Date/Time of Meeting	Wednesday, September 14, 2022, 9:00 a.m. – 1:00 p.m. MT Dial: 415-527-5035 Access code: 2761 860 2949 Meeting password: X5yAvWG3M3c (95928943 from phones and video systems) Webex: https://idhw.webex.com/idhw/j.php?MTID=mf8d406f0f5f4339fc838247c1f6c6b91 In-person Location: PTC, 450 W State Street, Boise, ID 83702, 3rd Floor, Conference Room 3A
Meeting Purpose	Interagency Governance Team (IGT)
Host	Janet Hoeke: Chair, Ross Edmunds: Co-Chair, Vice-Chair: Patrick Gardner, & Co-Vice-Chair: David Welsh

Voting Members	Att'd	Voting Members	Att'd	Ex-officio Members	Att'd
Ross Edmunds – DBH	X	Laura Scuri - Provider	X	KayT Garrett - DHW DAG	X
Janet Hoeke – Parent Leader	X	**Proxy Voting Members**	**Att'd**	Kim Stretch – DHW DAG	X
David Welsh – Medicaid	X	Candace Falsetti - DBH	X	Joy Jansen – School District	X
Patrick Gardner – Child Advocate	X	Michelle Weir - FACS	O	Georganne Benjamin – Optum	X
Howard Belodoff – Child Advocate	X	**Recorder**	**Att'd**	Matt Johansen – Optum	X
Jessica Barawed – County Juvenile Justice	O	Megan Schuelke - DBH	X	Joyce Broadsword – DHW Regional Director	O
Laura Treat - DBH CMH Representative	X	**Ex-officio Members**	**Att'd**	Dora Axtell – Nimiipuu Health	X
Marquette Hendrickx - Tribal Representative	X	Shane Duty – DBH	X	Candice Jimenez - NPAIHB	O
Ruth York – Family Advocacy Agency	X	Jon Meyer – DBH	X	Caroline Merritt – Association of Providers	O
Kim Hokanson – Parent Leader	X	Jenna Tetrault – Medicaid	X	Michelle Batten - FYIdaho	X
Madeline Titelbaum - Youth Leader	X	Mallory Kotze – Medicaid	X	Emily Brown – YES Project Manager	O
Juliet Charron - Medicaid	X	Francesca Barbaro – Medicaid	X	Ellyn Wilhelm - Provider	X
Alex Childers-Scott - Medicaid	X	Dori Boyle – Medicaid	X	Jill Randolph – LSO	X
Sara Bennett – Parent Leader	X	Nicole Gaylin – Medicaid	X	Christine Otto – LSO	X
Eric Studebaker - SDE	X	Ashley Porter – Medicaid	X	Raini Bowles – Parent Representative	X
Chad Cardwell – FACS	X	Andie Blackwood – FACS	X	Laura Wallis – Parent Representative	X
Monty Prow – IDJC	X	Kylie Turner – Member of the Public	X	Nate Williams – BSU & Presenter	X

MEETING NOTES

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
1	**9:00am**	**10 mins** *(All times are aspirational & are subject to change.)*	Welcome, Roll Call & Approve Minutes	IGT Executive Committee	The following document(s) were shared with the IGT members: • Sponsor's Status Report • YES Communications Strategic Planning Workgroup Monthly Report from September 2022 • YES Communications Strategic Planning Workgroup Strategic Communication Plan: Medicaid and Liberty Document Review ***Action Item:*** Approve IGT Meeting Notes from August 2022. Ross Edmunds motioned to approve the IGT Meeting notes from August 2022 and Juliet Charron seconded this motion.	***Vote:*** The IGT voting members voted unanimously to approve the IGT Meeting notes from August 2022.

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
2	**9:10am**	**65 mins**	Discuss Proposed One Kid One CANS Workgroup Charter	Janet Hoeke & Patrick Gardner	Patrick Gardner shared that, based on the feedback that the IGT shared regarding the CANS, we put together a questionnaire and Shane Duty previously provided a presentation on the One Kid One CANS Workgroup charter. The IGT Executive Committee took a look at how to best move forward on these items and reinvigorate the One Kid One CANS Workgroup. After further discussion, the IGT Executive Committee decided to come back to the IGT to determine how best to focus our efforts. This is in part because we are in the process of negotiating the IBHP and one of the components of the ITN may affect the recording of the CANS and this could impact what we can accomplish over the next year. Other items that we wanted to bring to the IGT were questions about how one might adjust the CANS and suggestions on how we could shorten it so that it is used as a screening. It appeared that the key concern and priority was how parents and youth engaged in developing or drafting the CANS, the access that they have to review it, and how it is shared among providers, including the Liberty process. There was some concern that the CANS is being used as a checklist and we are hoping to move the CANS into a more productive role. We would like to determine how we can turn these questions into a charter for the One Kid One CANS Workgroup as well as who would be best tasked with these responsibilities and the best timeframe for this work. Director Monty Prow shared that for the Department of Juvenile Corrections (IDJC), it is a challenge for them to get the CANS data for the children that are in our care. We often have to start the process over from the beginning. David Welsh noted that we should be mindful of talking about it from the Liberty perspective as they were doing a subset of the CANS, the CANS 50, for the assessment. Issues arose so Liberty had to switch back to completing the full CANS. Shane Duty noted, to provide clarification, that the CANS 50 was discontinued and Ashley Porter added that the contract monitor confirmed that Liberty is using the full CANS assessment. Janet Hoeke explained that the main issues are that there is no sharing of the CANS and there is a lot of misunderstanding about what the CANS is. The access point is a huge barrier to getting care. This is a discussion worthy of having in addition to the training issues. We also need to find a way to track where the youth has needs over time. Marquette Hendrickx shared that as a foster parent, she knows how difficult it is to get background information on the children in foster care and complete the assessments. These are vulnerable children, and this is a barrier to them getting mental	***Action Item:*** Patrick Gardner shared that the IGT Executive Committee will use all of this feedback to have the One Kid One CANS Workgroup charter proposal ready to present to the IGT at the next IGT meeting. ***Action Item:*** Medicaid will come prepared with an outline of the Medicaid and Optum requirements to review and discuss during the next IGT meeting.

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					health treatment. These services should be an automatic benefit the same way that other services are. Ross Edmunds clarified that there are several eligibility Medicaid types. Medicaid eligibility for children in foster care or in YES includes an automatic right to services, except for respite. It depends on connecting to Optum. Patrick Gardner shared that the state of Washington uses the CANS in the same way that Idaho does. However, their screener has 27 items rather than the 50 items that Idaho's has. It is possible for Idaho to trim back the number of items and create a more streamlined process. Doing multiple CANS is at the core of misunderstanding the purpose of the tool. Georganne Benjamin agreed and added that we have the opportunity to evolve how it should be working in our system. Shane Duty explained that it is important to remember that the CANS is intertwined with the system of care in a complicated but good way. This allows it to be powerful but in this case it may be best to focus on one item at a time. Three focus areas were listed in the One Kid One CANS Workgroup charter, including provider engagement and education and parent engagement and education. We may also want to look at the tool itself to determine how we maintain clinical reliability with the tool and how we maintain integrity for how the tool is supposed to be used in the system on a narrow scope, so it is easier for providers to use and parents to digest. Matt Johansen added that this is a good point about the CANS being practical for providers. As it relates to the length of the full CANS, a CDA is 1.5 hours per CMS rule. Providers have shared that it is difficult to get through 100+ CANS questions in that timeframe. For many states a full CANS is 61 questions with 0-2 narrative questions. If additional time length could be implemented during a CDA so that it is less burdensome for the providers then that would be helpful. Marquette Hendrickx shared that doing the full CANS is not going to work for our community. We are private and they will not want to answer these individual questions. This is adding more strain on the healthcare system. The providers would also prefer to go through all of the questions with their clients. Patrick Gardner stated that the CANS is about communication between the parents and the clinician. It does not make sense for Liberty to do the full CANS if they are not going to be the clinician for that family and child. Liberty should be the point where eligibility is determined and then we can make the CANS a lot shorter. Ross Edmunds explained that the described use for the CANS in Idaho is for eligibility, access, and communicating the strengths and needs. It is used to create a common	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					understanding about the needs but also to establish an agreed upon set of those needs with the family and youth. The CANS should be used to guide treatment. In Idaho we have done a good job on the eligibility and access pieces however, we have not done a good job as it relates to the communication instrument and a shared platform for clinicians to use to guide treatment. If we can map this out then that will help to drive these changes. Figuring out how best to share the CANS and how to drive the use at a clinical level also requires a shared understanding and work in the network. Providers will need to accept each other's opinions. We need to go back to the basics with the purpose of the CANS in Idaho. Shane Duty shared that it is a valid but huge undertaking to zoom out on the purpose of the CANS and determine how we want to build the use of the CANS around its purpose. There are also requirements of Medicaid around how the CANS is used, and these requirements effect the other pieces. As well, we still need to determine what we are going to ask the One Kid One CANS Workgroup to do. Before that, it may be helpful to know what we cannot change from a requirements standpoint for Medicaid and understand what they have to operate under. Patrick Gardner shared that he was previously talking with Dr. John Lyons and he explained that we need to switch the use of the CANS from an authorization for payment to a tool used to communicate with parents and youth to build a shared understanding. Then two other things can happen; it can help you focus on the important things to do to give a pathway forward and it can show and manage progress to avoid future problems. Another issue is around the way that we are training and educating the providers. There is some expectation that the state is imposing that is causing providers to use the tool in the way that is not effective. The big challenge is how you ensure that clinicians use the CANS to manage care. New York's answer for this was to set up an evaluation process. If the treatment plan is consistent with the CANS scores then the CANS decision-making leads to the treatment plan. Fundamentally, there needs to be a change from an approval process to a communication tool to understand the youth's strengths and needs. Janet Hoeke asked about the best next steps to move forward. Juliet Charron shared that she appreciated what Ross Edmunds explained about how we are using the CANS and what the intent is. It would be helpful to clearly outline that and to get clarity on what the requirements are so that we are clear on what we can and cannot	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					change. There is also a clear gap with providers about the administrative burden. We also need to discuss how we can make the CANS simple, but it still needs to be ongoing and evolving so the education should be tailored to this and additional supports should be in place for the providers. Janet Hoeke shared that the big thing that she has noticed in large part is the transition of the providers mindset from a medical mindset. The Transformational Collaborative Outcomes Management (TCOM) Institute is about changing that mindset to a person-centered perspective. The family has a deep knowledge of their child and the providers have a broad set of knowledge. The CANS can bring those together in a way that aligns everything. We need to determine how to help transition that mindset. Juliet Charron noted that this is a good point and providers are operating as they are trained, and we need to help to bridge that gap. Laura Scuri added that we have to look at the structure of the system. Productivity does not line up and the pay structure for services provided do not line up. We have come through a difficult time and we have a strained system. We do not have the infrastructure to accommodate that mind shift. Providers are working towards that, but we have workforce shortages that we have never seen before in combination with requirements that are burdensome and are creating barriers to care. Shane Duty suggested that we ask the One Kid One CANS workgroup to take on some of these issues, specifically the short-term goals. However, beforehand, DBH, Medicaid, and Optum should sit down to have a higher-level conversation about what some realistic expectations are. It is important that these three parties are in alignment before we make another request of this workgroup. Patrick Gardner expressed that he is deeply opposed to the strategy as this is at odds with the function of the IGT. Shane Duty clarified that the three parties would not come up with a proposal or a foundation. Rather, the group would establish an understanding of the Medicaid requirements and what can and cannot be done by Optum. We still want to empower the group of parents and providers to use their expertise to say, within those requirements, what realistic options are. Ross Edmunds added that we want to make sure that we are not wasting the workgroups time. Patrick Gardner proposed an alternative suggestion that we instead ask the One Kid One CANS Workgroup to take a look at the question of how we switch from a medical model to a person-centered model	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					and what is giving way to the CANS implementation that is causing challenges. The workgroup would include agency staff members in these conversations along with other stakeholders and then give this feedback to the IGT. Shane Duty explained that he feels that this ignores some past experience of us asking workgroups to drive to a solution without knowing the full extent of the environment that they are operating in. We want to set up the workgroup for success and make sure that they have all of the necessary pieces. Janet Hoeke shared that having that conversation would be a good step forward. It would be helpful to have the parents and advocates in the room as well so that we all understand where the requirements and barriers are coming from. Juliet Charron shared that, for Medicaid, it is important that we come prepared and have information to go through with the IGT members. This will help the conversation so that it continues to move forward.	
3	**10:15am**	**45 mins**	2022 Family Survey Results Presentation	Dr. Nate Williams	Dr. Nate Williams joined the IGT meeting and provided a presentation on the 2022 Idaho YES Family Survey Results. Overall, what we learned is that there was not a ton of change on the YES quality indicators. Caregiver ratings remained stables from 2021 to 2022. Only 1 out of the 18 items changed significantly, which was the community-based service array. Similar to 2021, results of the 2022 YES Family Survey indicated that 3 out of 10 survey respondents indicated they could not easily access the mental health services they believed their child needed the most. In 2022, a new question was also asked about whether families can access mental health services that are recommended by a provider. The results showed that 3 out of 10 survey respondents indicated they could not access all of the services recommended by their provider. While it is positive that 70% of Idaho families can easily access the mental health services they believe their youth needs, these results suggest additional work is needed to improve access to mental health services for all youth and families in Idaho. There were signs of improvement in this area, however; from 2021 to 2022, the percentage of caregivers of youth with a CANS of 3 who indicated they could easily access the services their youth needed most increased from 54% to 56%. Patrick Gardner asked if it was accurate that 8% of respondents said they experienced psychiatric hospitalization and 83 children were hospitalized. Dr. Williams confirmed and added that this data was extrapolated throughout the population. Dr. Nate Williams also explained that after adjusting for multiple comparisons, there was no evidence of variation in experiences of care by youth gender,	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					race, or ethnicity. Patrick Gardner asked if someone would be able to look at the regional CANS data, such as CANS level of services in each region. Dr. Williams confirmed that we can break that data out by region. One of the changes that will come with this is that the sample sizes will get smaller and the estimates will get less precise. However, we could look at doing this analysis to show the variation in responses by region and, furthermore, the CANS score by region. Patrick Gardner added that it would be informative to also get data on the difference in those who received what they needed and what was recommended. Dr. Williams shared that in the future they could do an oversample by area or CANS score. We would then be able to design the sample to get precise estimates on those items. It has always been challenging to figure out how to ask families about the issue of services. We have this data in the QMIA Quarterly Report and someone could do an analysis to break this out by the CANS data. Patrick Gardner asked when the conversation begins about what we are going to do this year for the Idaho YES Family Survey. Dr. Williams shared that it is not a fixed timeline. Patrick Gardner noted that he would be interested in being involved in that. Candace Falsetti shared that they usually start to look at the survey questions in December, January, and February. The questions are then reviewed by the QMIA Council and the Family Advisory subcommittee. Marquette Hendrickx asked if it is possible to get a breakdown of the tribal respondents. Dr. Williams explained that he could work with Candace Falsetti and DHW around that request. David Welsh explained that we have the provider information from the CANS so we could isolate that data for the tribes. Candace Falsetti noted that we would not look at it by provider but rather by the child that has the CANS. Marquette Hendrickx shared that it would be helpful to know about this ahead of time so that she could work with the individual providers and communities to prepare them to receive the survey so that they know that they can trust what the survey is about. Then, we may see an increase in tribal responses in the next year. Patrick Gardner shared that one concern to observe is that the tribes do not have to do the CANS in the ways that others have to. When looking at the survey results and using the CANS as the focus point, this could pose some issues. Dr. Williams agreed and added that this was a limited sampling frame so we may want to look at expanding the sampling frame in certain ways. We also want to be aware of oversampling specific populations in certain ways. Juliet Charron noted that since the CANS is no longer a requirement for the	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					tribal members, we may want to consider a separate survey. This survey could ask the tribal members how they are experiencing and accessing services. We would also want to determine how to best coordinate with tribal communities to get the word out that we are doing a survey and how to best engage families to participate in responding to that survey. Within Medicaid, we are having these conversations. Would it be worth pursuing a separate tool for this survey? Dr. Williams agreed that this next step would make sense.	
4	**11:00am**	**20 mins**	*Break*	*Break*		
5	**11:20am**	**15 mins** *(Due to time, this agenda item was moved so that it took place after the above identified break.)*	Update from ICAT Subcommittee	ICAT Subcommittee Members	Laura Scuri shared that the ICAT subcommittee has been primarily focused on the PRA workgroup recommendations. Laura Scuri shared the PRA Workgroup CBRS Core Competencies and Additional Recommendations document and added that this is the second time that we are providing recommendations to the IGT. This document includes the components that the workgroup felt were the most important and need to be covered in CBRS. Clarification was requested and Ross Edmunds explained that DHW previously requested assistance from the ICAT subcommittee regarding the PRA certification for CBRS. We requested that the subcommittee provide recommendations around a set of competencies. The ICAT subcommittee is now presenting their recommendations in lieu of a PRA certification. This recommendation is being present to IGT who will then send it to the state as a recommendation for competencies in to replace the PRA certification. Janet Hoeke confirmed and added that we will review the document today and vote on a decision at the next IGT meeting. Laura Scuri then reviewed the PRA Workgroup CBRS Core Competencies and Additional Recommendations document. We are in a critical time where we have a new group of providers and we have to make these changes to develop certification protocol. Patrick Gardner asked how many hours of training and education are ordinarily needed to master these competencies. Laura Scuri explained that it depends on if the provider has experience and what the agency can afford to deliver. Patrick Gardner then asked about a provider that already has experience. Laura Scuri shared that if the provider had 30 hours of experience, this would turn into basic training requirements. However, DHW asked the ICAT subcommittee to be less specific as this will be left up to the agencies. Patrick Gardner asked if the idea is that the state would develop a test that would evaluate these competencies and, if the provider passed, they would be certified to offer CBRS services. Laura Scuri explained that	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					she would defer to the state on this question. The ICAT subcommittee's initial recommendation was to develop a training. Ross Edmunds shared that the proposal was more of an attestation process. The state was looking for a proposal that included the recommended minimum education level and experience as well as what the industry believes the core set of competencies should be to provide this level of care. The agency would then certify that the provider has the competencies necessary to be able to do this. Laura Scuri stated that it is important to note that the turnover rate is at 12 months or less. This work is often seen as a stepping-stone, which is a serious issue that providers are facing. Additional clarification about the recommendations was requested and Ross Edmunds explained that the ICAT subcommittee is also suggesting to the IGT that it makes the recommendation for a standardized training program for certification. The IGT needs to agree with this recommendation or modify it before it is sent to the state. Laura Scuri added that this is a recommendation that ICAT believes will affect the quality of the services that we want within the state of Idaho. A key component to this is the service delivery system. Ross Edmunds thanked the ICAT subcommittee for coming up with these competencies. Janet Hoeke noted that all of the IGT members will come back next month to review and determine our decision. Patrick Gardner asked if providers are no longer certified, are there still CBRS providers available in Idaho? Laura Scuri shared that from her experience with the state, they understand the situation and have been accommodating. They have been working with providers to figure out it out in the meantime. Patrick Gardner asked if that means that this does not get in the way of access to care and Laura Scuri confirmed. Ross Edmunds added that we want to have a process that helps rather than creating further issues.	
6	**11:30am**	**10 mins**	Provide Update on QMIA Plan	Candace Falsetti	Ross Edmunds shared that the QMIA Council has been working on proposed updates to the QMIA Plan as this is one of the requirements within a deliverable that is listed in the Implementation Assurance Plan (IAP). We determined that the work that we are doing around compliance feeds into that updated QMIA Plan. Therefore, the state and the plaintiff attorneys came to a mutual agreement that we will push that deadline a little recognizing that we want to complete the compliance work in advance since it feeds into the QMIA Plan.	
7	**11:50am**	**20 mins**	Review Updated FACS	Cameron Gilliland	Cameron Gilliland shared the updated draft of the FACS Administrative Directive. All of the suggested changes from the last	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
			Administrative Directive		IGT meeting were incorporated into this version and are in red text. Cameron Gilliland clarified that this is not the final document and we are still happy to receive feedback and suggestions. Laura Wallis clarified that the language that should be used in this Directive is a "Quick Reaction Team". Additionally, Laura Wallis suggested that the child's primary mental health provider be included. David Welsh asked about referencing the Child Family Team (CFT) and KayT Garrett explained that this document was intentionally vague as it is referencing the team that is treating the child. Cameron Gilliland confirmed and explained that children come from different places and a treatment team is included if it exists. Laura Wallis stated that this could be a problem if the treatment team is the members that want the child to leave the hospital. To be clear, the primary provider should be included in this decision so that the members that are present do not redefine the treatment team so that it does what they want. Cameron Gilliland agreed and added that this issue is difficult as everything often happens very quickly. We are not necessarily in control of the whole situation. The problem is that we are brought in to do part of this work and the table is sometimes already set. Howard Belodoff shared that some children do not have treatment teams. If that is the case, who is the treatment team? As well, sometimes the hospital will state that you are ready to leave and you have to do so without the services that you need. This is where the issue arises as this does not change the view of the parent that it is not safe for the child to come home. It is important to define the treatment team to include the treatment providers, the primary mental health provider, and the parents. Cameron Gilliland clarified that the point of this Directive is to guide staff internally on a variety of situations. Defining the treatment team would be out of that scope. We are committing to the Quick Reaction Team (QRT) involvement. However, we cannot say that we have to have involvement from the parents and the providers. We are also obligated to act as soon as we arrive. Patrick Gardner suggested that FACS look at the statutory requirements of Section C and the mitigation measures that are in place. If the risks have been mitigated then you get yourself out of that box. Cameron Gilliland explained that sometimes they are called in at the last minute and whether or not we feel that mitigation has been done, they are claiming that we need to intervene to protect a child.	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					Howard Belodoff shared that he talked to a group of Police officers and a Police Chief recently. The officers shared that they are in a difficult position when the Police are called in and expected to solve these problems. That is why they call in staff from DBH and Child Welfare so that they make that decision. KayT Garrett clarified that this is specifically about the internal policy that relates to whether a parent is substantiated, which is different than whether a child is safe and where they go. This policy is about when staff members do safety assessments. When the parents are going through this process and Child Welfare is involved, it feels punitive to the parents, even though this is not the intent. Janet Hoeke shared that in the case where a child is a danger to themselves, this does not relate to abuse, neglect, or abandoning a child. This is not because of the parents. However, Child Welfare comes to determine if that child is safe to return home. Could Child Welfare place the child temporarily? Cameron Gilliland explained that when it is determined that a child is a danger to themselves, child oversight and supervision is put in place. This could mean that other statutes may need to be changed too. Howard Belodoff explained that House Bill 233 also provided agencies with six months to create a process to deal with these issues. That is where this needs to be figured out. KayT Garrett shared that, in regard to Janet Hoeke's question, this is where the QRT comes in. Shane Duty explained that broad expectations have been placed on this Directive and on the QRT. An update regarding the QRT communication materials for the parents and hospitals was requested and Shane Duty shared that Child Welfare recently provided their comments. These communication materials will be updated and then they will go to the QRT members for review. Once we have received the final approval, they will be posted on the YES website. Patrick Gardner shared that from his observations, this Directive is not adequate if the narrative does not incorporate risks being eliminated. Patrick Gardner suggested embracing KayT Garrett's statement about substantiation. This is not about what to do about the safety of the child. However, this does raise a concern. By not substantiating during that situation, does this tie Child Welfare's hands when it comes to being able to provide safety for a child? Andie Blackwood explained that substantiation and safety are separate decisions. The Child Welfare system is built to protect children from abusive or neglectful parents. If we do not have abusive or neglectful parents then questioning why Child Welfare is	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					involved is valid. Cameron Gilliland added that it entails the issue of where the child is going to sleep. This issue is about managing all of these issues when a child needs to leave the hospital. It should also be noted that the QRT does alleviate some of these issues. Cameron Gilliland shared that he will look at the statutory requirements of Section C and the mitigation measures that Patrick Gardner referenced. Howard Belodoff suggested that Cameron Gilliland also take a look at the second section of the statute as that gives additional direction for what the legislature intended. It was determined that Cameron Gilliland will review the statute and make the requested changes to the draft FACS Administrative Directive so that it can be reviewed at the next IGT meeting.	
8	**12:00pm**	**10 mins**	IDJC, FACS, & SDE Representation on Due Process Workgroup	IGT Executive Committee	Ross Edmunds shared that the intent of this agenda item was to share that the Due Process Workgroup has identified that they need regular representation at the meetings from IDJC, FACS, and SDE.	***Action Item:*** IDJC, FACS, and SDE will email Megan Schuelke the representative who will regularly attend the Due Process Workgroup meetings.
9	**12:10pm**	**10 mins**	Update on IGT Roles & Responsibilities Grid	IGT Subgroup Members	Janet Hoeke shared that the IGT Subgroup is continuing to work on the IGT Roles & Responsibilities Grid. The members are hoping to have something to bring to the IGT members for review either next month or the following month.	
10	**12:30pm**	**20 mins**	Review Sponsor's Status Report	DBH & Medicaid	Due to time, Ross Edmunds shared that the most recent Sponsor's Status Report was distributed to all of the IGT members for their review. However, no substantial changes were made.	
11	**12:40pm**	**10 mins**	New Business Items	IGT Members	*There were no new business items at this time.*	
12	**12:50pm**	**10 mins**	Public Comments	IGT Members	*There were no public comments at this time.*	
13	**1:00pm**	**10 mins**	Review Future Agenda Topics	IGT Executive Committee	**October IGT Meeting Agenda:** 1. Discuss the Communication Plan – Howard Belodoff 2. ICAT PRA Certification – Vote on Recommendation – IGT Voting Members 3. Present & Review the Proposed One Kid One CANS Workgroup Charter – IGT Executive Committee 4. Update on IGT Roles & Responsibilities Grid – IGT Subgroup 5. Review updated draft of the FACS Administrative Directive – Cameron Gilliland	

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
					6. Report from Due Process Workgroup – Due Process Members 7. Review Sponsor's Status Report – DBH & Medicaid	
14		--	Dismissal	IGT Members		

The IGT will track action items and their status from the meetings here:

Follow-up Items	Opened	Owner	Due Date	Comments	Status
Regional SOC Project and the intention to have one region present at each IGT Meeting.	3/6/20	Ross Edmunds	4/3/20	1/11 Update: Patrick Gardner suggested that we target the CMH subcommittees of the RBHBs to gather information. We could distribute a list of questions that the IGT would like answered by the CMH subcommittees.	**3/10, In Progress.** Ross Edmunds spoke with the RBHB Leadership members and sent the questions to the CMH subcommittees requesting feedback.
Gather information from community providers about the decrease in skills-building and the increase in TCC.	2/9/22	Laura Treat	N/A		**2/9, New.**
Based on the CANS Oversight Issues document from Patrick Gardner and the following item, "10. Do MCO policies undermine CANS? Are there unintentional financial incentives that cause some of the problems identified above?", Dennis Baughman will work with his Optum team to provide information on undermining versus fostering the use of the CANS.	6/8/22	Dennis Baughman	N/A		**6/9, New.**
Optum will work with Medicaid to extend the monthly Provider Engagement/Advisory Committee meeting invitations to the IGT members.	7/13/22	Georganne Benjamin	N/A		**7/13, New.**
IDJC, FACS, and SDE will email Megan Schuelke the representative who will regularly attend the Due Process Workgroup meetings.	9/14/22	IDJC, FACS, & SDE	N/A		**9/14, New.**