COUNTY OF SANTA CLARA
Behavioral Health Services

Children & Adolescent Needs and Strengths (CANS) & Pediatric Symptom Checklist (PSC-35)

Operational Standards

1. Purpose

The Child and Adolescent Needs and Strengths (CANS) is an assessment process in addition to a multi-purpose tool developed for children's services to: support decision making (e.g. level of care and service planning), facilitate quality improvement initiatives, and monitor the outcomes of services. The measure is based on research findings that "optimally effective treatment of children and youth should include both efforts to reduce symptomatology and efforts to use and build strengths" (Lyons, 2009).

The Pediatric Symptom Checklist (PSC) is a functional assessment tool that is used by health professionals to improve the recognition and treatment of cognitive, emotional, & behavioral problems so appropriate interventions can be initiated as early as possible.

2. System Standards

CANS

The CANS will be completed with every beneficiary served in the Behavioral Health Services Family and Children's Division System of Care for primary mental health programs. The information will be used to inform the beneficiary's treatment plan and measure service outcomes. In cases with beneficiaries served by DFCS, CANS summaries will be shared to coordinate care within the context of the CFT, as well as support the DFCS Care Plan.

a. The CANS will be provided in an interactive process, with the family reviewing CANS scores, in a client-centered and transparent manner.

b. The CANS will be provided in the preferred language of the beneficiary/family members. County of Santa Clara Behavioral Health Services Department (CSCBHSD) will provide CANS score sheets translated into the required threshold languages.

c. Each agency will ensure that provider staff are trained and certified in the CANS manual appropriate for the beneficiaries they serve. Manuals include:

    i. CANS 5+ (formerly CANS Comprehensive) for staff that serve beneficiaries aged 6 to 18 (see Section 3e for information on Transitional Aged Youth [TAY] over age 18). The CANS 5+ has a CSEC module built in to support youth who are sexually exploited.

    ii. CANS-Early Childhood [CANS: EC] for staff that serve beneficiaries from birth through age 5 (see Section 3d for information on those in Birth to 5 programs who are ages 6-8)

d. CSCBHSD provided an initial series of trainings for all required provider staff. Each program/agency are to arrange subsequent certification and recertification of their provider staff as needed. Please reference the CANS Certification and Recertification Policy for requirements and recommendations.

e. Each program/agency will ensure that supervisors/managers are trained and certified in the CANS and that directors/executives receive an overview of the CANS training.

f. CSCBHSD will provide an initial "Train the Trainer" program. Each program/agency will implement a sustainable "Train the Trainer" method and will follow a program/method approved by CSCBHSD and the CANS developer. Programs/Agencies must have at least two (2) trainers to maintain support and sustainability of the CANS.

g. Any exceptions to the use of the CANS 5+ (e.g. CANS Juvenile Justice version) will require approval of CSCBHSD.

PSC-35

The PSC-35 will be completed with every beneficiary ages 3 to 18 served in the Behavioral Health Services Family and Children's Division System of Care for primary mental health programs. The information will be used to inform the beneficiary's CANS, treatment plan, and measure service outcomes.

a. The PSC-35 is to be provided to the parent/caregiver with minimal support from staff during the rating time. Staff will then score, analyze, and communicate their observations with the family.

b. The PSC-35 will be provided in the preferred language of the beneficiary/family members. Santa Clara County Behavioral Health Services Department (CSCBHSD) will provide PSC-35 form translated into the required threshold languages, many of which are provided via the Massachusetts General Hospital website, including pictorial versions for those with limited reading abilities.

c. Each agency will ensure that provider staff are trained in the use of the PSC-35, including how to use it collaboratively with the CANS.

d. CSCBHSD provided an initial series of orientations for all required provider staff as well as administrators and managers. Each program/agency are to arrange subsequent overviews to their provider staff as needed. Certification is not needed for the use of the PSC-35.

e. All programs/agencies must have at least two (2) trainers to maintain support and sustainability of the CANS; it is recommended CANS Trainers weave the PSC-35 into their general trainings.

f. Any exceptions to the use of the PSC-35 will require approval of CSCBHSD.

3. Standards for CANS & PSC-35 Completion

a. CANS & PSC-35 will be completed with new beneficiaries and with current beneficiaries at intake, every 6 months, and at discharge. These tools are to be used to inform care through the treatment plan ("care plan").

b. To avoid duplication, a primary service program/agency will be identified and will be responsible for the initial and subsequent CANS & PSC-35.

c. For beneficiaries with multiple MH providers ("open episodes"), each program/agency must collaborate to select the primary provider for CANS & PSC-35 completion, which will be identified as follows:

    i. The program/agency providing the most intensive service level (i.e. hours per month) of service will be considered the primary provider (excluding TBS, which is an adjunct service).

    ii. For programs of equivalent service level, the program/agency with the longest history and/or expected length of service will be the considered the primary provider.

    iii. The primary provider will be responsible for obtaining the PSC-35 and completing the CANS and will collaborate with the beneficiary, family, and other CSCBHSD network programs/agencies serving the beneficiary to share the information. All concurrent providers will incorporate the information to create a coordinated treatment plan and update the plan regularly.

d. The primary provider will complete the CANS: EC version for beneficiaries whose program admit date is prior to their 6th birthday and include PSC-35 starting at age 3.

    i. The primary provider will continue to review/update the CANS: EC version and PSC-35 (starting at age 3) until the program discharge date, even if the beneficiary turns age 6 prior to program discharge date.

    ii. In the event the primary provider continues beyond the beneficiary's 8th birthday, the CANS 5+ version will be used for subsequent measures and will continue to use the PSC-35 as it is indicated for ages 3 to 18.

e. Programs that are designed and funded for Transitional Age Youth (TAY) will complete the CANS 5+ with all beneficiaries admitted and PSC-35 for those youth under 18.

    i. The 18+ module is "triggered" by the age of the youth, not by any specific item within the CANS. You would still use the CANS 5+ if they are 17 at the time of initial assessment. The next assessment, when they are 18, would trigger the use of the 18+ module.

    ii. The PSC-35 is not indicated for use with beneficiaries age 18 or older.

f. The CANS will be initially completed with the beneficiary/family within the first 60 days of beginning services (admit date), but prior to the treatment plan completion date. The PSC-35 is intended to precede the CANS to inform the assessment process.

    i. An initial CANS does not have to be completed if a beneficiary was not opened or they were closed within the initial 60 day window. That said, if you have completed it, we encourage you to file it (whether in your own EHR/EMR or KIDnet) in case the youth re-opens. This can be helpful historical information for you or others that may work with that youth.

g. The PSC-35 and the CANS will be reviewed and updated with the beneficiary/family a minimum of every six months from the admit date (or more frequently if clinically

indicated to measure progress and revise the treatment plan) and at discharge. Reasons to review/update the CANS include changes in environment or beneficiary/family functioning.

h. If a beneficiary is transferred from one program/agency to another, the two programs will work together to ensure that a PSC-35 and CANS review/update is completed prior to discharge.

i. The "receiving" program/agency has the option to review/update the PSC-35 and CANS at admission if it is in the beneficiary's best interests. Otherwise, the provider should use the prior completion of the PSC-35 and CANS for baseline functioning and treatment planning.

j. In any event, the "receiving" program/agency will review/update the PSC-35 and CANS no later than six months from a prior completion of these tools.

4. Documentation Standards:

a. The PSC-35 and CANS forms will not replace the CSCBHSD approved assessment forms (e.g. "orange/salmon assessment form"), but will supplement the assessment process.

b. The PSC-35 is to be completed by the parent/caregiver, therefore the completion of the form, including assisting the completion, is not billable. The evaluation of the scores and discussion with the youth and family and its incorporation with the CANS may be billed as an assessment activity.

c. Completion of the CANS with the beneficiary/family may be billed as "assessment" at any point where review/update is clinically indicated. The provider should consult the CSCBHSD Clinical Practice Guidelines Manual for recommendations on how to document assessment activities.

d. Once the "initial assessment" is done and signed, there can be additional episodes of "follow-up assessment" provided, when clinically indicated. Assessment is a recurrent process, especially with developmental changes of children.

5. Use of CANS & PSC-35 for Reporting and Outcomes Measurement

a. Each program/agency will share CANS information with CSCBHSD to create a reliable data set in order to improve beneficiary and system level decision making.

b. The program/agency will capture CANS data electronically and transmit the data to CSCBHSD using a method and frequency agreed upon with CSCBHSD. Those options include:

   i. direct entry to KIDnet,

   <u>or</u>

   ii. use of a data interface between your agency's EHR/EMR and KIDnet (please contact BHSD Decision Support for more information).

c. CSCBHSD will monitor completion rates and provide notices for corrective action.

d. County sites will utilize KIDnet for entry, alert reports to track dates of CANS completion, and report review.

e. KIDnet will host reports to inform decisions at the beneficiary, program, and system levels. CSCBHSD will also provide extracted reports, as requested, to programs/agencies upon request.