

Illinois Department of Healthcare and Family Services
IM+CANS Workgroup
Meeting Minutes
November 17, 2021
Held virtually via WebEx

Workgroup Members Present

Stephanie Barisch	Center for Youth and Family Solutions
Matt Stinson	University of Illinois School of Social Work
Ellie Feldmann	JCFS
Carmen Gonzalez-Djangi	Metropolitan Family Services
Cris Murgage	Sinnissippi Centers
Chelsea Mueller	Heritage Behavioral Health
Kathryn Bangs	Egyptian Public Health Department
Carlie Kasten	Community Resource Center
Daphne Bogenschneider	The Helen Wheeler Center
Michelle Zambrano	Will County Health Department
Rebecca Horwitz	Kenneth Young Centers
Laura Kuever	Catholic Charities
Eileen Niccolai	Thresholds
Virginia Rossi	Thresholds

A quorum was established with all members present.

I. Roll Call

II. Open Meetings Act Review

- a. HFS provided an overview of the requirements of the Open Meetings Act
 - i. Meeting Schedule has been posted to the [HFS Website](#)
 - ii. Agendas will be posted to the [HFS Website](#) minimally 48-hours in advance of the meeting
 - iii. A quorum must be established to be able to hold a vote
 - iv. 5 or more members of the Workgroup cannot meet outside of the official meeting without it being subject to the Open Meetings Act

III. Approval of Minutes of November 3, 2021 Meeting

- a. The workgroup decided to defer approval of the minutes until the December 1, 2021 to allow members time to review.
- b. Future meeting minutes will be sent the week prior to the meeting to allow time to review.

IV. Open Discussion

- a. A review of items from the November 3 meeting was discussed
 - i. Newer staff are less comfortable with the clinical interview; the training portrays the tool differently than the intention (every question must be answered vs. only issues that need to be addressed are identified); the tool is too child/youth focused; dual population needs are not addressed including developmental disabilities and substance use; the organization of the tool could be improved; no way to document progress/maintenance clients; doesn't meet the needs of seriously mentally ill population; frequency of completion expectations; does not integrate well with other tools/credentialing requirements; the tool is not culturally competent; not LGBTQIA (no preferred name/pronouns)
- b. Health Risk Assessment
 - i. Can be off-putting for clients, particularly adolescents who may be asked to disclose information their parents are not aware of.
- c. Confidentiality/Consumer's Right issues
 - i. Concerns regarding who has access to the client's information and who has rights for their information
 - ii. What if the client doesn't want to share their information with other agencies/providers?
 - iii. An adult has to sign the IM+CANS, and adolescents (ages 12-17) may not want to share the information with a parent/guardian
 - iv. Concerns over collaborative use of the IM+CANS and who is responsible for service delivery
 - v. Clients should have consumer choice and dictate who they want to see what.
 - vi. Sharing the document could lead to documentation quality. If a therapist knows the document will be shared, they can't put all of the information in to ensure client privacy is protected.
- d. Requirement for Medical Necessity and LPHA signature
 - i. CST/ACT require monthly care plan reviews with an LPHA
 - ii. Williams-Colbert assessment requirements by Department of Human Services – Division of Mental Health
 - iii. LOCUS assessment completion requirements for the MCOs
 - iv. The 180-day completion timeline is too frequent, particularly for some populations served.
 - v. With the workforce challenges, meeting the 180-day timeframe is unrealistic.
 - vi. Providers operate without needing to establish medical necessity and used it responsibly, can medical necessity/prior auth for these services be waived?
- e. IM+CANS Portal Issues
 - i. Documents can be edited without knowing what has been changed; Document's are not 'locked' after submission
 - ii. How does collaborative work/'shared' treatment plan work in the Portal? Who owns the document?
 - 1. Does a provider have to request to add services to the treatment plan from the provider who "owns" the IM+CANS?

- iii. Can't create a new IM+CANS in the system if one is already existing
 - iv. How will the IM+CANS Portal Upload requirements impact billing?
 - v. Character limit in the narratives provide limits on the amount of information that can be provided
 - vi. Account setup based on the NPI is painful, and leads to delays in accessing information
 - vii. Errors in batch upload process are not always discernable
 - viii. Cannot close or discharged clients in the Portal to make it clear they are no longer providing services.
 - ix. The Treatment Plan did not translate well to the Portal. What could be one line on the paper document may require more.
 - x. The Portal is too "technical" and not intuitive for clinicians, and the document from the Portal is too hard for clients to understand.
 - xi. The narrative sections in the Portal for batch uploads cannot have special characters is them
 - xii. 42 CFR part 2 is not included in the Release of Information for the IM+CANS portal.
- f. IM+CANS 'Ownership'
- i. Is the LPHA who signs the IM+CANS responsible for other's services/updates?
 - ii. If an agency does the IM+CANS in their system, how do agencies that are not the primary get access to the IM+CANS?
 - iii. What if the clinicians disagree with content/diagnosis on the IM+CANS? They will have to change/modify the content.
 - iv. How does a shared IM+CANS work when the youth is receiving residential treatment? The Treatment Plan looks different than when receiving outpatient services.
- g. Audit Concerns
- i. If it is a shared document among multiple providers, who has the final say so?
 - ii. If there is an audit and one LPHA signed the documents but others are updating, that is a liability concern.
 - iii. How is progress tracked for maintenance clients? How does this impact auditing if progress cannot be documented?
 - iv. Challenges with getting signatures from guardians. Verbal consent can often be obtained, but physical signatures are harder. Will allowance for verbal consent go away?
- h. Billable services before completion of IM+CANS
- i. What is allowed to be completed before completion of the IM+CANS/clinician isn't fully engaged?
 - ii. The context of when the IM+CANS is used can be a problem, like immediately post crisis. Paperwork has to be finished before being able begin services.
 - iii. The CANS was not designed to be a medical necessity tool – providers need a tool kit to give providers the ability to engage and get buy in.
- i. General

- i. A psychological assessment cannot be completed until the IM+CANS is completed
- ii. For FSP Residential providers, they must update the IM+CANS monthly, upload it to a separate Portal
- iii. There should be a Rule 140 FAQ similarly to how there was one for Rule 132.
- iv. The tool can be difficult to use with mandated populations (DCFS, court ordered treatment, etc), as they may not be in a place where they want to engage.

V. Next Steps

- a. HFS to identify buckets and topics and send to Workgroup Members for review.

VI. Adjournment