COMPASS-PH™

Developing Behavioral Health Capability in Primary Health Settings

(Version 1.0)

Demonstration Version

Beta Test Version

A Self-Survey Tool for Primary Health Clinics, Programs and Teams

ZiaPartners, Inc.
Changing the World through Partnership

Clinic Name: _____

Program/Team Name: _____

Contact Person: _____

Change Agents: _____

COMPASS-PH™ Participants: _____
_____
_____
_____
_____

Date Completed: _____

TERMS OF NON-EXCLUSIVE LICENSE

ZIAPARTNERS, INC. ("Licensor") is the Owner of all right title and interest in the **COMPASS-PH™ (All Versions)** (the "Licensed Materials").

Purchase and Use of the Licensed materials constitutes the following agreement by the purchaser/user ("User"):

1. Grant of License. The Licensed Materials are the sole and exclusive property of Licensor and are copyrighted. Upon the terms and conditions set forth herein, Licensor hereby grants to User a non-exclusive license to use the Licensed Materials. The License is limited to use in a single project only and may not be used in connection with any other project or for any other purpose. Nothing contained herein shall be construed to prevent Licensor from granting other licenses for the use of the Licensed Materials. The license herein granted does not include the right to obtain supplements, additions, republications, renewals, reissues, and extensions of the Licensed Materials.

2. Limitation on Use of Trade Name or Trademark. Neither the granting of the license herein nor the acceptance of royalty hereunder shall constitute an authorization or approval of, or acquiescence in the use of the Licensor's name or any trade name or trademark of the Licensor in connection with the use of the Licensed Materials, and the Licensor hereby expressly reserves all rights with respect to thereto.

3. Warranty Exclusion. Information and materials provided by Licensor in the Licensed Materials are licensed to User on an "AS IS" basis, without warranty or conditions of any kind, express or implied, including but not limited to warranties of merchantability, merchantable quality, satisfactory quality, fitness for a particular purpose. The results of the information contained in the Licensed Materials or the results from the use or application of the materials and systems contained in the Licensed Materials is not guaranteed or warranted by Licensor and all such results are assumed by the User. Nothing contained in the Licensed Materials shall be deemed to constitute the giving of medical advice or the establishment of any medical treatment or treatment regimen. Licensor shall have no liability to User or to any other person for any direct, incidental, special or consequential damages whatsoever, including any loss of revenue, profit, increase in expense, or other commercial or economic loss, even if any such damages may be foreseeable. Licensor is not responsible for the claims of any third party. It is expressly understood that the limit of Licensor's liability is the amount of royalty paid by User.

No representation or warranty has been made by the Licensor that the Licensed Materials or parts thereof may used free of rights of others, it being understood that Licensor shall not be liable for any loss damage or expense arising from any claim of copyright infringement upon use thereof.

4. Limitation on User. The Licensed Materials are licensed to User solely for User's use in its business for a single project and for no other purpose. User shall not, without the express written permission of Licensor:

(a) Assign, transfer, sub-license or otherwise convey an interest in the Licensed Materials, or any part thereof.

(b) Reproduce and/or disseminate in any manner, including but not limited to electronically, the Licensed Materials, or any part thereof, to any third person, with the exception of User's own employees or project participants who will implement the use of the Licensed Materials for User.

User shall inform all project participants of the restrictions imposed by this Agreement.

5. Governing Law. This Agreement is made in California and shall be interpreted, construed and governed according to the laws of the State of California.

LICENSOR: ZIAPARTNERS, INC.

COMPASS-PH™ Guide (Demonstration Version)

Welcome!

We are delighted that your clinic has an opportunity to use COMPASS-PH™ to help develop behavioral health co-occurring capability in your primary health setting. We trust that you will find your group conversation an enlightening, creative and enjoyable experience. Remember--progress, not perfection.

Background

One of the most significant advances in the delivery of health care to people and families with multiple medical, behavioral health, and social wellness issues that has been emerging over the past decade is the concept of "whole person" care. Increasingly, primary health settings are becoming "health homes" for people, and with the advent of health care reform, much more movement in this direction is likely to occur. Many primary care settings are working to develop a successful approach that is effective and rational in already over stretched health care systems. Some are hiring behavioral health specialists as consultants, some are developing partnerships with complementary programs, and some are becoming full service behavioral health organizations. The approaches are varied and the learning and growth are sure to be enormous. One common denominator is that service settings that will be effective in responding to this great need will have to have systematic and organized ways of managing profound change in partnership with others.

The **COMPASS-PH™** is a tool for primary health settings to organize themselves to develop core capability in meeting the needs of complex populations with co-occurring health and behavioral health needs. The tool does not require any particular level of experience or expertise in primary health/behavioral health integration. Both "newbies" and "seasoned veterans" will benefit from the process. **COMPASS-PH™** supports a wide variety of organizational approaches in that it targets the development of universal and essential features of integrated health and behavioral health service delivery, both at the program and the clinical level. **COMPASS-PH™** "raises the bar" on every piece of care that is delivered, whether your primary health setting decides to "hire" behavioral health specialists or not. **Any primary health setting can achieve co-occurring capability**. In fact, this matrix or environment of co-occurring capability will help define more rational and effective use of any specialty care that might be available inside or outside the primary health setting.

As you will see, **COMPASS-PH™** is a continuous quality improvement tool that can be used by any primary care setting as it is currently designed. It helps establish a baseline, define initial starting places or building blocks of previous success, allows organizations to demonstrate measurable progress, and - most importantly - promotes an empowered team approach to managing complex change.

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

Helpful Definitions

Co-occurring Issues (Also termed Co-occurring Conditions or Co-occurring Disorders): An individual in a primary health care program has co-occurring behavioral health issues if he or she has any combination any mental health issue and/or any substance use problem and primary health care 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 behavioral health issues. Co-occurring behavioral health 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 in primary health care services, and another member has another kind of problem, such as a family member or caregiver with a mental health or substance use problem.

Co-occurring Capability: Within the mission and resources of a program, co-occurring capability involves designing every aspect of that program at every level on the assumption that the next person and family "coming to the door" of the program is likely to have co-occurring issues in their lives and have complex needs, and they must be welcomed for care, engaged with empathy, hope, and kindness and provided what they need in a person-specific and integrated fashion in order to make progress toward having happy productive lives. Co-occurring capability necessitates that all services and supports are welcoming, respectful of autonomy and centered on the person's own vision of happiness. This recovery/resiliency based approach to service is attuned to people and families with diverse goals, strengths, histories and cultures. Co-occurring capability involves looking at all aspects of program design and functioning 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 individual delivering clinical services to provide effective care.

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.

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, stage matched and developmentally matched interventions, strength-based skill-based learning, and using positive reinforcements and rewards to support learning. CCISC implementation helps programs in the system, through the use of **COMPASS-PH™** (and other companion COMPASS™ tools for other kinds of providers) learn how to apply the CCISC principles to build co-occurring capability into all areas of services and programming.

Complexity Capability: Individuals and families with multiple co-occurring needs are an expectation, not an exception in general populations. Individuals frequently have legal issues, transportation issues, housing issues, parenting issues, educational issues, vocational issues, in addition to medical, mental health, trauma and substance use issues. In addition, these individuals and families are culturally and linguistically diverse. 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 co-occurring 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 scarce 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 a welcoming "Complexity Capable" program. Some systems implementing CCISC have begun to use this terminology to reflect this broader and more inclusive perspective. Although **COMPASS-PH™** primarily uses the terminology Co-occurring Capability, we anticipate that over time this term will be replaced with Complexity Capability.

Design of COMPASS-PH™

The most important purpose of COMPASS-PH™ 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™** is designed to help individual primary health settings organize a baseline self-assessment of co-occurring capability as the first step in a continuous quality improvement process in which the program designs an action plan to make progress. **COMPASS-PH™** is designed to help programs have a consistent method for measuring progress, and continuing the learning and change process, by repeating the self-assessment at regular intervals.

COMPASS-PH™ is designed to produce a number of important organizational outcomes. **COMPASS-PH™** helps programs:

- **Communicate using common language and understanding of co-occurring capable services for individuals and families with complex needs,**
- **Understand the program baseline of co-occurring capability so that there is an organized and rational foundation for a change process,**
- **Provide a common tool and shared process that can be used in any system for an array of diverse programs working collectively on co-occurring capability development, and**
- **Create a continuous quality improvement framework regarding co-occurring capability development for ALL types of programs in any system of care that serves individuals and families with complex lives.**

COMPASS-PH™ is organized by sections that address aspects of co-occurring capable program design. These are:

1. **Program Philosophy**
2. **Program Policies**
3. **Quality Improvement and Data**
4. **Access**
5. **Screening and Identification**
6. **Recovery Oriented Integrated Assessment**
7. **Integrated Person-Centered Planning**
8. **Integrated Treatment/Recovery Programming**
9. **Integrated Treatment/Recovery Relationships**
10. **Integrated Treatment/Recovery Program Policies**
11. **Psychopharmacology**
12. **Integrated Discharge/Transition Planning**
13. **Program Collaboration and Partnership**
14. **General Staff Competencies and Training**
15. **Specific Staff Competencies**

COMPASS-PH™ is designed to be helpful to programs offering primary health care to individuals and families. Examples include:

- **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**

COMPASS-PH™ is also informative for other service settings, such as mental health and substance treatment organizations that may be partnering with a primary health setting in working on improving their co-occurring capability to serve individuals with co-occurring health and behavioral health issues. These programs also can use their own designated self-assessment tool, the Health Integration Supplement to the **COMPASS-EZ™. COMPASS-PH™** also has companion tools that have been tailored to meet the needs of a variety of programs. Examples are:

- **COMPASS-Prevention™ - For prevention and early intervention programs (Issue 2008),**
- **COMPASS-EZ™ - For mental health and substance abuse treatment programs working on co-occurring capability development (Issue 2009) Note: COMPASS™** was updated in 2009 and is now replaced by **COMPASS-EZ™.**
- **COMPASS-ID™ - For providers serving people with intellectual disabilities (Issue 2010)**
- **COMPASS-EZ™ Health Integration Supplement - For mental health and substance abuse treatment programs working on co-occurring primary health capability (Issue 2010)**
- **And, more...**

What is the Best Way to Use COMPASS-PH™?

1. **Self-Survey:** **COMPASS-PH™** is used primarily as a program self-survey. The goal is for the participants in the process to discuss the items on 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™** is designed to help programs develop and take ownership of the continuous quality improvement process.

2. **Group Discussion:** **COMPASS-PH™** 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 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 people have 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 co-occurring issues. This opportunity for a deep and rich discussion engages the **COMPASS-PH™** participants in learning about co-occurring capability, often gets people excited about the opportunity to make real change, and jump starts the process of improvement. The most common mistakes that programs make are to have the tool completed by a single manager or to have people complete the tool separately without a discussion, and then "average" the scores. Proceeding this way is a missed opportunity to get value out of the sharing of perspectives and ideas in a group conversation using **COMPASS-PH™**.

3. **Preparing the Group:** It is extremely helpful for the group to have some background about the clinic's participation in a process of co-occurring capability development before using **COMPASS-PH™**. If this is part of 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 review some material about CCISC ahead of time, and to read through **COMPASS-PH™** briefly (without answering the questions) in order to get ready to talk to each other.

4. **Structuring the Discussion:** It is not necessary to have a facilitator for **COMPASS-PH™.** 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.

5. **Planning the Time:** Completing the **COMPASS-PH™** 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, but 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 through the process or too slowly may be an indication that the group needs to have a little more framework built for the discussion to work well.

6. **Specifying the Program:** **COMPASS-PH™** is designed as a survey of a "program". In very small clinics, it is often easy to determine what the program is --it's the whole clinic and everybody gets involved in **COMPASS-PH™!** In larger service settings, this may sometimes be harder to figure out. Here are some guidelines:
    a. **A large service setting should plan to have each distinct program use COMPASS-PH to perform its own self-survey.**
    b. **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 service setting, the Walk-in Clinic, Urgent Services 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™** process.
    c. **It is possible, and sometimes helpful, to bring representative teams (not just individuals) from different programs in an service agency together to share a common conversation and experience. In this instance, the distinct programs might score differently from one another on various items and maintain a unique score sheet for each program.**
    d. **Learning from the Experience: The most important outcome of using COMPASS-PH™ 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" at the end of each section.

How do We Score COMPASS-PH™?

1. **Read Each Item Aloud:** The best way for **COMPASS-PH™** 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. Then, the timekeeper identifies one member of the group to read the first question aloud, and 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.

2. **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 most quiet 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™** process**,** just recognize there is one.

3. **Follow "Evidence-Based" Scoring:** Just like an accreditation survey, the purpose of **COMPASS-PH™** is to score based on "the evidence". **COMPASS-PH™** 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 to be. It is important to realize, however, that because many programs are not well organized in their approaches to co-occurring 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 provided 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.

4. **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 chooses 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.

5. **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 co-occurring 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™*** *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™****. On the other hand,* ***COMPASS-PH™*** *often provides enough structure to the conversation so that people have an easier time talking more openly with each other.*

6. **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 pediatric services.

7. **Consider Diverse Issues:** As the group talks, it is likely that highly prevalent issues like exposure to traumatic experiences will naturally be incorporated into the conversation and identified as a co-occurring issues. But, just in case, it is a good idea to spell this out in the beginning and reinforce it during the conversation. Trauma issues are common and they are a routine consideration in co-occurring capable care. 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 medications. When present, these issues are serious and need attention in the framework of integrated care.

8. **Do Not Over Use Not Applicable:** With very few exceptions, every item applies to every program. Only a few of the items might not apply to your program.

9. **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 the box at the end of 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.

10. **Summarize Section Scores:** After completing **COMPASS-PH™**, 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. There is also a place to record the Total **COMPASS-PH™** Score. Scoring prompts are written at the bottom of each section to help with filling out the **COMPASS-PH™** Score Sheet.

11. **Do Not Over Emphasize the Score. Learn from the Experience:** Don't forget that the most important part of the **COMPASS-PH™** process is the collective learning experience as a team, not the score.

What Do We Do after We Complete COMPASS-PH™?

1. **Develop an Action Plan:** The most important next step for the program is to organize some 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™** conversation, the vision and the values of the program. They should be achievable, and they should make sense within the existing resources of the program. Many programs start by trying to make progress in the area of welcoming individuals and families with co-occurring issues. Another common starting place is working on improving screening and identification of co-occurring issues in individuals and families, both clinically and within the data system. Other programs choose to work on motivational engagement. The goal is to begin an organized quality improvement process by creating a written "action plan" that helps the program to continually improve over time in the direction of co-occurring capability.

2. **Use the "Serenity Prayer of System Change":** Some programs mistakenly focus on issues over which they have no control. This leads to frustration. The goal of the **COMPASS-PH™** process is to identify the areas of improvement that the program does have some control over and to be capable of making progress. Note that none of the items on the tool requires the program to hire additional staff, acquire additional funding resources, or change its program designation or licensure. All of the items relate to improvement activities that not only can be accomplished within existing resources, they can often result in more efficient use of those resources.

3. **Be Thoughtful about Sharing the Scores:** If the program is part of a larger organization or a larger system, that larger system may want the program to share its scores. If the 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.
    - First, 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.
    - Second, systems should resist the temptation to over analyze the scores. The tools are designed to stimulate dialogue and quality improvement partnerships.
    - Third, this is a learning process, and many programs will find that the first time they use the tool they are still learning what "co-occurring capability" means. Programs will often work hard, and make progress, and then repeat **COMPASS-PH™** 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.

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

5. **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™**. Over time, many programs will make significant change within existing resources and will continue finding opportunities to improve. In this type of honest process, **COMPASS-PH™** scores will in fact slowly improve. Hopefully, 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™.

[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

Section 1: Program Philosophy

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

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Section 2: Program Policies

Program billing instructions indicate how to bill for behavioral health interventions within the context of a medical visit.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

Section 3: Quality Improvement and Data

Section 4: Access

Individuals and families receive welcoming access to appropriate health care regardless of active substance use issues (e.g., blood alcohol level, urine toxicology screen, length of sobriety, or commitment to maintain sobriety.)

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Section 5: Screening and Identification

Section 6: Recovery Oriented Integrated Assessment

Integrated assessments document current and past information to support the identification of a mental health issue or diagnosis when present, including if possible, describing mental health symptoms during previous periods of non-harmful substance use or sobriety.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Section 7: Integrated Person-Centered Planning

Section 8: Integrated Treatment/Recovery Programming

Section 9: Integrated Treatment/Recovery Relationships

Section 10: Integrated Treatment/Recovery Program Policies

Program policies state clearly that individuals are <u>not</u> routinely discharged for active substance use, displaying mental health symptoms, or having trouble following a treatment/service plan because of behavioral health issues.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Section 11: Psychopharmacology

The clinic organizes and documents routine communication between primary health prescribers and other internal or external prescribers to ensure quality of care regarding prescribing practices.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Section 12: Integrated Discharge/Transition Planning

Section 13: Program Collaboration and Partnership

The clinic has developed a network of partner programs offering differing services to function as a learning collaborative to develop its own co-occurring capability.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Section 14: General Staff Competencies and Training

Section 15: Specific Staff Competencies

Examples of Items in the COMPASS-PH

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