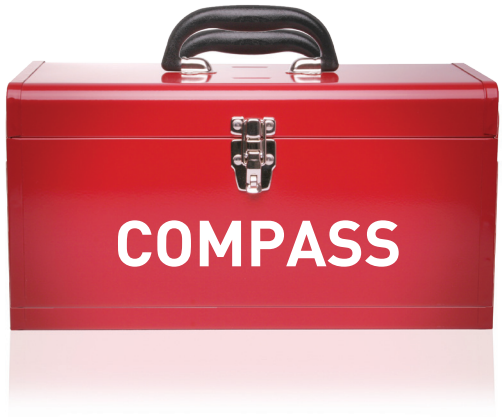

TOOL 4:
COMPASS Primary Health and Behavioral Health™

A SELF-ASSESSMENT TOOL FOR BEHAVIORAL HEALTH AND PRIMARY HEALTH CLINICS AND PROGRAMS

The **COMPASS-Primary Health and Behavioral Health™ (COMPASS-PH/BH)** is a continuous quality improvement 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.

Outcomes:

- 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 primary health and behavioral health capable services.
- Establishes an organizational baseline of integrated primary health and behavioral health 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 primary health and behavioral health 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.

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.

Helpful Definitions

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

An individual has comorbid 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 comorbid issues. Comorbid issues also apply to 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 meet the 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 comorbid capable.** In addition, every person delivering and supporting care is engaged in a process to become welcoming, person-centered, and competent as well. The development of integrated primary health and behavioral health capability for programs and staff is one component of this larger system framework.

We now have enough knowledge to know how to successfully embed practices in any program in order to be helpful to individuals and families. 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. Through the use of **COMPASS-Primary Health And Behavioral Health™** (and other companion COMPASS™ tools for other kinds of providers), programs can learn how to apply the CCISC principles to build all types of co-occurring capability, including integrated primary health and behavioral health capability, into all areas of services and programming.

Organization of the COMPASS-Primary Health and Behavioral Health™

The COMPASS-PH/BH™ is organized by sections that address aspects of integrated primary health and behavioral health 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

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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.

- 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-PRIMARY HEALTH AND BEHAVIORAL HEALTH?

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 in order to identify the program baseline and opportunities for improvement..

Group Discussion

COMPASS-Primary Health And Behavioral Health™ 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. People in the same program often 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-Primary Health And Behavioral Health™** participants in learning about integrated primary health and behavioral health 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-Primary Health And Behavioral Health™**.

Preparing the Group

It is extremely helpful for the group to have some background about the clinic's participation in a process of integrated primary health and behavioral health capability development before using **COMPASS-Primary Health And Behavioral Health™**. 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-Primary Health And Behavioral Health™** 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-Primary Health And Behavioral Health™**. 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.

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-Primary Health And Behavioral Health™** 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-Primary Health And Behavioral Health™** 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 plan. 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.**

Clinic Name: _____

Program/Team Name: _____

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ Participants:_____

_____

_____

Date Completed: _____

Section 1: Program Mission and Vision

1. The program (your agency, clinic, treatment setting, etc.) operates under a written vision, mission or goal statement that communicates to all staff and stakeholders the goal of becoming an integrated physical health/behavioral health program.

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

2. Written program descriptions specifically say that individuals with comorbid physical health and behavioral health conditions are welcomed for care.

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

3. The program environment (i.e., waiting rooms, interview and exam rooms, offices, wall posters, flyers, etc.) creates a welcoming atmosphere and communicates that physical health, mental health and substance use issues are routinely addressed within the program setting.

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

4. The program welcomes individuals with active physical, mental, and substance use conditions, and cognitive disabilities, without discrimination, in all admission areas and waiting areas.

❑ 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

1. Billing instructions provided by the program to staff indicate how to bill, collect, and track revenue for integrated physical health/behavioral health interventions within the context of standard billable visits provided by the program.

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

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

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

3. Clinical record-keeping policies support integrated documentation (e.g., in assessments, treatment plans, and progress notes) of attention to mental health, physical health, cognitive disability, and substance use issues in a single medical/clinical record or chart.

❑ 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 3: Quality Improvement and Data (PCMH*)

4. The program has a continuous quality improvement team with representation from all levels of staff and across disciplines that meets regularly, using a written plan to guide, track, and measure progress toward becoming an integrated physical health/behavioral health capable program.

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

5. The program has identified and empowered front line and consumer change agents or champions to assist with the continuous quality improvement process to move toward integrated physical health/behavioral health capability.

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

6. Program management information systems routinely collect quality improvement data that is used to support progress on specific and measurable quality indicators that represent progress in achieving program-wide integrated physical health/behavioral health capability.

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

7. Program management information systems routinely collect accurate data on how many individuals in the program have co-occurring physical health, mental health, and/or substance use conditions, including those related to nicotine dependence, sexual abuse or emotional/physical abuse/neglect.

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

8. Program management information systems collect accurate data on how many individuals in the program are receiving physical health/behavioral health interventions within the program.

❑ 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 4: Access (PCMH*)

9. The program has "no wrong door" access policies and procedures that emphasize welcoming and engaging all individuals and families with physical health and behavioral health needs from the moment of initial contact.

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

10. Individuals and families receive welcoming access to appropriate care regardless of active issues in any area (e.g., infectious disease status, need for injections or oxygen, presence of physical disability, blood alcohol level, urine toxicology screen, length of sobriety, commitment to maintain sobriety, intellectual functioning, active mental health symptoms, type of psychiatric diagnosis, or type of prescribed psychiatric medications, such as antipsychotics, stimulants, benzodiazepines, or opiate maintenance).

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

11. The program has functional policies for facilitating routine (non-emergent) access to integrated primary health and behavioral health assessment and intervention for all individuals who need "same-day" 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 5: Screening and Identification (PCMH*)

12. The program's screening policy states that all individuals are to be screened for issues and immediate risk in a welcoming and respectful manner for mental health issues (including trauma), substance use issues, cognitive issues, physical health issues, and basic safety and social needs.

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

13. The program uses evidence based screening processes, checklists, or other tools that are appropriately matched to the person being screened.

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

14. The program has an evidence screening process for identifying and documenting nicotine use/dependence.

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

15. The program has procedures for providing evidence screening and intervention services for a full range of physical health and behavioral health conditions or behaviors (e.g., addiction, suicide, metabolic syndromes, infectious diseases such as HIV and Hepatitis C, domestic violence, child/elder abuse, unsafe sexual practices).

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

16. The program has procedures for routine evidence based screening/re-screening, monitoring, and tracking a full range of basic indicators of health and well-being, such as substance use and gambling; common mental health conditions such as depression and anxiety disorders; health indicators such as weight, BMI, and waist circumference; blood pressure; and metabolic status (HbA1c or FBS, liver and kidney function, etc.).

❑ 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 6: Integrated Assessment (PCMH*)

17. Assessments document individual and/or family goals for hopeful, meaningful and "happy life" outcomes using the person/family's own words.

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

18. Integrated assessments identify specific time periods of recent strength or stability, and skills and supports the individual or family used in order to do relatively well during that time, including those used to manage physical health, mental health, cognitive, substance use issues, and other risk factors.

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

19. Integrated assessments include diagnostic criteria or supporting information to illustrate the presence of specific physical health conditions, mental health conditions, and substance use conditions, including distinguishing between use, abuse and dependence for each substance.

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

20. Integrated assessments for individuals taking prescribed opiates for chronic pain (or other potentially addictive medication for a medical condition) clearly identify if the person has a substance use disorder or is at risk of developing one.

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

21. Integrated assessments routinely document the diagnosis for each physical health/behavioral health condition, active or stable, when previously diagnosed or when identified/diagnosed during the current assessment.

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

22. Integrated assessments document the stage of change (i.e., precontemplation, contemplation, preparation, early action, late action, maintenance) the individual is in regarding each disorder, condition or issue (if appropriate to the individual's age and cognitive status).

☐ 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 7: Integrated Person-centered Planning (PCMH*)

23. Hopeful person-centered goals, recent successes and strengths are the foundation of the treatment/service plans for continuing care.

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

24. Treatment/service plans list all the relevant physical health/behavioral health issues in the plan.

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

25. For each of the physical health/behavioral health issues listed in the plan, there is an identified individualized and matched intervention with achievable steps to help the person be successful (Examples include, but are not limited to stage-matched interventions and stepped care protocols.)

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

26. Treatment/service plans regularly include integrated physical health/behavioral health interventions provided in the program setting, not just outside referrals for specialized care in other settings.

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

27. Person-centered (or, if appropriate, family-centered) plans focus on building whole health self-management 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	

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 8: Integrated Treatment/Recovery Programming (PCMH*)

28. Multimedia and culturally appropriate educational materials about a wide array of physical health, mental health, trauma, cognitive disabilities, and substance use conditions are routinely provided to patients/clients and families.

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

29. *All* patients/clients receive basic education and assistance with choices and decisions regarding *prevention* of physical health and behavioral health conditions and disorders, as appropriate.

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

30. The clinic/service setting uses evidence-based protocols to manage and track common physical and behavioral health conditions (e.g., major depression, anxiety disorders, alcohol abuse, opiate dependence, diabetes, obesity, hypertension, sexually transmitted diseases, immunization status).

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

31. The program organizes the use of stage-matched interventions for treating nicotine dependence.

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

32. The program has an organized protocol to address psychosocial issues related to pain management.

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

33. 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	

34. The program has symptom management skill training manuals or materials that staff use to assist patients/clients who have common physical health, mental health, trauma and substance use conditions.

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

35. Individuals and families with physical health/behavioral health issues are helped to get involved with peer coaching, self-help or peer support groups for those issues, as appropriate.

☐ 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 9: Integrated Treatment/Recovery Relationships

36. Each patient/client has a primary relationship with an individual (e.g., physician, nurse, care navigator, care coordinator, peer recovery coach) or an integrated team that integrates attention to physical health and behavioral health issues inside the relationship.

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

37. The primary clinician or team that is responsible for integrated care *continues* ongoing work with the patient/client on each physical health/behavioral health issue even when the person is having difficulty following one or more aspects of the treatment/service plan (e.g., may still be using substances, may not be following diet recommendations, may not be taking medications as prescribed).

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

38. Physical health and behavioral health staff meet regularly as a team to promote routine collaboration in sharing care responsibility for integrating physical health/behavioral health services to clients/patients.

☐ 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 10: Integrated and Welcoming Program Policies

39. Organization policies state clearly that individuals are not routinely discharged for problematic symptoms or behaviors, such as difficulty following medical recommendations, active substance use, displaying mental health symptoms during visits, cognitive and learning challenges, medication non-adherence, etc.

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

40. Organization policies and procedures are designed to reward and reinforce individuals for making progress in asking for help when they are having difficulty or are beginning to relapse with any issue, rather than focusing on providing "consequences for non-compliance."

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

41. Organization policies reinforce that necessary treatment for any condition is initiated and maintained, with adaptations as indicated, even when individuals have active symptoms in another area (e.g., treatment of diabetes or depression in individuals with active substance use; treatment of complex medical conditions in individuals with active psychosis and/or developmental disability; treatment of mental illness or substance use disorders in individuals with active hepatitis, etc.).

❑ 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 11: Medication Management

42. The organization has procedures/forms/materials—adapted for individuals who may have cognitive disabilities—to help patients/clients learn about physical health and behavioral health medications, and communicate more easily with prescribers about medications and side effects.

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

43. The organization 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	

44. All prescribers have knowledge and capability in prescribing practices and medications for treatment of common physical health (e.g., antihypertensives, oral diabetic agents), mental health (e.g., antidepressants, anxiolytics), and substance conditions (e.g., anti-craving agents, buprenorphine).

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

45. The organizations practice guidelines support access to medication assessment for any condition without requiring a mandatory period of sobriety or symptom remission for another condition.

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

46. Common risks associated with all medications, including risks of interaction between behavioral health and physical health medications, are routinely monitored by medical/nursing staff.

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

47. Policies or practice guidelines specify that necessary non-addictive medications for treatment of known serious medical or mental illness are appropriately continued (with close monitoring if necessary) even though the individual may continue to use substances.

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

48. Medications with addictive potential (e.g., benzodiazepines and opiates) are not routinely initiated nor routinely refused in ongoing treatment, including for individuals with substance dependence. Prescription of such medications is individualized based on careful evaluation and consultation, with second opinion when indicated.

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

49. The organization has an organized risk management protocol (including written contracts) for psychopharmacologic evaluation and management of individuals with chronic pain who may require ongoing opiate treatment.

❑ 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 12: Integrated Discharge/Transition Planning

50. Discharge plan policies, procedures, and practices address specific matched continuing care needs for all physical health issues, behavioral health issues, and other risk factors.

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

51. Discharge summaries integrate attention to physical health and behavioral health concerns and are routinely provided in a timely manner to the receiving providers.

❑ 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 13: Program/Organizational Collaboration and Partnership

52. The program/organization participates with one or more partner programs/organizations 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	

53. The program/organization has policies and procedures for documentation of care coordination and collaborative service planning for patients with physical health/behavioral health issues who receive services in collaborative programs.

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

54. There is a routine process by which staff provides consultation to a collaborative program delivering complementary services.

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

55. There is a routine process by which staff receives consultation from a collaborative program providing complementary services.

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

56. Designated staff participate in regularly scheduled physical health/behavioral health interagency care coordination meetings that address the needs of individuals or families with complex issues who use significant levels of service in multiple settings in the community.

☐ 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 14: General Staff Competencies and Training

57. Human resource policies and job descriptions include identified integrated care 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	

58. The organization has written procedures for routinely documenting integrated interventions provided by staff with any level of licensure or training.

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

59. The organization has a written plan for integrated competency development (e.g., supervision, practice monitoring, training activities, etc.) for all clinical and support staff.

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

60. Supervisors have the appropriate knowledge and skills to help staff become more capable of providing welcoming, hopeful, strength-based, trauma-informed and integrated physical health/behavioral health care.

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

61. Integrated physical health/behavioral health competencies are evaluated as part of all staff performance reviews.

☐ 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 15: Specific Staff Competencies

62. The staff demonstrate competency to welcome and address the needs of patients/clients with physical health/behavioral health issues who are from different cultures and/or linguistic backgrounds.

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

63. The staff demonstrate specific competency in providing education to family members and caregivers regarding physical health and behavioral health issues.

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

64. The staff demonstrate specific competency in providing developmentally matched physical health/ behavioral health services to the age-specific populations that are served (e.g., older adults, adolescents, children, etc.).

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

65. The staff demonstrate specific competency in providing physical health/behavioral health care to patients/clients with cognitive impairments (e.g., learning disabilities, intellectual disabilities, traumatic brain injuries, thought processing difficulties, etc.).

❑ 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

ACTION PLAN

Summarize the notes from each section, identifying and listing those items that have been prioritized as important areas to address in the change process, as well as identifying any creative change strategies.

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			