COUNTY OF SANTA CLARA
Behavioral Health Services

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

Operational Standards

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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). Use of the CANS in the County of Santa Clara Behavioral Health Services (CSCBHSD) Children, Youth and Family (CYF) System of Care began in 2012, and has become a requirement in all specialty mental health (SMHS) youth programs throughout California in 2017 (MHSUDS Information Notice 17-052) with start in 2018.

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. The PSC-35 became a requirement in all behavioral health youth programs throughout California in 2017 (MHSUDS Information Notice 17-052) with start in 2018.

2. System Standards

2.1. CANS

The CANS will be completed with every beneficiary served in the Behavioral Health Services BHSD CYF System of Care for primary mental health programs that are expected to provide services for more than 90 days. The information will be used to inform the beneficiary's personal and treatment goals and measure service outcomes. In cases with beneficiaries served by Department of Family and Children's Services (DFCS), CANS summaries will be shared to coordinate care within the context of the Child and Family Team meetings (herein referred to as "CFT"), as well as support the California Department of

Social Services (CDSS) Case Plan (see Section 7 for more information on sharing CANS data and summaries).

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

2.1.2. The CANS will be provided in the preferred language of the beneficiary/family members. CSCBHSD will provide CANS score sheets translated into the required threshold languages.

2.1.3. Each program/agency (County-run program and/or CCP) will ensure that provider staff are trained and certified in the CANS manual appropriate for the beneficiaries they serve. Manuals include:

2.1.3.1. CANS 5+ (formerly CANS Comprehensive) for staff that serve beneficiaries aged 5 through 25 (including 18+ module for beneficiaries over age 18 - see Section 3.5 for information on Transitional Aged Youth [TAY] over age 18).

2.1.3.2. CANS-Early Childhood [CANS:EC] for staff that serve beneficiaries from birth through age 5 (see Section 3.4 for information on those served in Birth to 5 programs who are ages 6-8)

2.1.4. 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 on the CSCBHSD website for requirements and recommendations.

2.1.5. Each program/agency will ensure that supervisors and clinical managers are trained and certified in the CANS and that directors/executives receive an overview of the CANS training. This ensures clear and consistent supervision, communication, and support across the system.

2.1.6. CSCBHSD provided initial “Train the Trainer” trainings. Each program/agency will implement a sustainable “Train the Trainer” method and will follow a program/method approved by CSCBHSD and the CANS developer. Ongoing, programs/agencies must have at least two (2) trainers to maintain support and sustainability of the CANS.

2.1.7. Any exceptions to the use of the CANS (e.g., CANS Juvenile Justice version, CANS IP) will require approval of CSCBHSD.

2.2. PSC-35

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

1. 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.

2. The PSC-35 will be provided in the preferred language of the beneficiary/family members. 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.

3. 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.

4. 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.

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

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

3. Standards for CANS & PSC-35 Completion

3.1. CANS & PSC-35 will be completed with new beneficiaries and current beneficiaries at intake, every 6 months (at minimum), and at discharge. These tools are to be used to inform care through the Problem List and treatment plan (“care plan”), where applicable.

3.2. To provide trauma informed care and reduce duplication, beneficiaries with multiple MH providers (“open episodes”), will identify a primary service program/agency (herein referred to as the “primary provider”) who will be responsible for all required CANS & PSC-35 completions.

3.3. To avoid duplication, a primary service program/agency (herein referred to as the “primary provider”) will be identified and will be responsible for the initial and subsequent CANS & PSC-35.

- 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.
- 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).
- 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.
- Should a beneficiary be closed to the primary provider, the next most intensive service level will be responsible for completion of the CANS and obtaining the PSC-35.

3.4. Programs that are designed to provide services for children Birth through age Five, 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.

- 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.
- 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.

3.5. Programs that are designed and funded for Transitional Age Youth (TAY) will complete the CANS 5+ (including 18+ module for beneficiaries over age 18) with all beneficiaries admitted and PSC-35 for those youth under 18. The primary provider will continue to review/update the CANS 5+ version until the program discharge date, even if the beneficiary turns age 26 prior to program discharge date.

- The 18+ module is "triggered" in AMS's Qualo 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 additional use of the 18+ module.
- The PSC-35 is not indicated for use with beneficiaries aged 18 or older. Once a beneficiary is 18, it is no longer required to collect or enter the PSC-35.

3.6. The CANS will be initially completed at intake with the beneficiary/family within the first 60 days of beginning services (admit date) and will be used to help inform the beneficiary's Problem List and treatment goals. The PSC-35 is intended to precede the CANS to inform the assessment process.

3.6.1. 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. If the CANS has been completed, it should be filed in AMS's Qualo (and your own EMR/EHR, if required by your agency) in case the youth re-opens. This can be helpful historical information for you or others that may work with that youth. It is encouraged to also indicate the CANS and PSC-35 completion within a progress note.

3.7. 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 Problem List and/or treatment goals) and at discharge. Reasons to review/update the CANS in between the six-month follow-up timeframe include, but are not limited to, changes in environment, level of care changes, significant changes to diagnosis and/or beneficiary/family functioning, etc. Programs/Agencies may choose to increase the frequency of completion to every three (3) months, though that is not required by CSCBHSD.

3.8. 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 via the warm handoff process.

3.9. 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 and reflective of the beneficiary's current status. Otherwise, the provider should use the prior completion of the PSC-35 and CANS for baseline functioning and care planning.

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

4. Documentation Standards

4.1. The PSC-35 and CANS forms will not replace the CSCBHSD approved clinical assessment forms, but will supplement the assessment process.

4.2. 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 scores in combination of active direct service discussion with the beneficiary and family as well as incorporation into the CANS may be billed as an assessment activity.

4.3. Completion of the CANS with the beneficiary/family may be billed as "assessment" at any point where review/update is clinically indicated and completed as a direct service. The provider should consult the CSCBHSD Mental Health Companion Guide for recommendations on how to document assessment activities.

4.4. 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. Discharge CANS & PSC-35

5.1. All beneficiaries should have CANS at discharge.

5.1.1. If a beneficiary was closed due to no contact and the most recent CANS was ≤90 days ago, it should be used as the discharge CANS and indicated in a progress note as to what date the CANS represents and reasons for not being updated.

5.2. If no CANS or PSC-35 was obtained, an administrative discharge should be completed. A progress note should detail why there is no CANS or PSC-35 at closing.

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

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

6.2. 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:

6.2.1. direct entry to AMS's Qualo,

or

6.2.2. use of a data interface ("API") between your agency's EHR/EMR and AMS's Qualo (please contact BHSD Quality Improvement Decision Support for more information).

6.3. Submission of data should be in AMS's Qualo no later than two (2) weeks after the close of the month. For direct entry, best practice is immediately after or during the session where the assessment is being completed with the beneficiary and their family.

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

6.5. County sites will utilize AMS's Qualo for entry, alert reports to track dates of CANS completion, and report review.

6.6. AMS's Qualo 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.

7. Collaborating with Department of Family and Children's Services (DFCS)

7.1. Per ACL No. 18-81, Requirements and Guidelines for Implementing the Child and Adolescent Needs and Strengths (CANS) Assessment Tool Within a Child and Family Team (CFT) Process, "county child welfare agencies and MHPs are jointly responsible for completion of the CANS and thus are expected to share completed CANS assessment information to avoid unnecessary duplication and over-assessment of children, youth, and NMDs." ACL No. 18-85 further clarifies that the program/agency is required to share an existing CANS assessment with child welfare as early as possible, and that this sharing of information is allowable under 45 C.F.R. Section 164.506(c)(1) of the HIPAA Privacy Rule.

7.1.1. A signed release of information/authorization is required to release ***substance use*** information in compliance with 42 CFR Part 2, and to share the CANS assessment with entities other than DFCS or CSCBHSD as part of the CFT.

7.1.2. The goal, whenever possible, is for program/agency staff completing the CANS to attend the CFT to share actionable needs and useful strengths highlighted in the CANS Summary document. When a program/agency is unable to attend a CFT where the CANS will be discussed, the program/agency will connect with DFCS prior to the CFT to review the CANS Summary document.