CANSNews

"News for the CANS Community"
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CANSNews – Summer 2013

Welcome to the summer edition of *CANSNews*. As CANS compliance increases, so do our efforts to develop new and better ways to support CANS in daily practice. In this edition, you will find access to two articles by Jack Simons, Ph.D. "*What we've learned about the CANS population*" is in this edition in its entirety and provides insight into the data collected about the strengths and needs of the children served. Additionally, a link is provided to a second article "*Assessing CANS outcomes*". This article offers clinical guidance on multiple approaches for assessing child outcomes using the CANS.

Also at this time, CBHI is pleased to announce a new resource, ***The CANS Family Guide***. The guide, which can be downloaded as a hand-out, provides a simple explanation of the CANS to share with families.

In "*Providers and MCEs Work Together to Improve Consent Compliance and Practice"* two providers share their experience with increasing CANS compliance by using the CANS as an engagement tool in their work with families. These providers offer excellent ideas and examples of collaborative practice to improve compliance and family engagement.

Additionally, there is much effort underway to transform the CANS into a valuable and dynamic tool that guides treatment planning and CBHI service delivery. You'll preview some of the fresh changes coming to CANS training approaches, materials and resources. You'll also find highlights from the recent CANS focus group sessions that were convened to get essential input from providers for the development of CANS reporting tools for clinicians and organizations.

CBHI hopes that you will find all of these CANS resources useful. As always, we thank you for your continued effort to help children and families.

Without continual growth and progress, such words as improvement, achievement and success have no meaning.
Benjamin Franklin

What we've learned about the CANS population

The CANS system on the Virtual Gateway has over 250,000 records entered by providers, relating to over 67,000 MassHealth youth as of August, 2012. Some 17% of these records contain only limited data because the caregiver or member declined consent to enter full CANS data into the system; in those cases, the provider completes the CANS in the local medical record but not in the CANS system on the Virtual Gateway. (The number of CANS in the system probably slightly underestimates the overall use of the CANS, since there is evidence that some providers complete the CANS but do not comply with the requirement to use the Virtual Gateway.) Sixty-one percent of these records were entered by outpatient providers, 19% by In-home Therapy providers, 16% by Intensive Care Coordination, and 4% by inpatient and CBAT providers.

What does the CANS data tell us about the 67,000 youth for whom we have some data?

The median age is 12, and the middle 50% falls between 8 and 15. Fifty-five percent are male. The boys (median age 12, inter-quartile range 8 to 15) tend to be a little younger than the girls (median age 13, inter-quartile range 9 to 16). Eighty-two percent are living at home at the time of assessment, with 9% living in foster care (including kinship care); 5% in a shelter, group home, or residential setting; 3% in hospital or CBAT; and around 2% in "other".

Ninety-two percent meet the SAMHSA criteria for SED, 82% meet the IDEA criteria, and 96% meet at least one of the two definitions. Only 4% meet neither definition.

Child diagnostic data are not easily summarized, but for the group of children aged 5 through 20, there were 219 primary diagnostic categories used for Axis I. Among these, the most common diagnoses were ADHD (14%), PTSD (11%), Mood Disorder Not Otherwise Specified (8%), and Oppositional Disorder (7%). Large numbers of children have diagnoses closely related to these leading four, including many with adjustment reactions. The number of children with frank diagnoses of bipolar disorder or any psychotic disorder is small (less than 2% for bipolar, fewer for psychotic disorders).

The CANS also includes the GAF or Axis V diagnosis, which is a global clinician rating of child functioning. The median for both boys and girls, pretty consistently across the age range from 5 to 20, is 55. A GAF of 55 falls in the middle of the range of 51-60, which is described in the DSM-IV as follows: "Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). " A slightly different description derives from a related scale, the Children's Global Assessment Scale (CGAS), which describes this range thus: "Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings." The inter-quartile range for the GAF in this

group is 50 to 60. This raises interesting questions about whether the SED determination is consistent with other clinical data reported in the CANS system. Most people would probably agree that variability from one time to another and from one setting to another is extremely common in the presentation of child mental health symptoms, and that a GAF in the fifties signals a pressing need for intervention, even if the child's impairment is not constantly in evidence.

The CANS is designed to tell us about the strengths and needs of children, and about the needs of their families (our version of the CANS does not have a family strengths domain). Here we summarize briefly some of the CANS findings for our 67,000 youth and their families, organized by each CANS domain. When more than 25 percent of children have a rating of 2 or 3 on a CANS item, indicating a need for action, we report on that item. Of course, many children have needs across multiple items. And of course an item may be infrequently rated and yet enormously significant for subgroups of children and their families. (For the present we have omitted summarizing the new Cultural Considerations domain.)

Life Domain Functioning

Social Functioning	37% of youth have a need for intervention
School Behavior	29% of youth have a need for intervention
School Achievement	29% of youth have a need for intervention
It is perhaps notable that two of the three items where children most often struggle to function relate to school.	

Child Emotional/Behavioral Needs

Impulsivity/ Hyperactivity	35% of youth have a need for intervention (Note: a rating on this item does not amount to a diagnosis of ADHD)
Depression	32% of youth have a need for intervention
Anxiety	32% of youth have a need for intervention
Oppositional	33% of youth have a need for intervention
Adjustment to Trauma	28% of youth have a need for intervention
Emotional Control	40% of youth have a need for intervention
Note that the emotional/behavioral needs identified here are quite consistent with the most frequent diagnoses cited above.	

Child Risk Behaviors

Judgment	No item in the domain of Child Risk Behaviors reached the 25% level, as these tend to be low-frequency behaviors, but 24% of youth were rated as needing intervention to deal with their poor judgment.

Transition to Adulthood

These items are relevant for older youth approaching the transition to adulthood.

Independent Living Skills	26% of youth age 14 or over have a need for intervention
Education Attainment	33% of youth age 14 or over have a need for intervention
Financial Resources	28% of youth age 14 or over have a need for intervention

Child Strengths

Strengths are conceptually differently from needs. Having a zero or one means there is some useable level of the particular strength. In this case we report the percentage of children who exhibit a strength, so in this domain high percentages are good news. It is a good question whether raters know how to capitalize in treatment on the strengths they identify in the CANS.

Family	60% of youth had a useable strength in this area
Interpersonal	62% of youth had a useable strength in this area
Optimism	66% of youth had a useable strength in this area
Education	80% of youth had a useable strength in this area
Vocational	40% of youth had a useable strength in this area
Talents and Interests	71% of youth had a useable strength in this area
Spiritual/Religious	46% of youth had a useable strength in this area
Community Life	60% of youth had a useable strength in this area
Resiliency	64% of youth had a useable strength in this area

Family Needs and Resources

Family Stress	36% of caregivers are rated as needing intervention to deal with the stress of parenting
Note: More than one third of families are struggling with the demands of raising the child, which appears to confirm the strong positive response that we get from families that work with Family Partners. No other family item was rated 25% of the time, but Natural Supports and Financial Resources were rated in the low 20s.	

Assessing Child Outcomes with the CANS

CBHI is pleased to add with a new article written by Jack Simons, Ph.D., Assistant Director of CBHI to the Clinical Guidance section of the CANS page on the CBHI website. The article, "Assessing child outcomes with the CANS" provides direction at both the individual level and for use in clinical supervision.

The CANS Family Guide is here!

The CANS Family Guide is a tool for engaging youth and families during a behavioral health assessment. Developed by CBHI with input from Parent/Professional Advocacy League (PPAL) and the MCEs, this simple, two page guide explains what the CANS is and why it is used. You can give it to families to read on their own or use it to guide a conversation during the assessment period.

Click here CANS Family Guide to download a copy or go to Link to Mass.Gov website to the Clinical Guidance section.

CANS Training Program Update

The CANS Training Program is focused on strategic projects leading to quality improvement for CANS implementation in Massachusetts. As a result of a comprehensive evaluation of CANS training in Massachusetts, exciting changes and improvements are on the horizon for CANS training and support. This means that you can expect a more interactive initial training experience, as well as support for using CANS in daily practice that is targeted to specific needs. A new array of training tools will offer support for both new and advanced CANS users.

The evaluation included input from an instructional design expert who assessed features of the on-line CANS certification training, key informant interviews, and results of the satisfaction survey that training participants complete after on-line certification. A broad cross section of clinicians and administrators provided informed opinions and feedback in the key informant interviews. A full report with a summary of findings and recommendations will serve as the centerpiece for revisions and improvements. Our goal is to provide CANS Assessors with an array of training tools to better meet a range of training needs. Recognized experts and members of the CANS community will be tapped to motivate users with the latest information on topics that matter.

The revised training program will offer a post-certification “toolbox” of dynamic learning opportunities with user-friendly technology for learners with a variety of learning styles. Changes to the training program will be developed over the next year, with implementation expected in the summer of 2014.

Focus Groups for Reporting Tools Conducted

In May, the CANS Training Program convened three focus groups with clinicians, supervisors, and MCE representatives to collect essential input for developing CANS reporting tools to use in the field. There was a very enthusiastic response in the sessions with a broad consensus that having reporting tools to include CANS information in practice will greatly enhance services and the use of CANS at all levels. Important highlights from the focus groups include the need for:

- flexible reporting tools that serve the needs of multiple audiences
- capacity to better highlight strengths
- viewing information across levels of care

CBHI has long been aware that in order to fully integrate CANS in practice, clinicians and supervisors must be able to access and view CANS information about the children and families they serve. The reporting tools are intended to illustrate and track progress over time, facilitate greater family engagement and provide CANS activity information for supervisors. We will keep you posted on project developments.

CANS Training Program Training Directory

The CANS Training Program is developing a CANS Training Staff Directory. We are grateful to those of you who have already responded to this request. If you serve as a training director or a supervisor and are responsible for training in your organization, we are interested in adding you to the directory. Also, if you are a solo practitioner, who would like to participate in the training community, please join in.

The purpose of this directory is to create a direct line of communication between CBHI and those supervisors/directors within your organization who are responsible for overseeing CANS training and certification. Please complete the training information form we have attached with the newsletter and return it to Gretchen.Hall@umassmed.edu to be added to the Directory.

Providers and MCEs Work Together to Improve Consent Compliance and Practice

In the past year, the MCEs have monitored more closely CANS compliance indicators, including the CANS completed on the Virtual Gateway and the number of CANS that providers are obtaining consent from parents to enter into the Virtual Gateway. The MCEs have reported that in recent months they are seeing significant improvement in consents being signed to enter CANS data in the Virtual Gateway. While initially some providers perceived the consent as an option, providers are now indicating that MCEs have improved communication and offered helpful support to make this important improvement.
Providers that made significant strides in this area have shared strategies that made a difference. One organization identified that parents needed to be assured that the Virtual Gateway was secure. As a first step in increasing the rate of consent signatures, the organization developed internal training that was presented by the most knowledgeable staff on how to convey the notion of secure information in a way that families could understand. Information security is now one of the first things that this organization discusses with families when completing an intake. This approach provided the organization an opportunity to offer guidance on educating families about CBHI and services offered as well as the importance of family empowerment which was identified as a key factor in helping families be assured that their information is secure.

Another provider organization identified cultural factors in obtaining consent to enter CANS into the Virtual Gateway. The IHT Coordinator found that multi-lingual families withdrew and were hesitant to sign the consent because the amount of information provided at intake was overwhelming to the family. In response, this innovative provider identified a "mix and match" approach which targets priority domains/items that were presented by the family as the largest focus at referral and upon intake. Rather than having the CANS ratings at the core of the meeting with the family, providers found that discussing and documenting key findings fostered stronger conversations with the family. Explaining how using the CANS may help meet their needs has been a useful way to engage families. Prioritizing domain/items identified by the family has helped to build rapport and focus on the family's priority needs in treatment planning.

As a second step, providers go back and complete the CANS with their supervisors and include helpful narrative comments. The CANS is then shared with the family for their input before the CANS is finalized. This solution makes using the CANS more manageable and allows the family to see that the CANS is a tool which can help them meet their needs and build on their strengths. Using this approach has resulted in an increase in the successful completion of the CANS. This organization also developed internal support in the form of supervision and a tutorial to instruct staff on how to complete the CANS effectively. This is an excellent example of collaborative practice that improves both compliance and family engagement and we encourage you to incorporate these techniques in your practice.

These approaches are proving to be very promising and are in compliance with the policies that allow enhanced billing for two assessment sessions and up to 45 days to enter CANS into the CANS application in the Virtual Gateway system. Providers are encouraged to speak with the MCE(s) to learn more about the rates of compliance in regards to consents being signed.

CANS Conference SAVE THE DATE!

2013 ANNUAL CANS CONFERENCE, November 3 - 5, 2013

Hilton San Francisco Financial District

The goal of this year's conference will be to assist in the development of specific skills involving the full use of Total Clinical Outcomes Management [TCOM] and its associated measures (The Child and Adolescent Needs and Strengths [CANS], The Family Advocacy and Support Tool [FAST], Adult Needs and Strengths Assessment [ANSA]). There will be three tracks: First, a **clinical track** for people who work in direct service. This track will include workshops on the use of these tools in treatment planning, trauma-informed care, strength-based work, and integration with various evidence-based practices (e.g. motivational interviewing, collaborative problem solving). The second track will be a **program management and supervisory track** which will include workshops for supporting staff development and managing effectiveness. The third track will be designed for **system administrators** which will focus on the use of information collected with these tools to support system management, design, and evolution.

CANS Tech Buzz

Did you know…

CANS Consent:

- Consent in the CANS application is by organization, so if one program gets consent, it covers the whole organization.
- Consent can be valid for up to 24 months when specified on the consent form. After that time, you will receive an expiration notice and will need to obtain consent again.
- When consent for a child expires, the next person in the organization who needs to enter CANS for that child should obtain consent and put the new consent into the system. You do not need to get consent for every service separately.

When Entering a Reassessment, Copy the Mass CANS!

Providers can copy a previously completed CANS that has been completed within their organization and edit it when doing a reassessment. When performing the 90-day re-assessment, you can save a copy of the most recent CANS. Using the copy of the previous record you may then edit it to update only those items and additional narrative text that reflects any clinical or life changes that have occurred since the previous MASS CANS. Don't spend your time entering data that the application could copy for you! See ***page 15*** of the following job aid for detailed instructions on using the copy feature Virtual Gateway job aid, see page 15 for details

The copy feature also works if the child or youth has a MASS CANS assessment entered by another service within your organization (e.g., he /she had a MASS CANS assessment done in your outpatient clinic and now he/she is in your CBAT). Note that if the member has reached age 5 since the last MASS CANS, the application will copy only the demographic information and the SED determination because the MASS CANS tool itself is different for children over the age of 5. In this case, you will need to enter the ratings for all items.

The CANS page on the CBHI website offers a broad range of information to answer your CANS program and policy questions and is available 24 hours a day, seven days a week. Please save it as a *Favorite* for easy access to the website page at: (Child & Adolescent Needs & Strengths Resource page)

CANSContacts

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CBHI Website: www.mass.gov/masshealth/cbhi

The University of Massachusetts Medical School is the contracted provider for MASS CANS Training and Certification for the Children's Behavioral Health Initiative (CBHI) of the Massachusetts Executive Office of Health and Human Services.

CBHI Mission The Children's Behavioral Health Initiative (CBHI) is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services. Our mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive community-based system of care to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

CANSNews

A collaborative effort of CBHI,
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