop successful integrated approaches that are effective and rational in already over-stretched delivery systems. Creating manageable strategies that truly improve the care delivered, all within existing resources, is the challenge. Some organizations are hiring physical health or behavioral health specialists as consultants, some are developing partnerships with complementary programs, and some are becoming full-service integrated physical health/behavioral health organizations. The approaches are varied and the growth in understanding is sure to be enormous in the coming years. One common denominator is that, for service settings to be effective in responding to complexity, all will need to have systematic and organized ways of managing profound change in partnership within the organization and with others. **To help you in your process of creating manageable and effective integrated responses to the complex needs of people and families you serve, we created the COMPASS-PH/BH™.**

Outcomes

The **COMPASS-PH/BH™** is designed to produce a number of important outcomes. The **COMPASS-PH/BH™**:

- Empowers organizations and staff to accomplish step-by-step goals to create integrated care for people and families with complex needs.
- Communicates a common language and understanding of integrated PH/BH capable services.
- Establishes an organizational baseline of integrated PH/BH capability so there is a rational foundation for a change process.
- Creates a shared process using a common tool that can be used in any system for an array of diverse programs working in partnership on integrated PH/BH capability development.
- Produces a universal continuous quality improvement framework for all types of programs in any system of care that serves individuals and families with complex lives.

For Primary Health and Behavioral Health Settings

The COMPASS-PH/BH™ is for programs offering physical health care to individuals and families, such as:

- **Federally Qualified Health Centers**
- **Child and Adolescent Primary Health Settings, including School-based Services**
- **Adult and Older Adult Primary Health Settings**
- **Public Health Centers**
- **Hospital-based Settings**

The COMPASS-PH/BH™ is equally for programs offering behavioral health care to individuals and families. Examples include:

- **Mental Health Centers**
- **Substance Abuse Treatment Programs**
- **Developmental Disability Programs**
- **Brain Injury Rehabilitation Programs**
- **Child, Adolescent and Family Behavioral Health Programs**
- **Behavioral Health Inpatient and Residential Programs**

Helpful Definitions

Integrated Physical Health/Behavioral Health Capability

Within the mission and resources of any type of behavioral health program, primary health program, or primary health/behavioral health collaborative program, integrated PH/BH capability involves designing every aspect at every level on the assumption that the next person and family "coming to the door" is likely to have behavioral health and physical health issues and other complex needs. They must be welcomed for care, engaged with empathy, hope, and kindness, and provided what they need for both physical and behavioral health issues in a person-specific and integrated fashion in order to make progress toward having happy, healthy, productive lives. Integrated PH/BH capability necessitates that all services and supports are welcoming, provided in a context of partnership and shared decision-making, and centered on the person's own choices and goals. This recovery-/resiliency-based approach to service is attuned to people and families with diverse goals, strengths, histories and cultures. Integrated PH/BH capability involves looking at all aspects of program design and function in order to embed integrated policies, procedures and practices in the regular operations of the program to make it easier and more routine for each person delivering clinical services to provide effective care. Integrated PH/BH capability is *not* equivalent to either administrative integration or geographic co-location of primary health and behavioral health services. While administrative integration and co-location may be supportive of integrated PH/BH capability, they are neither necessary nor sufficient to achieve it. Whatever the structure or the layout of the services, integrated PH/BH capability requires the development of the specific organizational processes and clinical practices that are addressed in the **COMPASS-PH/BH™** tool.

Complexity Capability

Individuals and families with *multiple* needs are an expectation, not an exception in general populations. Individuals frequently have legal issues, transportation issues, housing issues, parenting issues, educational issues, and vocational issues, in addition to physical and mental health issues, trauma, substance use issues and cognitive disabilities. These individuals and families are culturally and linguistically diverse as well. In short, these are people and families who are characterized by "**complexity**." People with complex lives tend to have poorer outcomes, as well as higher costs of care. However, instead of systems being designed to clearly welcome and prioritize these complex individuals and families with high risk and poor outcomes, individuals and families with complexity have historically been experienced as "misfits" at every level. This realization has become a major driver for comprehensive system change. In order for systems with scarce resources to successfully address the needs of the individuals and families with complex issues who are an "expectation," it is not adequate to fund a few "special programs" to work around the fundamental care delivery system. We need to engage in a process of

organizing everything we do at every level with every resource we have to be about all the complex needs of the people and families seeking help. By doing a self-assessment of its own capability to routinely address complexity in an integrated manner, each program can begin an organized process to become "complexity-capable."

Co-occurring Issues (Also Termed Co-occurring Conditions or Co-occurring Disorders)

An individual has co-occurring physical health and behavioral health issues if he or she has any combination of any mental health issue and/or any substance use problem and/or any cognitive disability with *any* physical health care need or needs, even if the issues have not yet been diagnosed. Many systems and programs are including trauma issues, problem gambling and nicotine dependence in the list of co-occurring issues. Co-occurring issues also apply to families ("families with co-occurring issues" or "co-occurring families") where one member has one kind of problem, such as a child with serious emotional issues, and another member has another kind of problem, such as a family member or caregiver with a significant physical health issue or disability.

CCISC

CCISC (Comprehensive Continuous Integrated System of Care) (Minkoff and Cline, 2004[1], 2005[2]) is both a framework and a process for designing a whole system of care to be about the complex needs of the individuals and families being served. In CCISC, **all programs in the system engage in partnership with other programs, along with the leadership of the system and consumer and family stakeholders, to become welcoming, person-centered and co-occurring capable.** In addition, every person delivering and supporting care is engaged in a process to become welcoming, person-centered, and co-occurring competent as well. The development of integrated PH/BH capability for programs and staff is one component of this larger system framework.

Implementation of CCISC in real-world systems with limited resources is based on significant advances in knowledge in the last two decades. We now have enough knowledge to know how to successfully embed practices in any program in order to be helpful to individuals and families with complex needs. Such practices are organized by **Eight Core CCISC Principles** (See Minkoff and Cline, 2004[1], 2005[2]), and placed in an integrated framework to create a common language throughout the whole system. Such practices involve welcoming access, integrated screening and assessment, empathic hopeful integrated relationships, integrated best-practice treatments, stage-matched and developmentally matched interventions, strength-based skill-based learning, and use of positive reinforcements and rewards to support learning. CCISC implementation helps programs in the system, through the use of **COMPASS-PH/BH™** (and other companion COMPASS™ tools for other kinds of providers), learn how to apply the CCISC principles to build all types of co-occurring capability, including integrated PH/BH capability, into all areas of services and programming.

Companion Tools

COMPASS-PH/BH™ also has companion tools that are tailored to meet the needs of a variety of partner programs working on various aspects of integrated co-occurring capability. Examples are:

- **COMPASS-Prevention™** for prevention and early intervention programs.
- **COMPASS-EZ™** for mental health and substance abuse treatment programs working on integrated mental health/ substance abuse co-occurring capability development.
- **COMPASS-ID™** for providers serving people with intellectual disabilities working on integrated ID/BH co-occurring capability development.

What is the COMPASS-PH/BH™?

A Continuous Quality Improvement Tool

The **COMPASS-PH/BH™** is a tool for clinics and treatment programs, whether working in their own integration process or in partnership with others, to organize themselves to develop core integrated capability to meet the needs of service populations with physical health and behavioral health issues. The tool does not require any particular level of experience or expertise in physical health/ behavioral health integration. Both "newbies" and "seasoned veterans" will benefit from the process. **COMPASS-PH/BH™** supports a wide variety of organizational approaches in that it focuses on the development of universal and essential features of integrated PH/BH service delivery, both at the program design level and the clinical practice level. **COMPASS-PH/BH™** "raises the bar" of quality of care on every piece of service that is delivered. Whether a setting decides to "hire" complementary specialists or not, **any primary health or behavioral health setting can achieve integrated PH/BH capability.** Developing a fundamental environment of integrated PH/BH capability will help define more rational and effective use of any specialty or collaborative care.

As you will see, **COMPASS-PH/BH™** is a continuous quality improvement tool that can be used in the context of a clinic or program's current design, and in the context of current partnerships or relationships with other types of programs or services. **COMPASS-PH/BH™** helps establish a baseline for the clinic/program, defines initial starting places or building blocks based on strengths and previous successes, allows organizations to demonstrate measurable progress, and, most importantly, promotes an empowered team approach to managing complex change.

Based in Core Values

COMPASS-PH/BH™ assists in developing welcoming services that inspire hope and provide help to people and families with a diversity of complex issues, including mental health issues, substance use issues, traumatic life experiences, physical health needs, and social welfare concerns. Individuals and families that have multiple physical health and behavioral health issues are the expectation in both primary health and behavioral health settings serving the general population. With hope, kindness, and help, people with complex issues can progress toward having healthier and happier lives. The tool helps programs begin the process of developing integrated PH/BH capability with high regard for the values of person-centered autonomy and self-efficacy, coupled with the provision of effective treatment services and positive supports. **COMPASS-PH/BH™** helps unite critical knowledge of what we have learned over the years about what helps individuals and families—knowledge about integrated screening, integrated approaches to treatment and intervention, chronic disease management, trauma-informed services, person-centered planning, cultural competency, population-specific services, and fundamentally, empathic relationships that inspire hope and build upon strengths and capacities.

Organization of the COMPASS-PH/BH™

The **COMPASS-PH/BH™** is organized by sections that address aspects of integrated PH/BH capable program design:

- Program Philosophy
- Program Administrative Policies
- Quality Improvement and Data
- Access
- Screening and Identification
- Integrated Assessment
- Integrated Person-centered Planning
- Integrated Treatment/Recovery Programming
- Integrated Treatment/Recovery Relationships
- Integrated and Welcoming Program Policies
- Medication Management
- Integrated Discharge/Transition Planning
- Program Collaboration and Partnership
- General Staff Competencies and Training
- Specific Staff Competencies

What is the Best Way to Use the COMPASS-PH/BH?

The most important purpose of COMPASS-PH/BH™ is to create a foundation for an improvement process through an empowered conversation that involves as many people working together to build the program and its services as possible. **COMPASS-PH/BH™** is designed to help individual agencies, clinics, and programs organize a baseline self-assessment of integrated PH/BH capability as the first step in a continuous quality improvement process in which the program designs an action plan to make progress. **COMPASS-PH/BH™** is designed to help programs have a consistent method for measuring progress, and continue the learning and change process, by repeating the self-assessment at regular intervals.

Self-Survey

COMPASS-PH/BH™ is a program self-survey. The goal is for the participants in the process to discuss the items in the tool and be empowered to examine diverse perceptions about the program policies, procedures, and practices in order to identify the program baseline and opportunities for improvement. **COMPASS-PH/BH™** is designed to help programs develop and take ownership of the continuous quality improvement process.

Group Discussion

COMPASS-PH/BH™ is designed to be used in a group discussion format that includes representation from *all* of the different perspectives in the program: **people representing all disciplines, managers, supervisors, front-line staff, support staff, and, when possible, representative "customers"—individuals and/or families who are or have been in service**. A typical group may have 10 to 15 participants, depending on the size of the clinic or setting. Your group size may be larger or smaller. One of the most important outcomes of using the tool is the discussion among people who hold different perspectives. It is quite striking how often people in the same program have very different opinions about what the "policies" *really* are regarding integrated care for physical health/behavioral health issues. This opportunity for a deep and rich discussion engages the **COMPASS-PH/BH™** participants in learning about integrated PH/BH capability, often gets people excited about the opportunity to make real change, and jumpstarts the process of improvement. The most common mistakes that programs make are to have a single manager complete the tool or to have individuals complete the tool without a discussion, and then average the scores. Proceeding this way is a missed opportunity to get maximum value out of the sharing of perspectives and ideas in a group conversation using **COMPASS-PH/BH™**.

Preparing the Group

It is extremely helpful for the group to have some background about the clinic's participation in a process of integrated PH/BH capability development before using **COMPASS-PH/BH™**. If this is part of a formal collaboration or a larger system effort, this should be explained. If the agency or program is committing to make some changes, this should be explained and discussed as well. It may be helpful for group members to read through **COMPASS-PH/BH™** briefly (without answering the questions) in order to get ready to talk to each other.

Structuring the Discussion

It is not necessary to have a facilitator for **COMPASS-PH/BH™**. Most programs organize themselves to have the conversation quite well. One person, usually *not* the clinic manager, can be identified as a timekeeper to remind the group to come to closure on the items and to stay on track. The same person, or a different person, may take notes to capture important parts of the conversation and write down scores. It is important to keep the discussion "democratic," in that everyone's opinion and perspective counts equally in the conversation and contributes to the consensus score. This will be discussed further below, in the scoring section.

Planning the Time

Completing the **COMPASS-PH/BH™** takes approximately two hours. It is ideal if the whole tool is done in a single session, but this is not always possible. Many programs will take a small amount of time in a regular weekly meeting with a consistent group and go through a few sections at each sitting. This way, the process has continuity and is less disruptive of normal work activities. As noted above, because the discussions on some items can get

pretty far-ranging, while other items go very quickly, it is helpful to have a timekeeper to bring everyone to closure in order to stay on schedule. Going too fast or too slowly through the process may be an indication that the group needs to have a little more framework built for the discussion to work well.

Specifying the Program

COMPASS-PH/BH™ is designed as a survey of a "program." In very small clinics or agencies, it is often easy to determine what the program is—it's the whole clinic and everybody gets involved in **COMPASS-PH/BH™**! In larger service settings, this may sometimes be harder to figure out. Here are some guidelines:

- **A large service setting should plan to have each distinct program use COMPASS-PH/BH™ to perform its own self-survey.**
- **A distinct program means that the program has a unique set of services, and/or that it is a distinct administrative unit that would be responsible for its own improvement activities.** For example, in a large primary health setting, the Walk-in Clinic, Urgent Services Clinic, each of the routine Outpatient Centers, Prevention Services Program, and the chronic disease management support team could each do their own **COMPASS-PH/BH™** process. In a large behavioral health setting, the Crisis Team, Adult Outpatient Clinic, Child and Family Program, Women's Program, Residential Program, and Inpatient Unit might each do their own **COMPASS-PH/BH™** process.
- **It is possible, and sometimes helpful, to bring representative teams (not just random individuals) from different programs in a service agency together to share a common conversation and experience of doing the COMPASS-PH/BH™ together. In this instance, the distinct programs might score differently from one another on various items and maintain a unique score sheet for each program, but would discuss the items as a group.**

Learning from the Experience

The most important outcome of using **COMPASS-PH/BH™** is the collective learning experience for the program and translating that learning into an improvement approach. The scoring, which is described in the next section, is not the main point. It is simply a method for focusing the conversation in order to facilitate a constructive discussion. Therefore, it is important for someone to take notes during the process to keep track of what is learned and what the program members feel might be inspiring ideas for next steps to make the services better. These notes can be jotted down in the boxes labeled "Action Plan Notes" in each section.

How Do We Score the COMPASS-PH/BH™?

Read Each Item Aloud

The best way for **COMPASS-PH/BH™** to be scored is for each member in the group discussion to have his or her own copy of the tool, and to have reviewed it briefly ahead of time without answering the questions. The timekeeper identifies one member of the group to read the first question aloud, then opens up the discussion about what the group thinks the score should be for the program, based on a Likert scale of 1 to 5. This process is repeated, taking turns reading each successive question aloud.

Reach Consensus as a Group

Members of the group will have differing opinions about the items. It is important that the group discuss each item to achieve consensus, and to literally poll each member to come to a conclusion on the score. In fact, one of the most important reasons for specifying a score is to reinforce the importance of continuing the discussion until consensus is reached. Often, the quietest members of the group will have important contributions to the discussion if their opinion is solicited. Their contribution may even change the consensus score on the item. As with most consensus processes, absolute agreement is not necessary. If after adequate discussion, some group members remain in disagreement, simply note the rationale and be aware that often this indicates an important issue that might become a targeted improvement opportunity. It is helpful to remind each other that you do not need to *solve* the issue during the **COMPASS-PH/BH™** process**,** just recognize there is one.

Follow "Evidence-based" Scoring

Just like an accreditation survey, the purpose of **COMPASS-PH/BH™** is to score based on "the evidence." **COMPASS-PH/BH™** does not ask questions like: "How welcoming do we feel?" It asks about the content of welcoming in specific policies, procedures, practices, and documentation. The group should therefore score based on objective content. This does not mean that the group should sit and read the policy manual or do chart reviews, although there are times when programs will actually look things up in the course of the discussion. It is enough to simply discuss what the group members believe the policies and procedures are. It is important to realize, however, that because many programs are not well organized in their approaches to integrated PH/BH capability, there will be much uncertainty and inconsistency in these perceptions within the group. There will also be inconsistency between the types of practices the group members feel are delivered and what is actually written down. This is an important part of the learning experience. Try not to be too troubled by this.... Progress, not perfection.

Use the Likert Scale

Each item is rated on a Likert scale from 1 "Not at All" to 5 "Completely." The ratings are easy to interpret. There is no "0." Each program can give itself a 1 just for answering the question. When scoring by consensus, individual group members may be advocating for different numbers on the scale. It is the task of the group to achieve closure by "picking a number." We recommend that the group choose a whole number whenever possible. If the group gets stuck and cannot choose a whole number, it is acceptable to split the difference and pick 1.5, or 2.5 and so on. Do not try to pick other decimals, like 1.75. It is beyond the purpose of the tool to have the score be that precise. Just do your best to pick a number reflecting your approximation of consensus, and move on to the next item.

Score Honestly

The goal of the conversation is for the group to have an open and honest discussion of the program's current status of integrated PH/BH capability. In this type of process, the best score is the most accurate score. An honest "1" deserves a round of applause for recognizing an improvement opportunity. A "4" or "5" that is essentially over-rated is much less helpful. Recognizing this is an important part of shifting the system culture to valuing efforts to improve. Give yourselves a big round of applause every time you discover opportunities for improvement for your program. *Note: If your program is having extraordinary difficulty with having an open conversation, it is reasonable to first talk this through with each other, rather than missing out on the value of* ***COMPASS-PH/BH™*** *by continuing on in the process. Sometimes creating a safe environment for conversation is part of the framework that needs to be built prior to using* ***COMPASS-PH/BH™****. On the other hand,* ***COMPASS-PH/BH™*** *usually provides enough structure to the conversation for people to have an easier time talking more openly with each other.*

Focus on Individuals and their Families

It is particularly important to think about items not only in relationship to the individual, but also in relationship to family members or caregivers as well. This is particularly true in child and adolescent services, but also may relate to older adults and disabled populations.

Consider Diverse Issues

As the group talks, it is likely that highly prevalent issues, like exposure to traumatic experiences or chronic pain, will naturally be incorporated into the conversation and identified as important issues to be aware of in the discussion. The same applies for addictive behaviors like problem gambling and addiction to substances that are legal but very unhealthy, such as nicotine, alcohol and over-the-counter or prescription medications. It is a good idea to spell this out in the beginning and reinforce it during the conversation. Trauma issues are especially relevant as a routine consideration in integrated PH/BH capable care, particularly with evidence from recent studies documenting the contribution of trauma to poor physical health throughout the life cycle. When present, all of these diverse issues are serious and need attention in the framework of integrated PH/BH capable care.

Take Notes

During the discussion, the group will generate ideas about next steps for action or questions to be followed up. It is best to take notes in each section. In addition, group members often like to take more detailed notes for their own purposes. This is encouraged, as long as it does not distract from the conversation.

Summarize Section Scores

After completing **COMPASS-PH/BH™**, it is helpful to summarize scoring in each of the sections. There is a score sheet in the back of the tool for this purpose. Each section will have a Total Section Score and an Average Item Score for the section. Scoring prompts are written at the bottom of each section to help with filling out the **COMPASS-PH/BH™** Score Sheet at the end of the tool.

Do not Overemphasize the Score. Learn from the Experience.

Remember that the most important part of the **COMPASS-PH/BH™** process is the collective learning experience as a team, not the score.

What Do We Do after We Complete the COMPASS-PH/BH™?

Develop an Action Plan

The most important next step for the program is to organize starting places for making progress. These starting places do not have to be numerous or complicated; they should, however, be connected to the **COMPASS-PH/BH™** conversation, and the vision and values of the program. They should be achievable and make sense within the program's existing resources. Many programs start by just acknowledging they are in the "integrated care business" by welcoming individuals and families with physical health/behavioral health issues. Another common starting place is working on improving screening and identification of physical health/behavioral health issues in individuals and families, both clinically and within the data system. Other programs choose to work on specific clinical strategies such as motivational engagement or disease management protocols. The goal is to begin an organized quality improvement process by creating a written action plan that helps the program continually improve over time in the direction of integrated PH/BH capability.

Use the "Serenity Prayer of System Change"

Some programs mistakenly focus on issues over which they have no control, leading to frustration. The goal of the **COMPASS-PH/BH™** process is to identify areas of improvement that the program *does* have some control over and to be capable of making progress. None of the items on the tool require any program to merge with another type of program, hire additional staff, acquire additional funding resources, or change its program designation or licensure. All items relate to improvement activities that can be accomplished within existing resources and can often result in more efficient use of those resources.

Be Thoughtful about Sharing the Scores

If the program is part of a learning collaborative or larger organization or system, that larger entity may want the program to share its scores. If scores are collected, it may be helpful for programs to know where they have scored in relation to other similar programs, and therefore it may be useful for the system to post average scores in each section for each type of program. However, it is important not to place too much value on the numbers themselves.

- The most important message is to have an honest conversation, not to have anyone think they should perform around the score. Every program should find opportunities to improve. That is the point.
- Systems should resist the temptation to over-analyze the scores. The tools are designed to stimulate dialogue and quality improvement partnerships.
- This is a learning process, and many programs find that the first time they use the tool they are still learning what integrated PH/BH capability means. Programs often work hard and make progress, and then repeat **COMPASS-PH/BH™** a year later, only to find that the scores went down slightly on certain items. This represents a situation in which increasing knowledge about the item leads to more accurate scoring over time. This is GOOD.
- Lastly, in some systems, programs may feel that having to share their scores would inhibit their ability to have an open conversation. In those systems, it may be better for programs just to report when they have completed the tool and what they learned, without sharing specific scores.

Plan to Repeat the Process

In most instances, programs will use **COMPASS-PH/BH™** about once a year for several years in order to support regular self-assessment in the quality improvement process. After repeated use, programs are more likely to demonstrate real progress on many of the items. Then the **COMPASS-PH/BH™** process may be used to inform the development of integrated PH/BH capability standards for the system that can then be anchored in place through routine program monitoring and technical assistance activities.

Remember—Progress, not Perfection, is Key

The goal for any program should not be to achieve a perfect score on all items on **COMPASS-PH/BH™**. Over time, many programs will make significant change within existing resources and will continue to find opportunities to improve. In this type of honest process, **COMPASS-PH/BH™** scores will in fact slowly improve. Ideally, the changes programs have made will be incorporated into evolving system policies and standards so that they are held in place. New concepts, knowledge and capabilities emerge in light of the progress, and the cycle of change continues.

We hope you all have a great conversation, learn much from sharing your ideas with each other, and feel better prepared to improve services as a result of using COMPASS-PH/BH™.

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[1]Minkoff K & Cline CA, Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. Psychiat Clin N Am (2004), 27: 727-743.

[2]Minkoff K & Cline CA, Developing welcoming systems for individuals with co-occurring disorders: the role of the Comprehensive Continuous Integrated System of Care model. Journal of Dual Diagnosis (2005), 1:63-89.

[3]Minkoff K &. Cline CA, Dual diagnosis capability: moving from concept to implementation. Journal of Dual Diagnosis (2006), 2(2):121-134.

Examples of Items in the COMPASS-PH/BH

Section 1: Program Philosophy

Written program descriptions specifically say that individuals with co-occurring physical health and behavioral health conditions are welcomed for care.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 2: Program Administrative Policies

The program confidentiality or release of information policies and procedures are written to promote appropriate routine sharing of necessary information between collaborative mental health providers, substance abuse treatment providers, and medical providers to promote quality of care.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Section 3: Quality Improvement and Data

Section 4: Access

Section 5: Screening and Identification

The program has a screening process for identifying and documenting nicotine use/dependence.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Examples of Items in the COMPASS-PH/BH

Section 6: Integrated Assessment

Section 7: Integrated Person-centered Planning

Person-centered (or, if appropriate, family-centered) plans focus on building skills and supports (e.g., "illness or disease management skills") for physical health and behavioral health conditions, using positive rewards for small steps of progress in learning and using the skills and supports.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Section 8: Integrated Treatment/Recovery Programming

The program routinely offers educational groups on physical health, mental health, trauma, and/or substance use issues to all patients/clients who are interested.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Section 9: Integrated Treatment/Recovery Relationships

Section 10: Integrated and Welcoming Program Policies

Section 11: Medication Management

The program organizes and documents routine communication and facilitates cross consultation between behavioral health and physical health prescribers to ensure quality of care regarding prescribing practices.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Section 12: Integrated Discharge/Transition Planning

Section 13: Program Collaboration and Partnership

The program participates with one or more partner programs offering differing services in a learning collaborative to develop physical health/behavioral health capability.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Examples of Items in the COMPASS-PH/BH

Section 14: General Staff Competencies and Training

Human resource policies and job descriptions include identified competencies for all staff regarding welcoming, engaging, and serving individuals with complex physical health and behavioral health needs.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Section 15: Specific Staff Competencies

COMPASS-PH/BH™ Score Sheet

Sections	*Total Section Score*	*Average Item Score for Section*
1. Program Philosophy		
2. Program Administrative Policies		
3. Quality Improvement and Data		
4. Access		
5. Screening and Identification		
6. Integrated Assessment		
7. Integrated Person-centered Planning		
8. Integrated Treatment/Recovery Planning		
9. Integrated Treatment/Recovery Relationships		
10. Integrated and Welcoming Program Policies		
11. Medication Management		
12. Integrated Discharge/Transition Planning		
13. Program Collaboration and Partnership		
14. General Staff Competencies and Training		
15. Specific Staff Competencies		
Total COMPASS-PH/BH™ Score:		

