

# Service Planning

Presented by  
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DHS Common Assessment Team

# Agenda



- Review of CANS/ANSA ratings
- Reading and Accessing CANS/ANSA reports
- Writing a service plan
- Service Planning Challenges
- Activity
- A Note About the SPANS

# Let's Start at the Beginning.....

## CANS/ANSA

Quality CANS/ANSA = Quality Plan....

Quality Plan = Quality Services/Supports....

Quality Services/Supports = Quality Outcomes

## Rating Scale - Needs

Score	Level of Need	Appropriate Action
<b>0</b>	No evidence of need	No action needed
<b>1</b>	Significant history or possible need which is not interfering with functioning	Watchful waiting/ Prevention/ Additional assessment
<b>2</b>	Need interferes with functioning	Action/ Intervention
<b>3</b>	Need is dangerous or disabling	Immediate/ Intensive Action

## Rating Scale - Strengths

Score	Level of Strength	Appropriate Action
<b>0</b>	Centerpiece Strength	Central to Planning
<b>1</b>	Strength Present	Useful in Planning
<b>2</b>	Identified Strength	Must be Built/Developed
<b>3</b>	No Strength Identified	Strength Creation or Identification may be Indicated

# Rating Scale – Trauma Experiences

<b>Score</b>	<b>Severity of Experience</b> (Rated over a Lifetime)
<b>0</b>	No evidence of any trauma of this type.
<b>1</b>	A single incident of this type of trauma occurred or suspicion exists that this type of trauma occurred.
<b>2</b>	The individual experienced multiple incidents or a moderate degree of this type of trauma.
<b>3</b>	The individual experienced repeated and severe incidents of this type of trauma with medical/physical consequences.

## Think of the CANS/ANSA as your GPS....

- The CANS/ANSA is a starting point in helping an individual plan where they want to go
- A “map” is laid out once the assessment is completed
- An individual’s strengths and needs outline specific routes to meet their goals



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## Two Types of Reports

- Preview Report – a pdf report that includes everything documented in the assessment
- Summary Detail Report – a pdf report that documents the identified strengths and needs



# Summary Detail Reports Include

- Individual demographic information
- The threshold score (0, 1, or 2) and justification
- Decision model questions and answers
- Strength Items rated as a 0 or 1 including justifications
  - Items that may be helpful in addressing needs
- Need Items rated a 2 or 3 including justifications
  - Actionable items identified as important or critical and should be addressed

# Summary Detail Reports Include

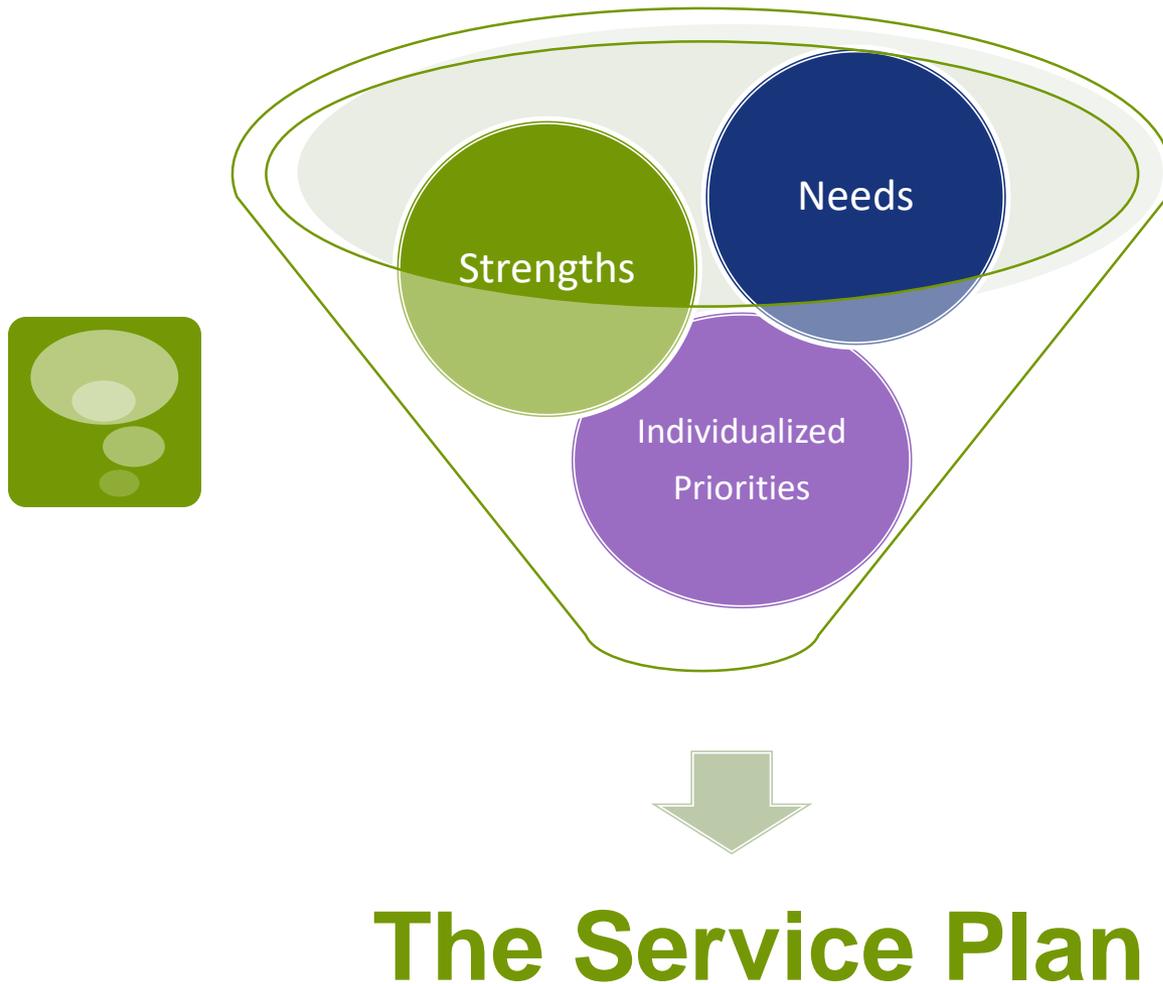
- **Trauma Experiences rated a 2 or 3 including justification**
  - Static indicators of Trauma History that should be considered in decision making
- **Critical Narrative Sections**
  - My Life...My Story, Natural Supports, Documented Information, and Assessor's Observations/Knowledge/Notes
- **Signature Page**

# Accessing reports:



- To access reports, user must have an open provider involvement with the consumer.
- The preview report tab is at the bottom of the screen.
- The summary detail report can be found by clicking on the reports tab near the top of the screen
- Note: if the assessment is complete, the report will be the final report. If the assessment is active, it means that it has not yet been approved and will have a draft watermark on it

# The CANS/ANSA Summary Detail Report Leads to.....



# What is a Service Plan?



A Service Plan is a “living, breathing” document that reflects **strengths and needs** as well as describes the **plan to coordinate services and supports** for individuals and families in a clear and comprehensive manner.

## When should a Service Plan be completed?



A Service Plan should be completed within **30 days** of opening an individual for service coordination services and then at least every **6 months** thereafter. The CANS/ANSA should be completed prior to inform the service plan.

## Elements of the Service Plan



- Target Domain/Area of Focus
- Current Situation/Recommendations
- Goal/Objective
- Action Steps/Interventions/Methods
- Person Responsible
- Target Date/Estimated Date of Completion
- Progress
- Signatures

## Elements of the Service plan continued:



- **Target Domain/Focus** area is what the goal pertains to; it could be the same as one of the CANS/ANSA domains or items
- **Current Situation/Recommendations** is where the individual is at right now and may highlight some strengths and may include current services/supports
- **Goal/Objective/Vision** refers to the long term outcome that the individual/family wants to achieve
- **Action steps/Interventions/Methods** refers to the short term goals/objectives that break down the long term goal/objective into smaller steps
- **Person responsible** refers to the actual name/role of person in charge of each action step (includes SC's involvement in process)

## Elements of the Service plan continued:



- **Target Date** refers to the estimated date of completion for each action step. This should be an actual date: (i.e.06/15/2014)
- **Progress** should be included during each update to the service plan. Action steps that are completed should be noted as such as well as those continued, modified and discontinued.
- **Signatures** are required to show the agreement of the plan between the consumer, family (if applicable), team members, SC and SC supervisor. Dates of signatures should also be included.

# Writing a Service Plan:

- Review the CANS/ANSA and/or summary detail report to identify the centerpiece strengths and priority needs
- Prioritize the needs
- Establish a goal(s) for the identified needs
- Use the individual/family's strengths to meet some of the identified needs (include natural supports and resources)
- List action steps for each goal including who is responsible and the anticipated date for completion



**Note: The ENTIRE service planning process should be completed with the Individual and anyone they wish to include.**

# Writing S. M. A. R. T. goals/action steps:



- Specific
- Measurable
- Attainable
- Realistic
- Time Specific

# Non-negotiables:



- Including a goal regarding mental health/behavioral health
- Including a goal pertaining to physical health/wellness
- Discharge/Transition planning goal or discussion
- All goals should be based on recovery oriented principles

# Recovery oriented service planning principles:



- Self-driven
- Individualized
- Voice and Choice
- Respect/honesty
- Strengths-based
- Includes natural supports
- Holistic
- Person friendly language

# Service Planning vs. Treatment Planning



Service planning is coordinating and linking an individual/family to supports and services to meet their needs

Treatment planning is the specific behavioral interventions utilized to meet their needs

# Service Planning Challenges:



- Multiple Needs/Competing Priorities
- Caregiver/Co-participant Needs
- Strengths-Based Planning
- Specific Interventions/Action Steps

# Multiple Needs/Competing Priorities:

Multiple needs can be addressed in one goal/objective through the specific action steps (Cross-cutting goals)

Examples:



A mental health goal might also address: family functioning, social functioning, and behavioral/emotional needs items.

A vocational goal might also address: financial stability and residential stability.

A goal to address substance use might also address: school/vocational, legal, family functioning, and sleep.

A goal to address sleep might also address: school/vocational, social functioning, and family functioning.

## Caregiver/Co-participant Needs:



Does the caregiver or co-participant have needs that are impacting the individual?

Try to incorporate the caregiver or co-participant's needs into an action step in one of the individual's goals.

## Strengths Based Planning:



Looking at the identified strengths of the individual and turning them into functional strengths that can be included into one or more action step(s) to meet a need.

What do we mean about functional strengths?

## Utilizing functional strengths to address needs:



### Inventory

- Non-specific or value statements that do not speak to the skill, ability or resources of the individual
- Examples:
  - “Her family loves her.”
  - “He goes to church.”

### Functional

- Is a specific skill, ability, resource, talent or support that a person can use to meet a need
- Examples?

# Writing Specific Interventions/Action Steps:

Look at the individual/family's goal/objective/vision

Ask the individual/family what needs to happen for that objective to be achieved



Assist the individual/family in breaking it down into manageable parts

Who will be responsible for each part?

How will you know when it is accomplished?

How soon can that part be accomplished?

Remember individualized, not cookie cutter

**Assessment Domain:** Behavioral Health

**Plan Date:** 3/1/2015

**Consumer Comment/Goal:** “I want to stop having anxiety and feeling depressed so that I can sleep better and work on my relationship with my husband.”

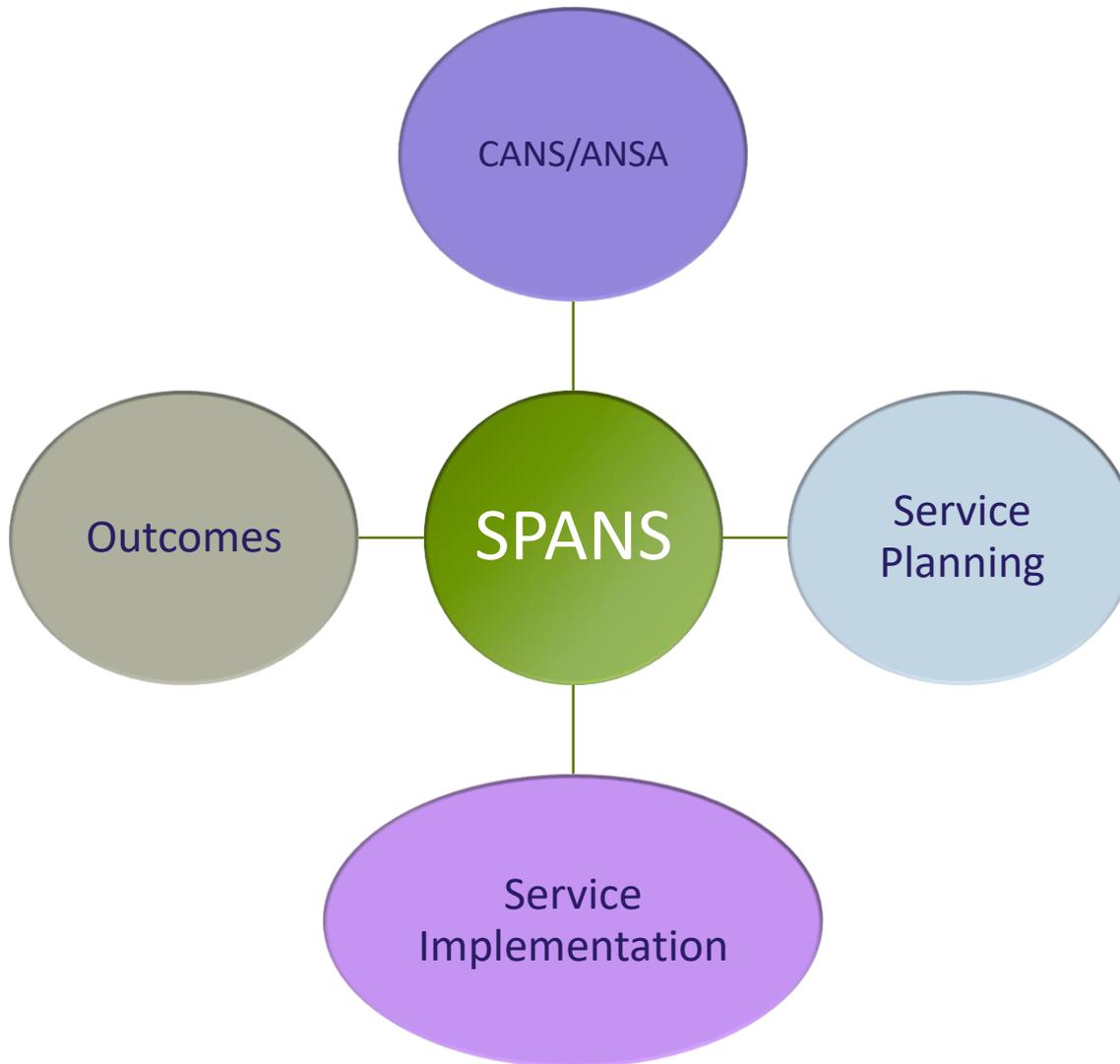
<b>Action Steps</b>	<b>Responsible Person</b>	<b>Target Date</b>
SC will educate Julie on Mental health agencies that provide individual and couples therapy.	Service Coordinator	3/15/2015
SC will refer Julie for an initial evaluation.	Service Coordinator	3/15/2015
SC will educate and assist Julie in obtaining a mental health advance directives.	Service Coordinator	3/30/2015
SC will assist Julie in developing a crisis plan and provide 24 hour crisis support if needed.	Service Coordinator	3/15/2015
Julie will work with therapist to reduce her anxiety and depression.	Julie, Therapist	9/1/2015
Julie and her husband will participate in couple’s therapy to improve their relationship.	Julie, Husband, Therapist	9/1/2015
Julie will use prayer to assist her in reducing her anxiety and depression.	Julie	9/1/2015
Julie will access her church supports and friends in the community to engage her in activities when she is anxious or feeling down.	Julie	9/1/2015
SC will make additional referrals as necessary, possibly a sleep study if her sleep patterns do not improve with MH treatment.	Service Coordinator	9/1/2015
SC will monitor progress towards this goal through regular communication with therapist and face to face contacts with Julie at least every 30 days.	Service Coordinator	9/1/2015

And now it's time to...



# What is the SPANS?

Service Process Adherence to Needs and Strengths



# How is the SPANS Utilized?



- Supervisors
  - Individual and Group Supervision
  - Case Reviews
  
- Contract Monitors
  - Site Visits
  - Quality Assurance
  
- Findings are used:
  - Identify Trends
  - Identify Training Needs
  - Quality Improvement

# The SPANS



- A score is given for each Need (2,3) and each Strength (0,1) on the CANS/ANSA and how well it is addressed within the service plan, case notes, and/or individual chart.
- Rating scale is similar to the CANS/ANSA
- If a Need (2,3) or a Strength (0,1) is not addressed or utilized in the Service Plan and there is strong documentation as to why it is not being addressed it will still receive full credit

# What is the SPANS looking for?



## Strengths

- Are strengths mentioned on the service plan?
- Are strengths being used to meet any of the needs on the plan?
- Are strengths being monitored?

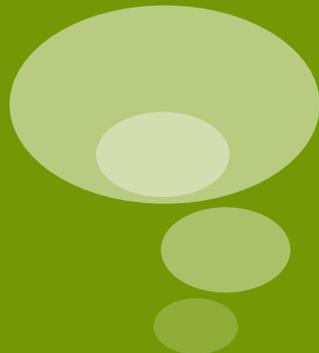
## Needs

- Are needs a focus of/included in the goals on the service plan?
- Are recommended services and/or supports included in the plan?
- Are needs being monitored and coordinated?

## Service Plan process review:



- Use CANS/ANSA or summary detail report to identify strengths and needs
- Write service plan goals and action steps regarding the prioritized needs and include strengths
- Obtain signatures from all parties involved indicating their agreement with plan
- Submit to supervisor for review/approval
- Provide copy of approved plan to all parties involved as well as one for the record
- SC activities should reflect goals of the service plan



Questions???

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