Coordination of Care Quick Guide – CANS & PSC-35

Coordination of Care is an important facet of our work. DHCS mandated the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC-35) in October 2018 to emphasize the importance of this coordination.

This guide exists to help programs make **decisions on cases** where Coordination of Care is in play, and to facilitate **good data entry practices** for the CANS and PSC-35.

1. **Coordination of Care** is defined as "the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services."
    a. Many of our clients are not only served by two or more programs within Behavioral Health, but also by **two or more systems**, such as Child Welfare, Probation, or even systems in other Counties and States
    b. Coordination of Care helps meet our client's needs no matter where they receive care

2. First, Coordination of Care **between** Behavioral Health programs here in Orange County
    a. **Questions 9 and 10** in the CYBH CANS/PSC-35 FAQ address the use of coordination of care and identify the **Primary Therapist** as the clinic and clinician responsible for completing the CANS/PSC-35
        i. How do you determine who the Primary Therapist is? There is no blanket rule, however; if a client is between two programs, the program who is providing therapeutic interventions rather than just case management is likely primary and thus responsible for completing the CANS and PSC-35
    b. If you are not sure whether you should be completing the CANS/PSC-35, ask your supervisor or reach out to AQIS!
    c. The fastest way to determine whether you should complete CANS/PSC-35 is by **looking in the client's chart in IRIS**. You have the ability to see any CANS/PSC-35 forms entered into IRIS from any County or Contracted Behavioral Health provider
        i. See the CYBH CANS/PSC-35 FAQ, question 24, for details on how to do so

3. Next, Coordination of Care **within** Behavioral Health programs
    a. There are times when assessment forms are completed by intake or interim clinicians, and then the case is handed off to a primary therapist
    b. In these instances, it is important to have a solid plan as who is responsible for completing CANS, PSC-35, and other intake and assessment-related documentation
    c. Clients are sometimes transferred within programs to new clinicians
        i. **Coordination of care between programs is important, and coordination within programs is just as important, if not more so!**
    d. This coordination exists between Clinical staff, and also between clinical and Front Office/Data Entry staff
        i. Some of the errors we have seen point to problems in this area as multiple CANS and PSC-35 forms are entered as duplicates (or even triplicate!)

ii. **Clinical staff should work with Front Office/Data Entry staff to learn what the CANS/PSC-35 status of a case is before administering them**
    1. County clinical staff can check IRIS themselves
    2. Contracted clinical staff can work with their front office staff to check the chart in IRIS before proceeding

4. Lastly, Coordination of Care with the **Social Services Agency (SSA)**
    a. We often receive referrals from SSA for a Mental Health Assessment on their clients
        i. Coordination with SSA has been limited given their rollout of CANS
        ii. Now that SSA is using CANS in their programs, we may see more referrals!
    b. Coordinating CANS scores with SSA during the Assessment process is important
        i. A draft CANS should be completed prior to the Child Family Team Meeting (CFTM) with client, family, and SSA
        ii. CANS scores should be agreed upon between client, SSA, and Behavioral Health, and then entered into IRIS
            1. SSA will enter their CANS into their system as well

5. How can we plan for Coordination of Care?
    a. You can reference **Questions 9 and 10** in the CANS/PSC-35 FAQ for examples on how to make decisions in those instances
    b. The **Primary Therapist** in charge of clinical work on a case is responsible for completing CANS and PSC-35
    c. Think of your usual referral sources and partners, and come up with plans to coordinate in the event you are sharing a case and/or receive a referral
        i. You may need to think outside the box at times, as no directive can be given that encompasses all situations

6. Use IRIS reports to determine a client's Episode of Care (EOC) history
    a. **BHS EOC Summary Report**: Main Menu → BHS & CMH Program Reports → Caseload and Open EOC Reports
    b. **Client History by MRN**: Main Menu → BHS & CMH Program Reports

7. Instances of clients dropping out of services and reappearing at the same or other programs occur
    a. In these cases, do your best to track the client's path through our system and complete CANS & PSC-35 as timely as you can (if applicable)

8. IRIS Reports to help track CANS and PSC-35, and to correct errors, are in development

Questions, comments, concerns? Contact Andrew Parker at 714-834-3172, or e-mail at AParker@ochca.com. You can also contact AQIS at 714-834-5601.

Version 1, 10/06/2021