ZiaTools

ZiaPartners has developed a comprehensive array of tools to facilitate implementation of Welcoming, Person-/Family-centered, Recovery-/Resiliency-oriented, Integrated Systems of Care in real-world systems. These tools use the Comprehensive Continuous Integrated System of Care (CCISC) as a framework and a process for designing a whole system of care in a quality improvement partnership to be about the complex needs of individuals and families being served. In CCISC, all programs in the system engage in partnership with other programs, along with system leadership, frontline staff, and consumer and family stakeholders, to become welcoming, person-/family-centered, recovery-/resiliency-oriented, trauma-informed and complexity (co-occurring) capable. In addition, every person delivering and supporting care is engaged in a process to become welcoming, person-/family-centered, recovery-/resiliency-oriented, trauma-informed, and complexity (co-occurring) competent as well.

The **ZiaTools** below are designed to be used by systems in transformation to help the system partners learn how to apply CCISC principles to build recovery-/resiliency-oriented complexity capability into all areas of practice, programming, and design.

Each tool is described in detail on a separate page. For more details, visit *http://www.ziapartners.com/tools*

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Clinical Practice Tools

- ILSA-Basic™ (soon to be released) – **Integrated Longitudinal Strength-Based Assessment**. A welcoming, hopeful, integrated assessment format

How to Purchase

Please contact us at *info@ziapartners.com* to obtain pricing and a licensing agreement.

SOCAT™

The SOCAT™ is a self-assessment tool that helps systems, agencies, and programs combine two system improvement activities—Children and/or Adult System of Care (SOC) development and CCISC implementation—in order to make progress in developing systems and services better designed to inspire hope and improve outcomes for individuals and families with multiple and complex challenges.

The SOCAT™ is intended for collaborative use by behavioral health programs, developmental disability support providers, community corrections, juvenile justice services, child or adult protective services, public safety programs, schools, primary health providers, housing programs, and other partners. Use of the SOCAT™ can help any type of local system collaborative, and each partner organization in the collaborative, to find meaningful "next steps" in integrated SOC implementation and develop its own SOC Quality Improvement Action Plan.

SOCAT™ is designed as a companion to other CCISC tools, to help systems, partner organizations, and programs working on developing welcoming, recovery-/resiliency-oriented, trauma-informed co-occurring capable or complexity-capable services to work in partnership to develop a local Children and/or Adult System of Care. SOCAT™ is also designed to help organizations working on SOC consider how to incorporate universal complexity (co-occurring) capability throughout SOC design.

SOCAT™ is designed to facilitate structured and meaningful conversation about the organization's efforts to bring SOC and CCISC values, principles and partnerships to life. The tool has three parts, each of which reflects different levels of implementation activity:

1. Being a Successful Organizational Partner at the Community Table (System Partnership Level)
2. Using SOC Core Values and Guiding Principles within the Organization (Agency or Organization Level)
3. Improving Practices inside Services, Treatment and Supports (Practice Level)

CO-FIT 100™

The CCISC Outcome Fidelity and Implementation Tool (CO-FIT100™) is designed to help systems of care monitor and measure success in CCISC implementation for individuals and families with co-occurring mental health and substance use conditions, and other complex needs. The tool reviews success in meeting each of these consumer-driven standards: Welcoming, Accessibility, Integration, Continuity, and Comprehensiveness, using a combination of specific outcome measures and implementation (process) measures based on the CCISC Model and the 12 Steps of CCISC Implementation.

For the purpose of the use of the CO-FIT100™ to measure progress in systemwide CCISC implementation, a system may be defined as any organized behavioral health delivery system, such as an entire state, a specific region within the state, a county, a network of agencies, or a single complex agency. Systems can also be defined by payor source, such as the Medicaid system, the state-funded system, the county-operated system, or by target population, such as the child and adolescent system. The use of the CO-FIT100™ must be directed carefully to assessment of the specific system that is the target of systems change, and the boundaries between that system and other collaborative systems must be clearly demarcated. In some instances, a large system such as a state may be implementing CCISC statewide, but implementation is mediated through regional or county behavioral health subsystems. In such a situation, it may make sense for each subsystem to use the CO-FIT100™ to evaluate its own progress, and then create a state-level composite.

The CO-FIT100™ has two key sections: Implementation (process) and Outcome, which includes sections on Welcoming, Accessibility, Integration, Continuity, and Comprehensiveness. Systems are likely to see progress in their implementation scores before seeing comparable progress in their outcome scores.

The CO-FIT100™ is intended for use as a tool to measure progress in system implementation of the CCISC model. As such, it is ideally scored first at the beginning of the change process, to measure the system baseline. Ideally, the CO-FIT100™ will be scored annually or semi-annually, either as a system self-audit involving system leadership, providers, change agents, and stakeholders, or through a formal systems audit conducted via system-level quality improvement personnel.

COCAP™

COCAP™ is designed to be used by behavioral health service system leadership, in partnership with service providers and other stakeholders. The COCAP™ has three purposes:

1. To create a system-specific set of indicators for monitoring progress toward recovery-/resiliency-oriented complexity (co-occurring) capability at a particular point in time.
2. To create a tool for agency- and program-level self-monitoring in relation to those indicators.
3. To create a tool that defines standards for system-level monitoring, oversight, and technical assistance of agency/program progress toward complexity (co-occurring) capability.

COCAP™ should *ideally* be used in the context of an organized system-level quality improvement partnership to achieve CCISC implementation. COCAP™ should only be used after the system has already worked for a minimum of one to two years on implementation, using system-, program-, and clinician-level self-assessment tools (CO-FIT 100™, COMPASS-EZ™ [and other COMPASS™ tools], CODECAT-EZ™, respectively) to create baselines upon which quality improvement activities will be built, before any standards are imposed or contemplated.

COCAP™ is designed to help systems identify a range of measurable indicators that can be used to document or monitor achievement of progress toward complexity (co-occurring) capability—for each agency, program, or service provider in the system—in each of **20 major program domains**—at a particular point in time. Progress toward (co-occurring) capability in an agency or program can be examined using the indicators in the 20 domains listed below.

Part I: Organizational Development

1. Creating a welcoming culture
2. Incorporation of the consumer/family perspective
3. Adoption of complexity (co-occurring) capability as an agency-wide goal
4. Establishing a baseline of complexity (co-occurring) capability
5. Creating and implementing a CQI plan for agency program development
6. Complexity (co-occurring) competency development for the workforce
7. Integrated clinical record documentation
8. Integrated billing
9. Recognizing and reporting co-occurring clients and families in the data system
10. Interagency partnership and collaboration

Part II: Clinical Practice Development

1. Welcoming and engagement in empathic hopeful relationships
2. Removal of access barriers
3. Integrated screening
4. Integrated assessment
5. Integrated treatment and rehabilitation/recovery planning
6. Integrated treatment interventions
7. Integrated treatment programming
8. Co-occurring disorder psychopharmacology protocols
9. Continuity of integrated care
10. Case consultation, coordination and collaboration with collateral caregivers

COMPASS-EXEC™

The COMPASS-EXEC™ is a self-assessment tool for leadership teams of behavioral health, health, and/or human services systems that are working on organizing themselves to develop, oversee, and support an integrated system of care. The tool is specifically created for executives, administrators, administrative staff, and core implementation staff working toward CCISC implementation at the system level in states, provinces, regional systems, counties, managed care networks, and so on. The focus of the tool is on identifying and improving administrative policies, procedures and practices that support the implementation of integrated systems and services.

COMPASS-EXEC™ is organized by sections. These are:

1. Setting the Direction and Creating the Partnership Framework
2. Organizing the Process
3. Departmental Staff Engagement and Competency Development
4. Implementation - Continuous Quality Improvement Philosophy, Structure and Function
5. Implementation - Targeting Initial Outcomes
6. Implementation - Policy Framework for Funding and Billing Practices
7. Implementation - Regulations, Standards and Contracts
8. Implementation - Project Management
9. Implementation - Development of Clinical Practice
10. Implementation - Co-occurring Competency Development
11. Interagency Collaboration
12. Subsystem Partnerships
13. System Transformation Outcomes and Evaluation
14. Continuation and Sustainability

Agency/Program Tools

COMPASS-EZ™

COMPASS-EZ™ is designed to help individual programs organize a baseline self-assessment of recovery-oriented complexity (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-EZ™ 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. Most broadly, COMPASS-EZ™ is designed to be used globally by systems in transformation. All programs in the system can work in partnership, with each program using a shared process to make progress toward the collective vision of recovery-oriented complexity (co-occurring) capability across the whole system.

COMPASS-EZ™ is organized by sections that address aspects of a co-occurring (complexity) capableß program's design:

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-EZ™ is designed to be helpful to a vast array of programs:

- Mental health settings, including inpatient, outpatient, and other levels of care
- Addiction settings, including residential, outpatient, and other levels of care
- Adult, Older Adult, Child and Adolescent services
- Supportive services settings, such as homeless shelters, correctional settings, child welfare settings
- Other service settings, such as primary care programs

COMPASS-EZ™ is designed to produce a number of important organizational outcomes. COMPASS-EZ™ helps programs, agencies and systems:

- Communicate a common language and understanding of recovery-oriented co-occurring-capable services for individuals and families with complex needs.
- Understand the program baseline of recovery-oriented co-occurring capability so that there is an organized and rational foundation for a change process toward this vision.
- 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.
- 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-ID™

COMPASS-ID™ is a program self-assessment tool for co-occurring capability or complexity capability that can be used by intellectual disabilities and supports programs, brain injury programs, and other programs working with individuals and families who have cognitive disabilities in the implementation of a Comprehensive Continuous Integrated System of Care (CCISC). It is designed to help these programs develop welcoming integrated services and supports that inspire hope and provide help to people and families with cognitive disabilities who have co-occurring issues in any area, including mental health, trauma, substance use, physical health, housing, legal, and/or parenting issues. Individuals and families that have multiple co-occurring issues are the expectation in intellectual and cognitive disabilities service settings, and with hope, kindness, and help, all can make progress toward having healthier, happier, and more meaningful lives.

COMPASS-ID™ is designed to be helpful to all types of programs offering services and supports to individuals with intellectual or cognitive disabilities and their families and caregivers, such as:

- Child and adolescent intellectual disabilities services
- Adult and older adult intellectual disabilities services
- Brain injury rehabilitation and support programs
- Supportive services settings (e.g., housing, vocational and educational)

COMPASS-ID™ is designed to produce a number of important organizational outcomes:

- Create a common language and understanding of complexity (co-occurring) capable services.
- Develop complexity (co-occurring) capability with the highest regard for the values of autonomy, self-determination, and self-efficacy, coupled with effective services and positive supports.
- Create a foundation for an improvement process through an empowered conversation involving people in the program partnering to improve the program and its services.
- Organize a baseline self-assessment of complexity (co-occurring) capability as the first step in a quality improvement process that leads to an action plan to make progress.
- Participate in a continuous quality improvement partnership regarding complexity (co-occurring) capability development for ALL types of programs in any system of care.

COMPASS-ID™ is organized by sections that address aspects of co-occurring capable or complexity-capable program design:

1. Program Philosophy
2. Program Policies
3. Quality Improvement and Data
4. Access
5. Screening and Identification
6. Integrated Strength-based Assessment
7. Integrated Person-centered Planning
8. Integrated Service/Support Programming
9. Integrated Service/Support Relationships
10. Integrated Service/Support 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-PREVENTION™

The COMPASS-PREVENTION™ is a program self-assessment tool for co-occurring capability or complexity capability that can be used by prevention and early intervention programs working in the context of systemwide CCISC implementation. The COMPASS-PREVENTION™ helps programs improve the design of prevention and early intervention services to be better matched to supporting holistic wellness promotion in populations where it is an expectation that individuals and families have complex lives, and that individuals and families at risk in one area are indicated targets for prevention and early intervention in many areas. COMPASS-PREVENTION™ is designed to be helpful to a wide array of programs providing prevention and early intervention services (education, information, screening, etc.) to individuals, groups, populations, or the public at large:

- Primary or secondary prevention
- Targeted or indicated prevention
- Early intervention

COMPASS-PREVENTION™ brings together critical knowledge about what helps individuals and families—knowledge about integrated services, trauma-informed services, person-centered interventions, cultural competency, population-specific services, and most fundamentally, empathic relationships that inspire hope and help.

COMPASS-PREVENTION™ is designed to help programs:

- Create a common language and understanding of complexity (co-occurring) capable services.
- Create a foundation for an improvement process through an empowered conversation involving people in the program partnering to improve the program and its services.
- Organize a baseline self-assessment of complexity (co-occurring) capability as the first step in a quality improvement process that leads to an action plan to make progress.
- Develop welcoming services that inspire hope and provide help to people and families at risk of developing health, mental health and/or substance use conditions.
- Provide services based on an integrated and holistic approach, in which health promotion, prevention, and early intervention address mental health and/or substance use issues together.
- Participate in a continuous quality improvement partnership regarding complexity (co-occurring) capability development for ALL types of programs in any system of care.

COMPASS-PREVENTION™ is organized by sections that address aspects of a complexity (co-occurring) capable prevention/early intervention program's design. These are:

1. Philosophy
2. Management Structure
3. Access
4. Screening
5. Intervention Planning
6. Program Content
7. Interagency Relationships and Continuity
8. Staff Competency and Training

COMPASS-PH/BH™

The COMPASS-PH/BH™ is a program self-assessment tool for primary health/behavioral health integration, commonly used in the context of CCISC implementation. The COMPASS-PH/BH™ can be used by all types of primary health and behavioral health clinics and treatment programs, whether working in their own integration process or in partnership with others, to develop core capability to provide integrated programs, interventions, and services to meet the needs of service populations with all types of physical health and/or behavioral health issues, as well as other complex human services needs. The tool helps programs begin the process of developing integrated PH/BH capability with high regard for the values of person-centered, self-directed, trauma-informed, and holistic care, coupled with the provision of welcoming, hopeful, and integrated screening and assessment, collaborative partnerships, effective treatment and disease management services, and positive recovery supports.

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

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

- Create a common language and understanding of integrated PH/BH-capable services.
- Create a foundation for an improvement process through an empowered conversation that involves many people partnering to improve the integration of the program and its services.
- Establish an organizational baseline of integrated PH/BH capability as a rational foundation for a continuous quality improvement change process.
- Empower organizations and staff to accomplish step-by-step goals to create integrated care for people and families with complex needs
- Create a shared process using a common tool that can be used in any system for any array of diverse programs working in partnership on integrated PH/BH capability development.

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

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 Programming
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

Clinical Competency Tools

CODECAT-EZ™

CODECAT-EZ™ is a tool for clinicians working on development of their recovery-oriented complexity (co-occurring) competency. This tool provides a way for staff to evaluate their own attitudes/values and knowledge/skills related to helping people and families with complex lives make progress in recovery. CODECAT-EZ™ also provides supervisory staff with a structured process to assist staff with competency development.

CODECAT-EZ™ is a key tool in the successful CCISC implementation. CODECAT-EZ™ is used by systems, agencies, and programs as part of the CCISC process to help improve services to individuals and families with co-occurring mental health and substance use issues and other complex needs (i.e., medical needs, disability needs, housing needs, etc.). The CCISC process is specifically designed to change the way programs and systems are organized to support good clinical care for people with co-occurring issues. Most important, from the clinician point of view, CCISC is also designed to help each clinician in each program feel more successful and have more fun working with the people and families with complex needs who they are already serving.

What are the Outcomes of Using the Tool?

For a clinician, the CODECAT-EZ™ allows you to see where you feel that you have strengths in working with clients with co-occurring disorders, and where you feel that you have room to grow. This helps you to identify areas that you want to work on, and areas in which further training or practice will be helpful for you. It also introduces you to the principles of CCISC and how they might be applied to help you with your own work.

For a supervisor, the CODECAT-EZ™ allows you to see how your perceptions of your staff's competencies compare to their perceptions of themselves. This helps you know where they might need more support or training, and helps you work with your staff more effectively in order for them to grow as clinicians and to be more effective with the people they serve.

For a program, looking at the results of the CODECAT-EZ™ for all clinicians as a group, or all supervisors as a group, can help the program identify clinical strengths as well as areas for further training and practice support.

Practice Tools

ILSA-Basic™ (soon to be released)

The Integrated Longitudinal Strength-Based Assessment-Basic™ (ILSA-Basic™) is a unique documentation format that organizes the core process of welcoming, hopeful, integrated, recovery-oriented assessment for adults or older adolescents. It is not a typical "assessment tool" that simply asks a list of questions. Rather, it is designed in content and visual layout to be a format that organizes *a process of assessment* that is designed to understand the hopeful goals and life story of a person with complex needs.

ILSA-Basic™ can be used with adults and adolescents who have any combination of mental health, trauma, substance use, and/or cognitive issues, needs, or disabilities, and other health and social needs.

ILSA-Basic™ is a part of the CCISC implementation toolkit, in which companion tools address system development, program co-occurring capability, and clinician competency. ILSA-Basic™ can be used independently as well as within the context of program-level CCISC implementation.

ILSA-Basic™ incorporates CCISC principles into the assessment process and documentation. Extensive experience in system-wide implementation of integrated services for individuals with co-occurring conditions has demonstrated that a hopeful, person-centered integrated assessment is a critical foundation for effective care.

ILSA-Basic™ incorporates the following "best practice principles" into the assessment documentation:

- Welcoming and engagement
- Identification of person-centered requests and hopeful (recovery-oriented) goals
- Opportunity for the client to tell his or her story
- ZIP-Screen™ to quickly identify multiple issues, including trauma, and level of risk for each
- Identification of periods of relative success, and the strengths used to make progress
- *Integrated* longitudinal history that includes attention to multiple issues (MH, SA, DD, health, legal, etc.)
- Identification of stages of change for each issue
- Identification of skills and supports for each issue
- Framework for eligibility and level of care determination for multiple issues
- Format to develop an initial integrated person-centered service /recovery plan

ILSA-Basic™documentation format has the following unique features:

- ILSA-Basic™ supports the development of an empathic hopeful working partnership between the person and the care provider.
- ILSA-Basic™ begins with "welcoming" and provides a structure for emphasizing person-centered engagement as a priority over simply collecting data.
- ILSA-Basic™ provides a process for gathering information *in the context of the flow of the interview* that will support completion of various screening and other information gathering tools that might be required in the program.
- ILSA-Basic™ is strength-based, longitudinal, and integrated in that it encourages the detailed description of periods where the person did *well*, and discussion of *all* elements of functioning, as well as health, mental health, substance abuse, and cognitive interventions during those periods.
- ILSA-Basic™ incorporates a multi-dimensional assessment framework consistent with multi-dimensional protocols that assist with placement and level of care determination, such as ASAM PPC- 2R and LOCUS.