

Illinois Department of Healthcare and Family Services
IM+CANS Workgroup
Meeting Minutes
November 3, 2021
Held virtually via WebEx

Workgroup Members Present

Stephanie Barisch	CYFS
Matt Stinson	SSW
Ellie Feldmann	JCFS
Carmen Gonzalez-Djangi	Metropolitan Family Services
Cris Mugrage	Sinnissippi
Chelsea Mueller	Heritage Behavioral Health
Kathryn Bangs	Department
Carlie Kasten	Community Resource Center
Daphne Bogenschneider	Helen Wheeler Center
Michelle Zambrano	Will County
Rebecca Horwitz	Kenneth Young
Laura Kuever	Catholic Charities
Eileen Niccolai	Thresholds
Virginia Rossi	Thresholds

A quorum was established, with all members present.

I. Introductions

- a. The meeting was opened, and roll call was taken. Members and attendees provided introductions.

II. Workgroup Purpose and Scope

- a. HFS Staff reviewed the purpose and scope of the workgroup and provided clarification that the State is intent on keeping the IM+CANS, and all topics except replacing the IM+CANS are open for discussion.
- b. Advise HFS with feedback in regards to the implementation and usage of the IM+CANS, and provide feedback on related policy, operations, technical and quality improvement activities and initiatives.

III. Workgroup Structure

- a. HFS clarified that State staff are available as technical advisors and hosts for the meeting, but that the workgroup would be driven by the members of the Workgroup.
- b. The Workgroup will be conducted in accordance with the open meetings act. The IATP Landing Page on the HFS Website will be the location for public information regarding the workgroup.
- c. HFS provided an overview of the requirements of the Open Meetings Act as follows:
 - i. A quorum must be established to be able to hold a vote

- ii. 5 or more members of the Workgroup cannot meet outside of the official meeting without it being subject to the Open Meetings Act

IV. Ground Rules

- a. An overview of the ground rules for the Workgroup was provided.
 - i. Active participation in the Workgroup by Members
 - ii. Encourage other members to provide their thoughts
 - iii. Respect all points of view
 - iv. Make the meeting productive and solution focused

V. Meeting Schedule

- a. HFS proposed a meeting schedule of every two weeks, with adjustment as needed for holidays.
- b. No specific duration of the Workgroup was identified
- c. Discussion on time was held, including moving times to the afternoon.
- d. It was determined that 90 minutes was the ideal length for meeting time to allow for administrative needs and voting
- e. A doodle poll was sent to the Workgroup members on Wednesday, November 3
 - i. The results indicated that 10:00 AM worked for the majority of participants.

VI. Purpose and Vision of the IM+CANS

- a. HFS provided an overview of the IM+CANS from their perspective.
 - i. IM+CANS was first standardized assessment that can be used across the lifespan and all payors, with the intent to be flexible and designed for frequent updates. It links assessment and treatment planning to ensure a thread of accountability between the two components.
 - ii. There are four primary outcomes the state is seeking with the IM+CANS:
 - 1. Person-Centered Treatment
 - a. “Mass customization”
 - 2. Data-Driven Decision Making
 - a. Establishes a baseline dataset from which quality improvement initiatives and outcomes can be measured
 - 3. Workforce Development Initiative
 - a. User certification carries across provider organizations
 - 4. Multi-Payer, Multi-System Platform
 - a. Allows for the reduction of duplicate collection of administrative and clinical data points
- b. Stephanie Barisch asked for additional information about the use of the IM+CANS from a clinical perspective, not just a systems perspective.
 - i. Daphne Bogenschneider added that the document feels more like a “numbers game” than a clinical tool
 - ii. Kristine Herman: The IM+CANS is designed to be a method of consistently engaging people who are seeking treatment. It is meant for them to tell their story, and for the clinician to be able to document that story in a way that can follow that person wherever they go so they don’t have to repeat it. It is meant

to be a tool for a clinician to use to have a conversation with the person about why they are there and categorize that in a systematic way.

- iii. Kati Hinshaw: The IM+CANS is meant to be a facilitation tool to ensure better communication. The family, clinicians, different providers, and agencies can all understand it. Rating is at the core of the IM+CANS, and is meant to help easily identify the itemized needs that have to be addressed, what are the strengths, how that is communicated to the family, and if the goals on the Treatment Plan tying back to the identified 2s and 3s.
- iv. Kati Hinshaw: Additionally, universal data can tell a more comprehensive picture that can be informative at an agency, system planning and child and family levels that can be used to hold everyone accountable. Data can help identify the gaps, what is working, what isn't, and where services and access need to be built, where to invest more money, et cetera.
- v. Matt Stinson: Providers are the engagement tool, not the IM+CANS

VII. Open Discussion

- a. Time was made for open discussion by Workgroup members to identify areas for feedback and discussion on future meetings.
- b. Workflow challenges: clinicians/agencies cannot be reimbursed for time completing the tool if the client is not present
- c. Feedback was provided that the tool was burdensome on providers and takes a long time to complete and doesn't tell a story how intended. It looks for objective information and creates a research approach to the clinical process. None of the client story makes it into the document.
- d. Additional feedback was provided that clinician like that it narrowed the focus and clinical attention to the client's current needs and where they are now, not 20 years ago. Previous Mental Health Assessments provided a more detailed story, but it wasn't always relevant.
- e. There are issues with cultural understanding and competency, the tool is too child focused and isn't a true lifespan tool, and the portal has major issues.
- f. Training was identified as needing updated, as the training focuses on how to rate items, which does not convey how the tool is meant to be used. This results in clinicians using it as a structured interview/checklist with the belief that it is supposed to be comprehensive and answer all the questions.
 - i. Several agencies indicated they do their own training sessions after the required 1-day training, and would be willing to share
 - ii. Training focuses on learning to pass the test vs. learning to do the IM+CANS
 - iii. Training of Trainers was meant to be implemented but was not, and should be.
- g. The sharing of the IM+CANS between organizations was identified as a topic that needed clarification, including who is ultimately responsible. There is a lot of expectation without clarity around confidentiality.
- h. Frequency of completion was also identified – that 180 days is too frequent.
- i. There has not been an audit on the IM+CANS, and it was asked to provide clarification on audit expectations, including uploading to the Portal.

- j. The IM+CANS does not meet requirements for CARF and other accreditations. It does not integrate with other assessment needs for accreditation and licensing requirements.
- k. The IM+CANS focuses on Mental Health, but doesn't meet needs for Substance Use.

VIII. Next Steps

- a. HFS will send out a doodle poll and PowerPoint slides
- b. Stephanie suggested using the November 17 Meeting for additional brainstorming and identify additional "buckets" for conversation. Workgroup members agreed.

IX. Adjournment

- a. Carmen Gonzalez-Djangi motioned to adjourn the meeting.
- b. Cris Mugrage seconded.
- c. Meeting was adjourned.