COMPASS-EZ™

(Version 1.0)

For Review Only

Creating Welcoming Recovery-Oriented Co-occurring Capable Services for Adults, Children, Youth and Families with Complex Needs

A Self-Assessment Tool for Behavioral Health Programs

DEMO VERSION

ZiaPartners, Inc.

Changing the World through Partnership

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Agency Name: _____

Program Name: _____

Contact Person: _____

Change Agents: _____

COMPASS-EZ™ Participants: _____

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Date Completed: _____

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COMPASS-EZ™ Users Guide (Demonstration Version 1.0)

Welcome! We are delighted that your program has an opportunity to use **COMPASS-EZ™** to help improve services for individuals and families with complex lives. **COMPASS-EZ™** is designed to help your program develop welcoming services that inspire hope and provide help to people and families with co-occurring issues. Individuals and families that have multiple co-occurring issues are the expectation in behavioral health settings, and with hope and help, all can make progress toward having healthier, happier, and more meaningful lives. **COMPASS-EZ™** helps programs begin the process of developing recovery and resiliency-oriented co-occurring capability. **COMPASS-EZ™** brings together critical knowledge of what we all have learned over the years about what helps individuals and families--knowledge about integrated treatment and services, trauma informed services, person-centered planning, cultural competency, population-specific services, and most fundamentally, empathic relationships that inspire hope and help. As you will see in the instructions below, **the most important purpose of COMPASS-EZ™ 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.

We hope that you find your group conversation an enlightening, creative and enjoyable experience.

Definitions

Co-occurring Issues (Also termed Co-occurring Conditions, Co-occurring Disorders and Dual Diagnosis): An individual has co-occurring behavioral health issues if he or she has any combination of any mental health or any substance use problem, 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 with an emotional disturbance, and another member has another kind of problem, such as a family member or caregiver with a substance use issue.

Co-occurring Capability: For any type of program, within the mission and resources of that program, recovery-oriented co-occurring capability involves designing every aspect of that program at every level on the assumption that the next person "coming to the door" of the program is likely to have co-occurring issues and needs, and they need to be welcomed for care, engaged with empathy and the hope of recovery, and provided what they need in a person-specific and integrated fashion in order to make progress toward having a happy productive life. Recovery oriented co-occurring capability necessitates that all care is welcoming and person-centered. This dynamic approach to service and care 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 operations of the program to make it easier and more routine for each clinician to deliver integrated care successfully.

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, recovery oriented, and co-occurring capable.** In addition, every person delivering and

supporting care is engaged in a process to become welcoming, recovery-oriented, and co-occurring competent as well.

Implementation of CCISC in real world systems with limited resources is based on significant advances in clinical 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 recovery 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 interventions, strength-based skill-based learning, and using positive contingencies to reward progress a day at a time. CCISC implementation helps all programs in the system, through the use of **COMPASS-EZ™**, to learn how to apply the CCISC principles to build recovery-oriented co-occurring capability into all areas of practice and programming.

Complexity Capability: In the past decade, CCISC has evolved to address more than just mental health and substance use issues. **COMPASS-EZ™** has similarly evolved. In real world behavioral health and health systems, individuals and families with multiple co-occurring needs are an expectation, not an exception. Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by "**complexity**", and they tend to have poorer outcomes and 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 the "expectation", it is not adequate to fund a few "special programs" to work around a fundamentally mis-designed 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 recovery-oriented "Complexity Capable" program. Some systems implementing CCISC have begun to use this terminology to reflect this broader perspective. Although **COMPASS-EZ™** primarily uses the terminology Co-occurring Capability, we anticipate that over time this term may well be replaced with Complexity Capability.

What is COMPASS-EZ™?

COMPASS-EZ™ is a key tool in the successful implementation of the **Comprehensive Continuous Integrated System of Care.** **COMPASS-EZ™** is designed to help individual programs organize a baseline self-assessment of recovery-oriented 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 continuing 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 co-occurring capability across the whole system.

COMPASS-EZ™ is organized by sections that address aspects of a co-occurring capable program's 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-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 and Older Adult services**
- **Child and Adolescent services**,
- **Supportive services settings, such as homeless shelters, correctional settings, child welfare settings, and**
- **COMPASS-EZ™ is informative for 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, 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-EZ™ also has companion tools that have been tailored to meet the needs of specialized services. Examples are:

- **COMPASS-Prevention™ - For prevention and early intervention programs (Issue-2008),**
- **COMPASS-DD™ - For programs working with individuals and families in DD/MR services (Issue 2008), and**
- **COMPASS-Primary Care™ - For Primary Health Care Settings (Issue-2009)**

What is the Difference between COMPASS-EZ™ and COMPASS™

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

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1. **Self-Survey:** **COMPASS-EZ™** 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-EZ™** is designed to help programs develop and take ownership of the continuous quality improvement process. Note: *For systems that wish to develop indicators of co-occurring capability that can be used in program oversight, ZiaPartners, Inc. has designed a tool/process called **COCAP™** to help systems partner to select indicators that developmentally fit the programs in the system. This approach to "auditing" supports transformational partnering and sustains change. **COCAP™** should be used only after the programs in the system have used the **COMPASS-EZ** over a period of time, usually at least one year.*

2. **Small Group Discussion:** The **COMPASS-EZ™** is designed to be used in a small group discussion format that includes representation from all of the different perspectives in the program: **managers, supervisors, front line clinicians, support staff, peer recovery specialists, and, when possible, representative consumers 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 program. 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 individuals with co-occurring issues. This opportunity for a deep and rich discussion engages the **COMPASS-EZ™** 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 mistake that programs make is 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 the most value out of using **COMPASS-EZ™**.

3. **Preparing the Group:** It is extremely helpful for the group to have some background about the process of co-occurring capability development before using the **COMPASS-EZ™**. 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 the **COMPASS-EZ™** 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 the **COMPASS-EZ™.** Most programs organize themselves to have the conversation quite well. One person, usually NOT the program 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-EZ™** 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 (like 30 minutes) 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:** The **COMPASS-EZ™** is designed as a survey of a "program". In very small agencies, it is often easy to determine what the program is --it's the whole agency and everybody gets involved in the **COMPASS-EZ™**! In larger agencies, this may sometimes be harder to figure out. Here are some guidelines:
    a. **A large agency should plan to have each distinct program use the COMPASS-EZ 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 mental health center, the Assertive Community Treatment team would use the COMPASS-EZ™ as it is a separate program, distinct from the Outpatient Counseling Center, Targeted Case Management Team, or the School Based Team. Similarly, in a large substance abuse treatment agency, the Women's Residential Unit would complete the COMPASS-EZ™ separately from the Men's Program, the Partial Hospital Program, or the Outpatient Counseling Program.
    c. **It is possible, and sometimes helpful, to bring representative teams (not just individuals) from different programs in an agency together to share a common conversation and experience. In this instance, the distinct programs might score themselves differently from one another on various items, maintaining a unique scoring for each program.**
    d. **Learning from the Experience: The most important outcome of using the tool 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 conversation. Therefore, it is important for the program 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 program better. These notes can be jotted down in the boxes labeled "Action Plan Notes" at the bottom of each section.

How do We Score the COMPASS-EZ™?

What Do We Do after We Complete the COMPASS-EZ™?

[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.

Section 1: Program Philosophy (5 Items)

EXAMPLE:
Written program descriptions specifically say that individuals and families with co-occurring issues are welcomed for care.

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

Section 2: Program Policies (3 Items)

EXAMPLE:

Clinical record keeping policies support documentation of integrated attention to mental health, health, and substance use issues in a single progress note and in a single client chart or record.

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

Section 3: Quality Improvement and Data (5 Items)

EXAMPLE:

The program has identified and empowered change agents or champions to assist with the continuous quality improvement process.

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

Section 4: Access (3 Items)

Section 5: Screening and Identification (6 Items)

Section 6: Recovery-Oriented Integrated Assessment (6 Items)

EXAMPLE:

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

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

Section 7: Integrated Person Centered Planning (4 Items)

EXAMPLE:

The person's/family's hopeful goals, recent successes and strengths are the foundation of the service plans.

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

Section 8: Integrated Treatment/Recovery Programming (6 Items)

Section 9: Integrated Treatment/Recovery Relationships (3 Items)

Section 10: Integrated Treatment/Recovery Program Policies (4 Items)

EXAMPLE:

Integrated service plans and behavioral policies provide for positive reward for small steps of progress in addressing any problem, rather than focusing on negative consequences for "treatment failure", "relapse", "inappropriate behavior" or "non-compliance".

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

Section 11: Psychopharmacology (6 Items)

EXAMPLE:

Policies or practice guidelines specify access to medication assessment and prescription without requiring a mandatory period of sobriety.

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

Section 12: Integrated Discharge/Transition Planning (2 Items)

Section 13: Program Collaboration and Partnership (5 Items)

Section 14: General Staff Competencies and Training (6 Items)

EXAMPLE:

There are specific recovery-oriented co-occurring competencies for all staff included in human resource policies and job descriptions.

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

Section 15: Specific Staff Competencies (5 Items)

COMPASS-EZ™ 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-EZ™ Score:		