Introduction to the CANS-NY for Managed Care: Webinar 3

USING THE CANS-NY TO SUPPORT QUALITY

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Learning Objectives For Today's Webinar

1. Participants will learn how the CANS-NY should be used to support a collaborative assessment process.

2. Participants will understand the importance of developing a shared vision as part of the collaborative assessment and care planning processes.

3. Participants will understand how to organize actionable needs to inform a focused, targeted Plan of Care.

4. Participants will learn how to use changes in the action levels of the CANS-NY items to evaluate progress and optimize the Plan of Care.

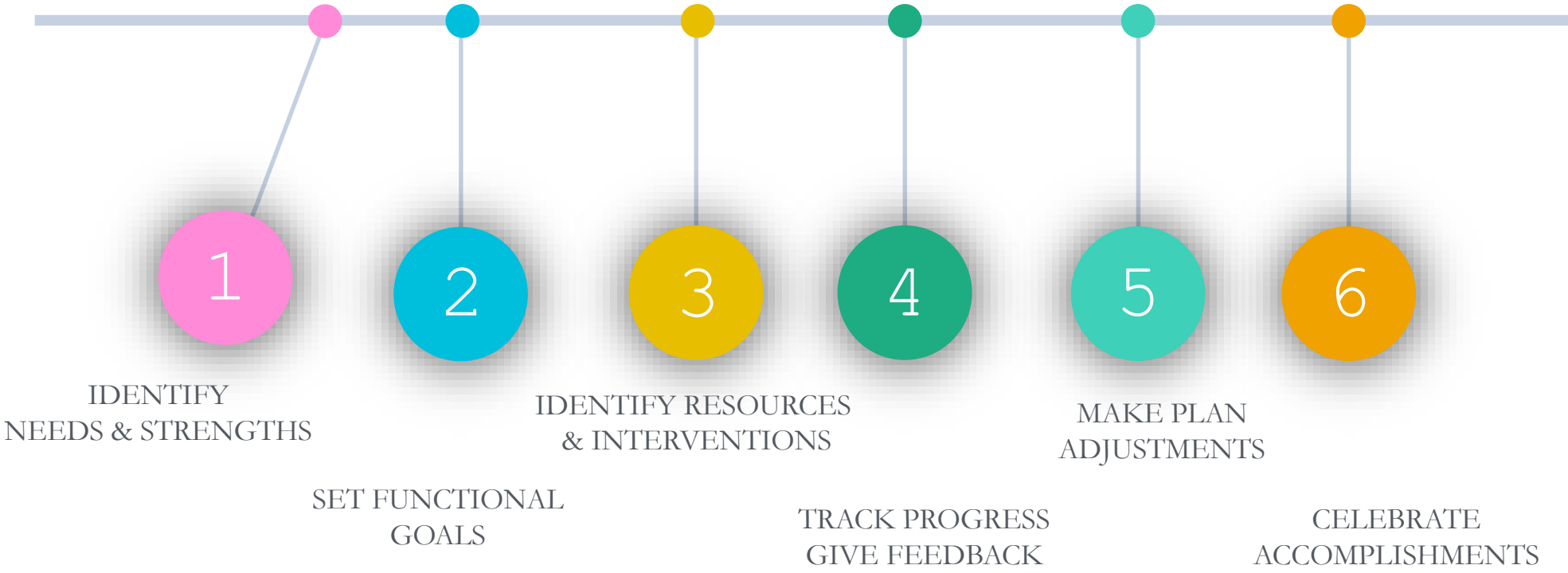
5. Participants will know about the training and coaching resources supplied by the CANS-NY Training & Technical Assistance Institute.

CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

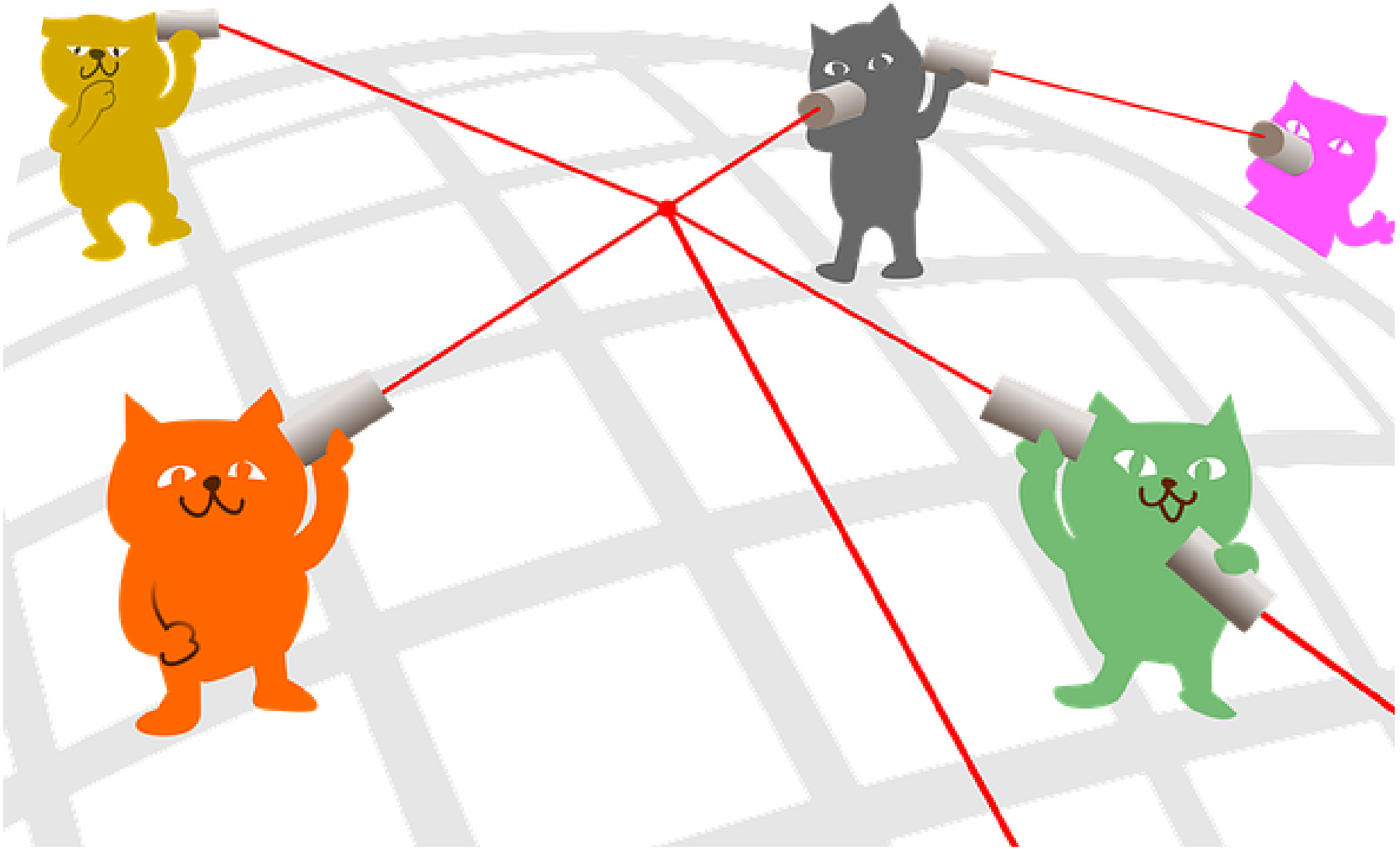
Collaborative Assessment

Engaging Clients and Families As a Foundation for Collaborative Practice

The Collaborative Assessment: Part of a Larger Process



How is the CANS-NY Completed?



Approaches to Collaborative Assessment with the CANS

Approach	Individualistic	Culturally Sensitive	Family & Youth Centered	Efficient
By Item	Extremely	Yes	Yes	Not at all
Flying Solo	Extremely (wrong individual)	Not Likely	Not Likely	Yes
Tabla Rasa	Perhaps	Perhaps	Perhaps	Not Terribly
Prioritizing	Possibly (not always)	Possibly	Possibly	Extremely
Collaborative Scoring	Yes	Yes	Yes	Yes

GOAL: COLLABORATION, COMMUNICATION, TRANSPARENCY AND SHARED VISION

Relevant Item Grid

Useful Strengths	Strengths to Build
Strengths to Use (0's and 1's) • from Strength Domain for child/youth • from the Caregiver Resources & Needs Domain that constitute strengths for Caregiver(s)	Strengths to Build (2's and 3's) from Strength Domain for child/youth
Target Needs – Child/Youth	**Target Needs – Caregiver(s)**
2's and 3's from all Child Domains & Relevant Extension Modules	2's and 3's from Caregiver Resources & Needs Domain

COLLABORATIVE PLANNING

Creating a Roadmap for Change using the CANS

Getting to the How: TCOM Treatment Planning

- Sort actionable items into background needs, treatment targets, and expected functional outcomes,
- Help to focus on high impact needs with a focus on youth and family priorities,
- Work together to understand the complexity of the needs,
- Use identified strengths and build absent strengths.

Translating TCOM Into the Care Plan

Theory of Change	Process	Aspect of Plan	TCOM Framework
Where are we now?	Complete the CANS	• Presenting Issues	• Relevant Needs and Strengths [Prioritized CANS items]
Where do we want to be?	Identify GOALS	• Goal	• Shared Vision • Anticipated Outcomes
How are we going to get there?	Identify OBJECTIVES	• Behaviorally-based Objectives • Action Steps/Strategies to Achieve Objectives	• Target Needs
What do we need to consider?	Identify ISSUES TO CONSIDER for the plan	• Contextual Issues	• Background Needs

TCOM Planning Practice: Julia

Julia is a 15-year-old girl who now lives with her aunt and uncle and her younger sister Sarah. Julia was born in Columbia and moved to New York State five years ago; she is a native Spanish speaker. Julia and her sister were removed from their biological parents' care because of abuse and neglect and were adopted by their maternal aunt and uncle a year later.

Julia's aunt and uncle have a strong marital relationship, own their own home and are very active in their church and community. Julia's aunt has some physical limitations due to a back injury.

Last year, the family moved to a new neighborhood and the girls had to change schools as a result. There are few Latino families living nearby. Julia attends church services regularly with her family. She also has been getting more involved with her relatives in community projects but says that she would like to be more involved in cultural activities in the Latino community.

Julia has had periods of depression for several years and says that she has nightmares and some flashbacks from her childhood. Julia says that she has not felt safe with her previous therapists. Recently, Julia's aunt and uncle brought her to the emergency room because she had threatened to kill herself by slitting her wrists.

Julia can become very agitated, anxious or angry when reminded of her traumatic experiences, and she will not talk about her history with her family. Julia refuses to do any activities that remind her of her biological parents, and sometimes rejects her aunt and uncle's attempts to connect to her.

Julia also can be argumentative, and her caregivers say that she responds to and follows some limits and directives but challenges them or ignores them at other times. Julia has missed her curfew repeatedly over the past few months, and her aunt and uncle report that nothing they say or do seems to make Julia respect their house rules. This month, Julia came home intoxicated twice.

Julia's Aunt says that sometimes her pain makes her grumpier than she should be with Julia, and that both times Julia came home intoxicated she had raised her voice with Julia earlier in the day.

Julia is in good physical health but has severe headaches when she is under stress. She has been having frequent headaches for the past few months but does not want to go to the pediatrics practice in her new neighborhood, because she says she does not want to "tell my whole story over again to a stranger."

Julia's family of origin spoke exclusively in Spanish at home, and she still has some difficulty reading and writing in English. In her old school, she was getting good grades and was a leader in the school with many friends. She is struggling with grades in her new school and says that she has experienced some racial discrimination in the neighborhood and at school. Her new teachers say that she has problems with concentration, frequently spaces out in class, and has difficulty staying organized and submitting completed assignments and projects on time.

Julia generally gets along well with peers and has close friends that she keeps in touch with from her old school. She does not get to see them as much as she would like since she moved. She says she has had difficulty making friends in her new neighborhood and school. She has been spending much of her after-school time with her sister and appears to enjoy this time a great deal. She makes a habit of taking her sister to the park almost every day after school. Other times, Julia spends alone either reading or writing in her journal. Julia is very talented at creative writing and wants to become a writer someday.

Preparing for the Meeting: Identify Relevant Strengths and Needs

Create a summary of the relevant needs and strengths:

- List the caregiver's strengths (from those items that could be considered strengths or resources for the individual).
- List the caregivers' needs.
- List the client’s strengths.
- List the client’s needs.

Useful Strengths – Individual/Caregivers	Strengths To Build – Individual
Strengths to Use (0's and 1's) from Strength Domain for child/youth Caregiver Needs and Strengths Domain that constitute strengths (0's and 1's) for caregivers	Strengths to Build (2's and 3's) from Strength Domain
Actionable Needs – Individual	**Actionable Needs - Caregivers**
2's and 3's from: Behavioral/Emotional Needs, Life Functioning, Risk Behaviors, Cultural Factors	2's and 3's from Caregiver Resources and Needs Domain

Useful Strengths – Julia, Aunt & Uncle	Strengths To Build - Julia
Optimism (1) Resourcefulness (1) Persistence (1) Talents/Interests (1) Spiritual/Religious (1) CG Partner Relationship (0) CG Informal Supports (1) Care & Treatment Involvement (0)	Family of Origin (2) Social Relationships with Peers (2) Adaptability (2) Cultural Identity (2) Resilience/Internal Strengths (3)
Actionable Needs – Julia	**Actionable Needs – Aunt & Uncle**
Acculturation/Language (2) School Achievement (2) Suicide Risk (2) ACES/Trauma Symptoms (2) Behavioral Health (2) Substance Use (2) Medical (2)	CG Physical Health (2) CG Supervision (2) CG Knowledge of Condition (2)

Developing a Shared Vision

When working on developing the Shared Vision Statement with the youth and family, it is helpful to try to answer one of both of the following questions:

- Where do we see ourselves when our work is completed? What will we have achieved?
- What will change look like in the youth or family given the context of our relationship and the work that we do?

Step 2B: Shared Vision

"Julia is struggling with a language barrier at school, despite her previous strong achievement at a bilingual school. She does not have the same strong relationships with peers that she had in her old neighborhood. At home, she is acting out with her aunt and uncle and they are challenged by the ways her trauma history impacts her behavior, her relationship with them, as well as her physical health. We need to find ways to help Julia succeed at school, connect with supportive peers, and continue to deepen her connection to her aunt and uncle."

Useful Strengths – Child/Youth and Caregivers	Strengths To Build – Child/Youth
Strengths to Use (0's and 1's) from Strength Domain for child/youth Caregiver Needs and Strengths Domain that constitute strengths (0's and 1's) for caregivers	Strengths to Build (2's and 3's) from Strength Domain
Actionable Needs – Child/Youth	**Actionable Needs - Caregivers**
2's and 3's from: Behavioral/Emotional Needs, Life Functioning, Risk Behaviors, Cultural Factors	2's and 3's from Caregiver Resources and Needs Domain

With the Client/Team: Sorting and Linking

Prioritize and link the items in order to help us focus and develop a Theory of Change. The theory of change should closely match the team's shared understanding of the worries and goals.

ACTIONABLE NEEDS		
Background/Context Needs	**Target Needs**	**Goals/Anticipated Outcomes**
Static needs – things that cannot change • Identified needs that inform our focus and choice of services and supports. • Background needs may require attention in order to prevent other needs from occurring.	**Causes** • Effective services/supports around these needs will likely result in direct change of the need. • Changes in these needs also likely to change Goals/Anticipated Outcomes. • Plan objectives will directly target these needs. • Can include strengths to build.	**Effects** • Needs expected to shift as a result of effectively addressing the target needs.
Needs we cannot change	**Needs we can change**	**Needs that shift as the effect of change**

Step 3: The Why — Understanding Needs

Background Needs/Strengths	Target/Prioritized Needs	Goals/Anticipated Outcomes
• ACES • CG Physical Health	• Acculturation/Language • Behavioral Health • Trauma Symptoms • CG Knowledge of Condition • CG Supervision • Medical Health	• School Achievement • Social Relationships with Peers • Adaptability • Suicide Risk • Cultural Identity • Substance Use
Needs we **cannot** change	Needs we **can** change	Needs that shift as the **effect** of change

Centerpiece Strengths	Useful Strengths	Strengths to Build
• A well developed strength; may be used as a protective factor. • Can be linked to a target need to facilitate change. • Includes Safety/Acts of Protection by a parent.	• Strength that is evident, but requires effort to maximize it. • Can be linked to a target need to facilitate change. • Includes parents' Supporting Strengths that do not meet the level of Safety.	• Strengths that require building efforts before they can be useful for the individual. • May be something important to build and by doing so, support change on a target need.
When linked to need, strength effects change	**When linked to need, strength effects change**	**If built, strength can support change**

Step 3: The Why — Understanding Strengths

Centerpiece Strengths	Useful Strengths	Strengths to Build
• CG Partner Relationship (0) • Care & Treatment Involvement (0)	Optimism (1) Resourcefulness (1) Persistence (1) Talents/Interests (1) Spiritual/Religious (1) CG Informal Supports (1)	Social Relationships with Peers (2) Adaptability (2) Cultural Identity (2)
When linked to need, strength effects change	When linked to need, strength effects change	If built, strength can support change

With the Client/Team: Clustering Needs towards Creating a Plan

- Identify the goal: What change will happen to the child/youth and family?
- Identify the needs that are getting in the way of the goal (target needs)?
- Identify the background needs, including trauma history. Link associated background needs to priority needs/service objectives and activities.

With the Client/Team: Clustering Needs towards Creating a Plan

- **Choose activities, services and supports to address the target needs:** What will improve as a result of your intervention? Identify those anticipated outcomes?
- **Cross-check your activities, services and supports with useful strengths:** What activities can bring out the strengths?
- **Cross-check with absent strengths:** How must those be factored in? How will their absence impair success toward the need? What activities could develop these strengths?

Background Needs	Target/Priority Needs	Activities/Interventions	Anticipated Outcomes
• ACES • CG Physical Health	• Acculturation/Language		• School Achievement • Social Rel. with Peers (Str) • Cultural Identity (Str) • Resilience/Internal Strengths (Str)
	• Behavioral Health • Trauma Symptoms (spell out)		• Adaptability (Str) • Suicide Risk • Substance Use
	• CG Supervision • CG Knowledge of Condition		• Family of Origin (Str) • Resilience/Internal Strengths (Str)

Useful Strengths	Actions or Behaviors	Strengths to Build	Actions or Behaviors
• Optimism (1) • Resourcefulness (1) • Persistence (1) • Talents/Interests (1) • Spiritual/Religious (1) • CG Partner Relationship (0) • CG Informal Supports (1) • Care & Tx Involvement (0)		• Social Rel. with Peers (2) • Cultural Identity (2) • Resilience/Internal Strengths (Str)	• See Anticipated Outcomes (above)
		• Adaptability (2)	• See Anticipated Outcomes (above)
		• Family of Origin (2)	• See Anticipated Outcomes (above)

Planning Around Needs

- For both Actionable Needs (ratings of 2) and Needs Requiring Immediate Intensive Action (rating of 3) the process is the same.
- When planning around needs simply…
  - Focus on the treatment target
  - Define an intervention, activity, of series of action steps that address the treatment target
  - Articulate the targets you expect to hit or the change you expect to see (measurable and achievable).

Planning Around Strengths

- For both Useful Strengths and Strengths to Build the process is the same. When planning around strengths simply…
  - identify the strength that is useful or that you would like to build
  - define the presumed benefit of the using or developing the strength
  - articulate the steps related to using or developing the strength

Shared Vision as Targeted Goals

- Connect Julia with language supports at school and support academic achievement.
- Connect Julia and her parents to a new pediatrician and a new, trauma-focused therapist to support Julia's success in relationships at home, at school, and in the community.
- Support Julia's attendance at medical and behavioral health appointments; empower Julia to advocate at these meetings so that she will build connections with trusted medical and behavioral health treatment providers.
- Request a focus on emotional coping, trauma recovery, wellness self-management and mindfulness in behavioral health services.

Monitoring Progress

Attending to Change and Optimizing Success

Attending to Progress

Assess

- Collaboratively define needs and strengths.
- Identify key areas in need of change.

Plan

- Develop a plan that incorporates all views.
- Implement plan that all understand and agree to.
- Determine interventions and supports.

Monitor

- Attend to changes in action levels for needs and strengths.

Optimize

- Change plan in the absence of progress and changes in status.

Celebrate

- Punctuate—and celebrate successes at all levels.

Re-Assessment

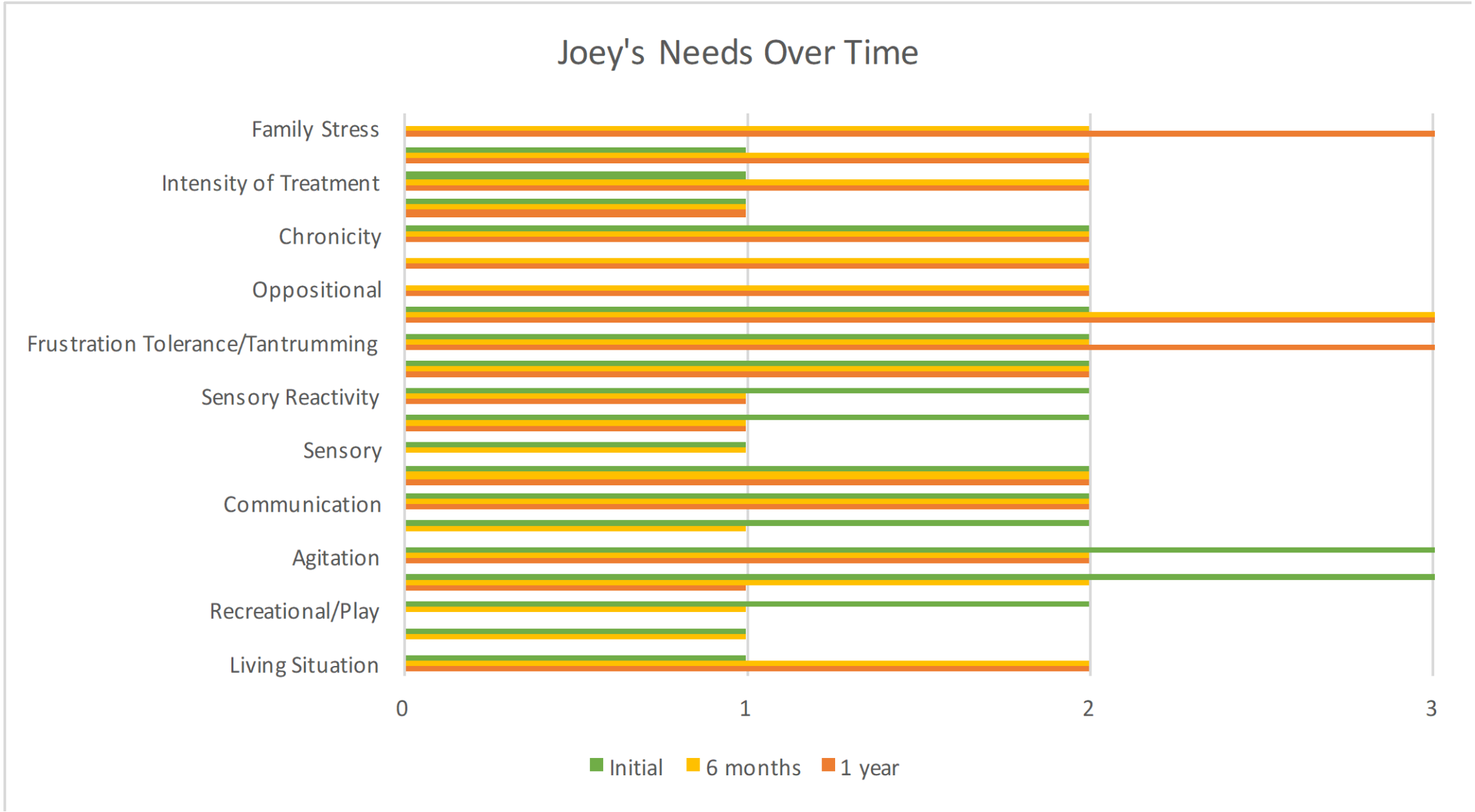
- How is the re-assessment different from the initial?
  - Team members
  - Level of involvement
  - Time frame
  - Action Plan
- How do we use reassessment to monitor progress?
  - Identify movement in the action levels
  - Identify any changes that have occurred since your last assessment

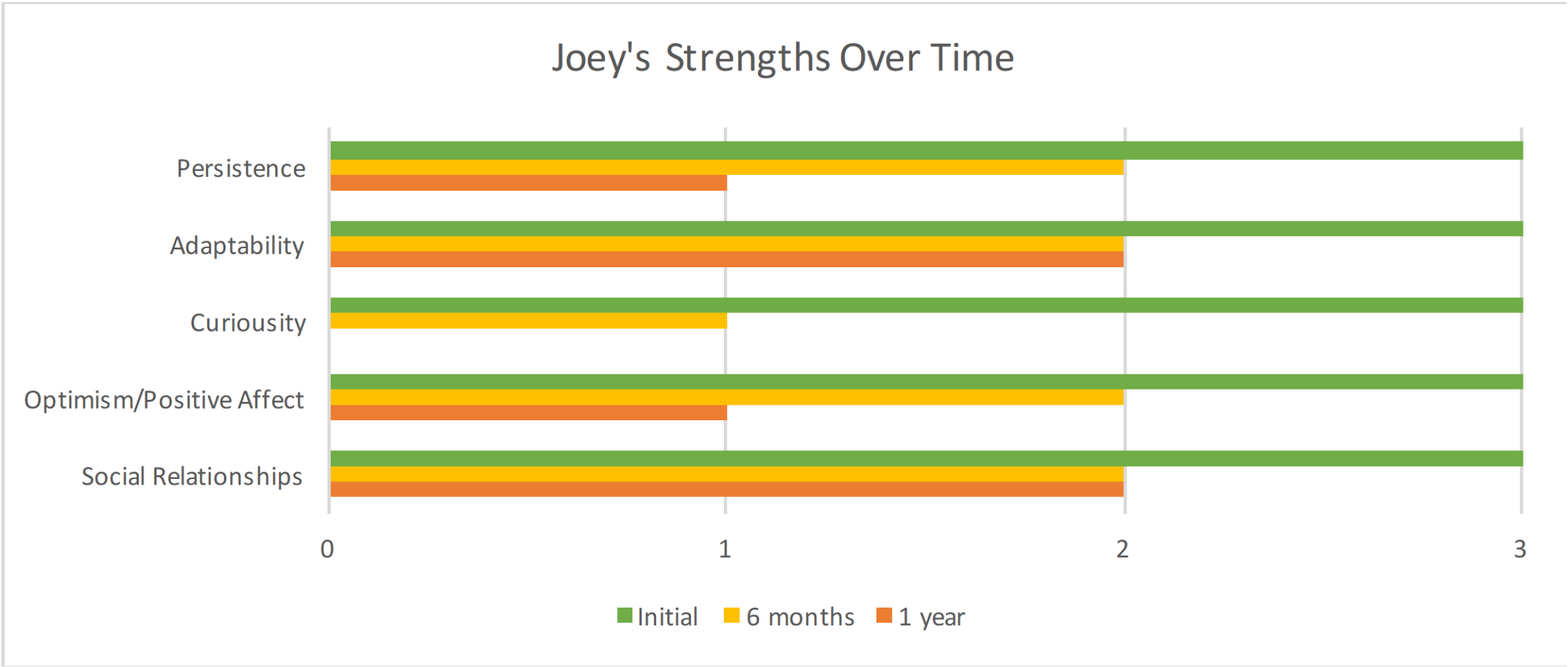
Example: Joey

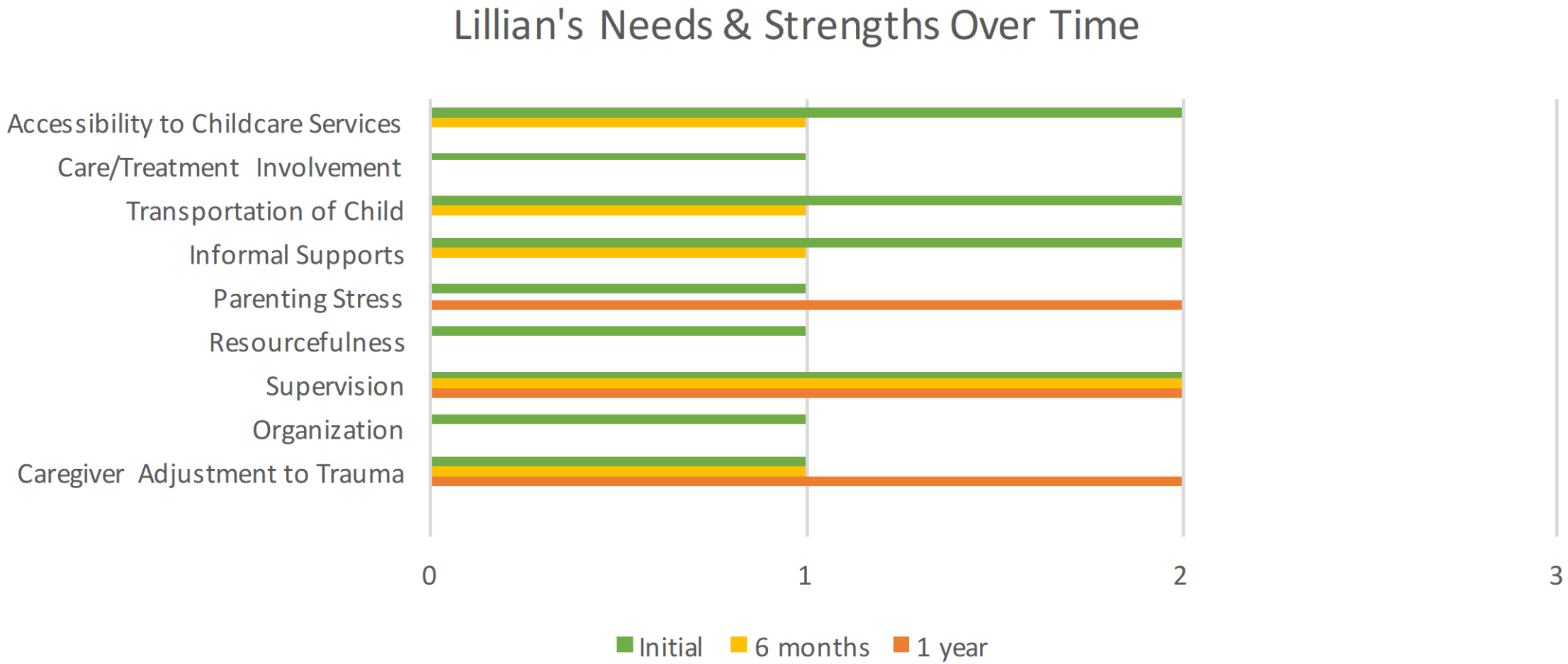
Joey is almost three. He lives with his mother, Lillian, and is involved with Early Intervention Services. Joey has a severe seizure disorder that has led to multiple ER visits and a few hospitalizations. He also is impulsive and has a history of severe tantrums. In his initial Plan of Care, referrals included occupational, speech, and physical therapy evaluations and supports for Lillian around transportation, responding to Joey's tantrums and sensitivity at mealtime, and expanded respite resources. Lillian and Joey's paternal grandparents were referred for family therapy because of a history of conflict. Finally, supports for better integration and communication among Joey's medical providers were implemented by the Care Manager.

Example: Joey (Monitoring Progress)

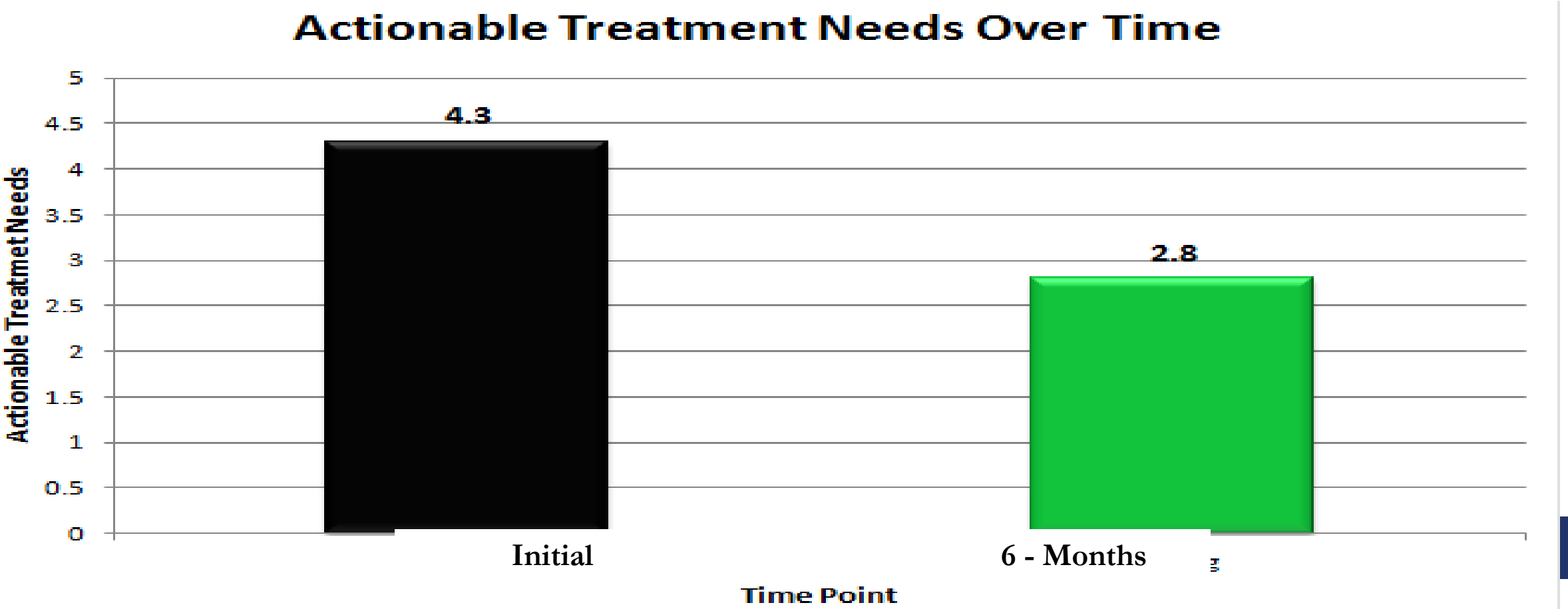
As a result of the Plan of Care, Joey's grandparents become reconnected to Joey and begin to provide support to Lillian. She has more respite, and Joey participates in more regular recreation activities with other children. Joey's seizures continue to be severe, and Joey is hospitalized twice for stop-breathing incidents secondary to prolonged seizures. A parent peer and an OT work together with Lillian at mealtimes and eating improves. However, Joey's tantrums in other areas become more severe and frequent, and Lillian says she has difficulty setting effective limits with him.


Joey's Needs Over Time
Family Stress
Intensity of Treatment
Chronicity
Oppositional
Frustration Tolerance/Tantrumming
Sensory Reactivity
Sensory
Communication
Agitation
Recreational/Play
Living Situation
0
1
2
3
Initial
6 months
1 year

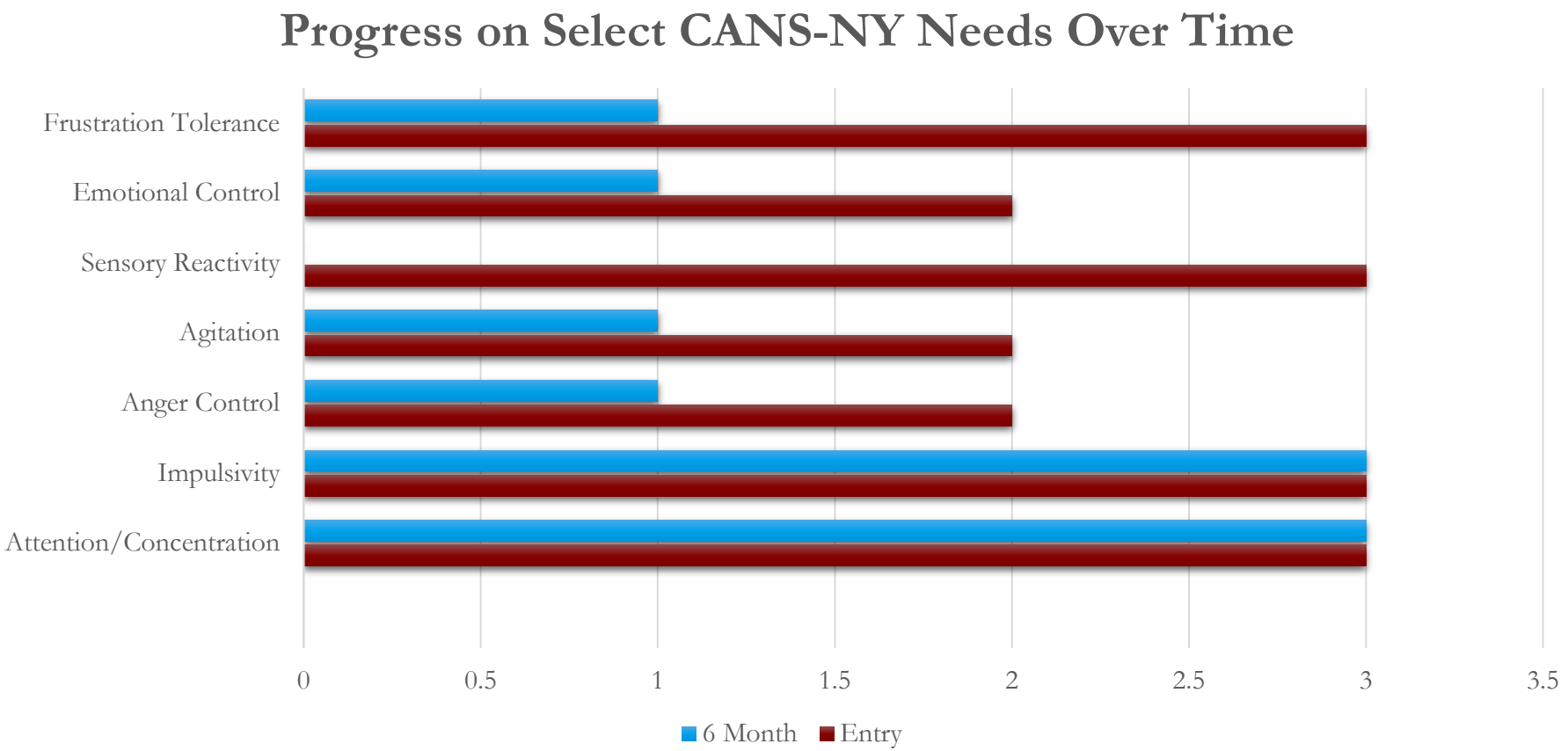

Joey's Strengths Over Time
Persistence
Adaptability
Curiousity
Optimism/Positive Affect
Social Relationships
0
1
2
3
Initial
6 months
1 year


Lillian's Needs & Strengths Over Time
Accessibility to Childcare Services
Care/Treatment Involvement
Transportation of Child
Informal Supports
Parenting Stress
Resourcefulness
Supervision
Organization
Caregiver Adjustment to Trauma
0
1
2
3
Initial
6 months
1 year

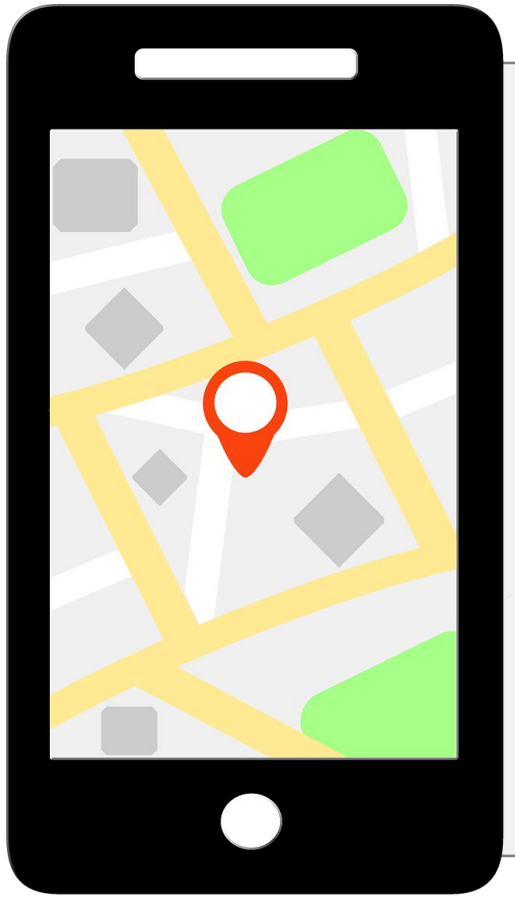
Service Effectiveness: *Quality Review*



Service Effectiveness: *Targeting Evaluation of Quality*



Supervision GPS … Support from the CANS-NY Institute



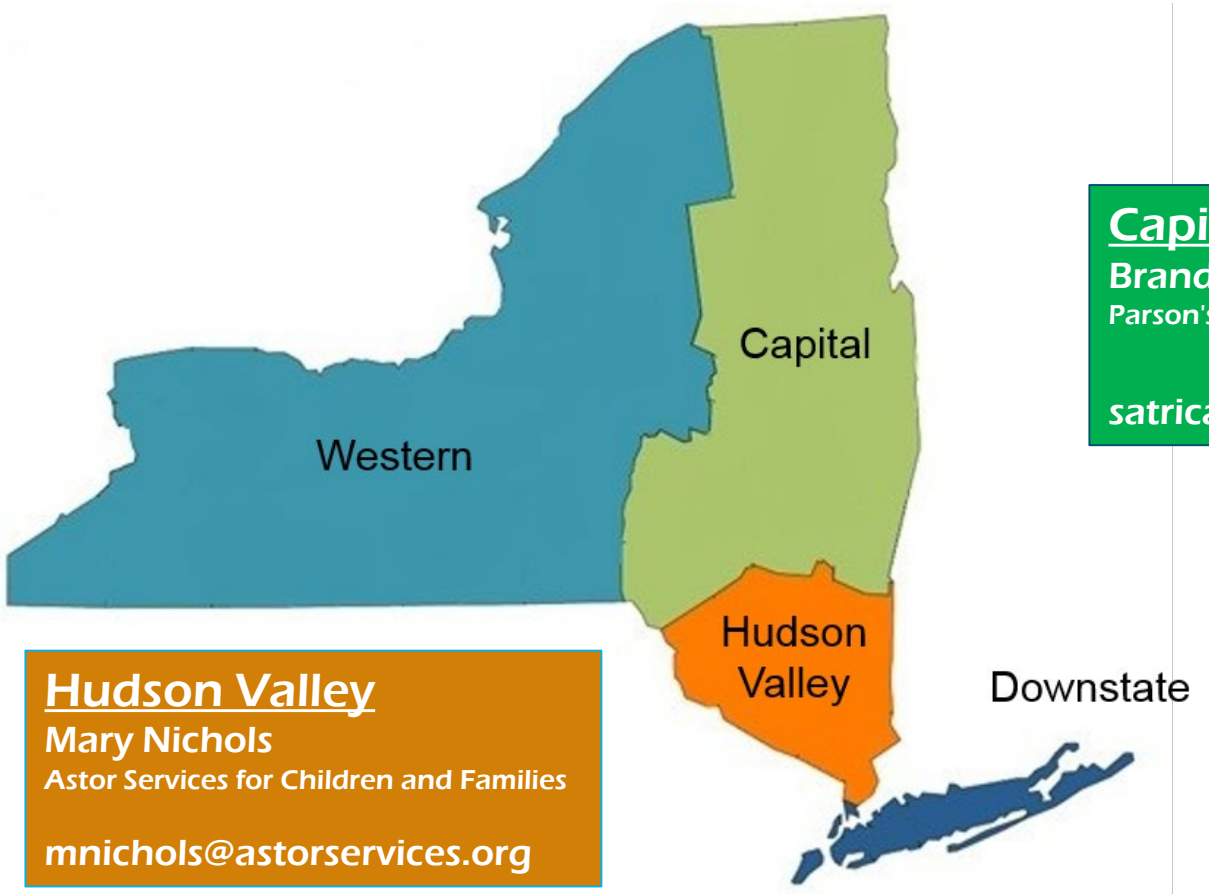
Support

- Dr. Button, CANS-NY Leads, and Regional Coaches can provide support to you and to your Care Managers.
- Ongoing learning and teaching resources are being added to the Institute website (www.cansnyinstitute.org), and to the tcomtraining.com New York course bundle.

CANS-NY Institute

A TCOM Learning Collaborative

cansnyinstitute.org



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ANY
QUESTIONS
?

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