

Outcomes Tool Selection  
Committee Meeting  
June 24, 2015

**In Attendance:**

Committee Members: Jason Turner, Dr. Roland Irwin, Dr. Peter Jensen, Kim Dean (Dixie Wallace), Angela Lassiter, Bob Darling, Trish Gann, Derek Spiegel, Noelle Stimach, and Dr. Keith Noble

DBHS Staff: Julie Meyer, Robert Nix, Paula Stone, and Dr. Elizabeth Childers

Public: Tracy Taylor, Jennifer Embry, Joel Landreneau, Charlotte Carlson, Cyndi Coleman, Debbie Roberson, Roselle Robinson, Serhan Al-Serhan, Alan Kaufman, Lisa Lucero, Dan Sullivan, Kendall Kamp, Melissa Ortega, Kerri Brazzel, Nicole May, Karen Denton, Sufna John, Shari Willding, Jo Thompson, Donna Reed, Gary Harris, and Clayton Mitchell

Committee Chair, Jason Turner called the meeting to order on June 24, 2015 at 1:00 p.m.

**1. Representative Dan Sullivan**

Chair recognized Rep. Dan Sullivan who explained the purpose of Bill HB1072, now Act 161 and emphasized the need to focus on cost to the state and providers. He also emphasized the need to focus on how the data is utilized.

**2. Review and Approval of Minutes from June 10, 2015**

- Dr. Noble suggested that “Functional Outcomes” be added to the list of tools discussed at the meeting.
- Dr. Jensen requested “Family Completed/Involved”
- Minutes were approved with changes by the committee.

**3. Top Considerations for Outcomes Instrument:**

Division of Behavioral Health Services (DBHS) staff presented a list of Top Considerations for tool selection based on previous discussion. The committee requested the following changes to the list of considerations:

- Item six and seven of the top considerations for the outcomes instrument were combined.
- Item eight was changed to clinician and family collaborate during the process
- Assist in determining level of care of clients was added to the list.
- Compliance with State and Federal law was removed from the list.

The committee finalized and voted on the following list of Top Considerations in the selection of the Outcomes instrument:

1. Shorter Length of Tool
2. Reduced Frequency of Administration
3. Valid/Reliable
4. Strengths-Based
5. Family and Youth Centered
6. Results Drive Treatment/Assists in Treatment Plan
7. Clinician and families collaborate in process

8. Cost of Implementation/Overall Budget
9. Customizable
10. Inputable to common data platform
11. Results can be inputted to EHR/EMR
12. Capacity to Sort/Query Data
13. Recognition of Specialty Populations
14. Assists in determining level of care of client
15. Consistent with CMS/SAMHSA metrics

#### 4. Overview of Selected Outcomes Instrument

Robbie Nix, MPA led the discussion of the Selected Outcomes Instruments

##### CANS

Representative for DCFS, Jo Thompson provided a brief update as to how they implemented the CANS statewide in February 2015. DCFS has used this tool and it is specified for Arkansas DCFS clients. One of the advantages of the CANS is that it is very specific to the population that you want to provide results for.

- Purpose of the CANS:
  - Support care planning and level of care decision-making
  - Facilitate Quality Improvement Initiatives
  - Allow for monitoring of outcomes of services
- How Outcomes are Monitored:
  - Scale for the different domains, two or three is high, zero to one is low. They are monitored over time to determine the percent of individuals who move from the high to the low level, which indicates that a need was resolved and strength was built for that client.
  - Within each dimension is how you can get scores generated to see if you are making progress
  - In order to utilize the CANS with the client, the provider must be CANS certified, which requires the completion of an in-person or online course.
  - It is an open domain tool that is free for anyone to use.
  - The tool can be used for individual's ages of 0-20 and there are different versions depending on the age level of the client.
  - Dr. Noble asked, "How long would it take to administer the CANS?" Jo Thompson, representative for DCFS, stated that it initially takes one to two hours, because it is a communications tools. The time varies, because you have to collect information, you can't sit down and answer every question when first meeting a child. As you build a relationship with the client, you can use the tools during treatment
  - CANS is completed by the behavioral health provider
  - High ratings on the initial and/or on going assessment would indicate items that should be considered high priority for treatment planning
  - It can track youths strengths and needs overtime
  - CANS has demonstrated reliability and validity

##### CAFAS

- Assess the degree of impairment in youth with emotional, behavioral, psychiatric, or substance use problems.
- It provides an objective and comprehensive assessment of a youths' needs that is sensitive to change over time

- Using information collected during the clinical interview, the practitioner selects problematic behaviors, strengths and goals for eight life domains:
  1. At School
  2. At Home
  3. In the Community
  4. Behavior towards others
  5. Moods/Emotions
  6. Self-Harm
  7. Substance Use
  8. Thinking
  
- For each subscale, which are the life domains the rater would read through each item and they have different types of scoring starting with the most severe and they find the descriptor that the client is showing during the interview
- Total and subscale score are generated, with the higher score indicating greater the impairment in the day-to-day functioning in life. Over time, lower scores and subscale scores indicate improvement.
- Shown to be an indicator of youth's functional impairment in a wide variety of service settings. It is not specific to a certain setting
- Online training to administer the CAFAS is free
- CAFAS is a web-based platform software system. Each facility must pay a fixed yearly maintenance fee for web access and for each assessment completed.
- Can be used for individuals between the ages of 3-19 with differing versions.
- It is a clinician reported instrument. It can be based on information gathered by someone who is knowledgeable of the youth's behavior or from direct observation during the interview
- Website states that it typically takes a trained rater about 10 minutes to complete
- It has shown current and predictive validity

The next meeting will be held on July 8, 2015 at 1:00 p.m. in the large conference room at the Arkansas State Hospital