One Kid - One CANS Decision Point Report for IGT and Stakeholders

Background

Many concerns with Idaho's implementation of the CANS exist with the primary being families repeating their stories unnecessarily and experiencing re-traumatization. The CANS is intended to be a communimetric tool that creates a shared understanding of needs and strengths. Idaho's implementation has not achieved the desired result of child and family teams consistently sharing information and priorities to support youth and families in an organized way through a consensus-based decision making. This workgroup was formed to improve the implementation of the CANS in Idaho and the user experience of both providers and youth and families. The One Kid One CANS charter was received by the co-chairs in November. Additional members were identified and invited to participate.

Per the charter's direction, "To begin, there will need to be some substantive training on what the CANS is or should be so that the Workgroup is coming from a shared understanding of the purposes and goals of the CANS" a training from Dr. Lyons was held on December 14th from 1-4pm and a recording was made available for those that were not able to attend. Regular workgroup meetings commenced on January 18 with subsequent meetings held the second Wednesday of each month from 1-3pm.

Substantial information was gathered from both families and providers and compiled into a spreadsheet to be organized and assigned to appropriate subgroups. Subgroups were developed beginning in February with the first addressing streamlining the CANS with several other subgroups addressing topics related to improving the user experience.

Objective 1: Streamlining the CANS

Under the direction of Dr. Lyons, a subgroup was formed to streamline the Idaho CANS and make recommendations for an Idaho CANS 2.0. This process relied heavily on data and Dr. Lyons' recommendations. A report from Praed Foundation was used to identify items not frequently used in Idaho.

Recommendations for Streamlining the CANS:

The subgroup went through multiple drafts and received feedback from the main workgroup. The major changes recommended in Idaho CANS 2.0 include:

- Changing the Trauma Domain to a simple yes or no instead of a 4-point rating scale. This aligns the Idaho version with all other CANS versions.
- Eliminating break out and drop-down items. Extra information was gathered on several items including developmental disability and substance use. Dr. Lyons recommended the removal of these to simplify Idaho's CANS.
- Increasing the age at which the transition age youth domain is required from 14 to 16 years old.

- Merging items and updating some of the language in the caregiver domain to emphasize supporting parents and not an intent to judge or evaluate.
- Adding an item for access to technology to reflect the importance and growth of telehealth options.
- Changing the order of the CANS domains to emphasize strengths in treatment planning.

The recommended Idaho CANS 2.0 would reduce the total possible items from 158 to 101. Work on updating the reference guide has already begun and with approval and support from IGT a detailed transition and communication plan will be created.


RATING
SHEET_Idaho CANS

Decision Point: Approve the recommended changes in the CANS 2.0 version for implementation planning or provide feedback and further instruction to the One Kid One CANS group.

Objective 2: Improving the User Experience

Feedback was gathered from a variety of sources to catalog existing strengths and challenges of the CANS in practice in Idaho. Optum provided concerns received from providers and members of the workgroup shared experiences. A survey of OK1C workgroup members was completed using Polleverywhere.com to gather feedback. In March after issues were identified subgroups were formed and tasked with developing recommendations for the issues identified.

Amy Olsen, a consultant with the Division of Behavioral Health's Center of Excellence, interviewed a group of ten providers to gather additional feedback and ensure their concerns and issues matched those previously gathered.

Subgroups were organized around the following topics: Portability and Confidentiality, Training, and Communications. Each subgroup met several times to review the list of concerns and brainstorm ideas to address them. Recommendations were generated and prioritized with some in the short term and others long term priorities.

Recommendations for Improving the User Experience:

- Portability
- Training
- Communication

The top three **short term** priorities recommended by each group are:

Portability:

1. Every family gets a copy every time! (training and advertising to providers).
2. Work with Liberty to make providing the CANS a part of the standard policy
3. Provide advertising and training on the ICANS consent for referral process.

Training:

1. Provide training to emphasize how CANS is not a separate assessment
2. Parent Education – Youtube videos, handouts, resources to be given by providers.
3. Sequel to CANS in 15 Minutes -> How to do an Update in 5 Minutes

Communications:

1. Provide a DBH contact info for parents who are unsure of what the CANS is and want to talk or email directly with a human.
2. Update YES website information on CANS and make sure all of it is organized and can be easily found.
3. Create a CANS "myth vs. fact" one pager to clarify misconceptions

The top three **long term** priorities recommended by each group are:

Portability:

1. Access for parents/youth to the CANS electronic record. Instant access for providers upon consent from parent/youth (similar to Idaho Health Data Exchange).
2. Reduce documentation burden by having information from a Comprehensive Diagnostic Assessment cross over to avoid redundant typing.
3. ICANS narrative carries over to updates and bubble ratings do not disappear at 100 days.

Training:

1. Offer CEUs for trainings.
2. Develop and implement a CANS 101 for university students and others
3. Implement regular CANS in practice trainings to emphasize use of the CANS throughout the course of treatment.

Communications:

1. Update documents and videos to reflect changes coming out of One Kid One CANS and replace outdated information.
2. Update ICANS user guidance to be more user friendly and focus on collaboration.
3. Provide basic CANS trainings for all YES system partners and providers.

Decision Point: Pursue a platform that would provide access to families and immediate access to providers upon consent from parents and youth

Conclusion

The Division of Behavioral Health's Center of Excellence will be a key contributor to improving the use of the CANS in Idaho. Having full time dedicated staff to work on these recommendations and particularly provide more frequent trainings will result in improved outcomes for youth and families. Improved outcomes have already been seen through the CANS Learning Collaborative's work on building Strengths in Idaho Youth.

Parent involvement in training will be a focus going forward. The Center of Excellence will work with Dr. Lyons' team at the Center for Innovation in Population Health to identify roles and how parents can participate in training of providers. Further work will be done to evaluate how family support partners, FYIdaho, and others with parent experience can help train providers to effectively use the CANS in consensus-based decision making.

The One Kid One CANS group has been well attended with many partners actively engaging and sharing ideas to improve Transformational Collaborative Outcomes Management in Idaho. It is recommended the One Kid One CANS group becomes the CANS Governance Council and continue meeting quarterly after the implementation of Idaho CANS 2.0 to continuously work on improving the CANS user experience.

Decision Point: One Kid One CANS workgroup becomes CANS Governance Council and continues to focus on improving user experience after implementation of CANS 2.0

Appendices

One Kid One CANS Charter

Frequency of Actionable Items

Idaho CANS 2.0 Draft Rating Sheet

Survey and Feedback Results

Subgroups Roster

Subgroups Initial Draft

Portability and Confidentiality Recommendations

Training Recommendations

Communications Recommendations

Meeting Notes

One Kid - One CANS Workgroup

Identify specific recommendations targeted to improve the CANS process, enhance user experience through simplification and education and continue to improve overall quality of care.

Team Summary

The CANS is a corner stone to the Idaho YES System of Care and is crucial to clients receiving effective and appropriate care. This workgroup will utilize diverse representation to empower a lean approach in completing projects. The work will need to consider the various components of our system currently being developed- specifically the ITN. Matching their projects to transition in other areas will be imperative to success.

Timelines

With an anticipated go live date of Winter 2022 the One Kid One CANS Workgroup should focus on projects that can be completed within six-twelve months.

Group Membership

Representation				
Co-Chairs: Kim Hokanson (Parent from Region 7) and Kyle Hanson (DBH)				
Mallory Kotze – Medicaid	Francesca Barbaro – Medicaid	Ashley Porter – Medicaid	Alex Childers-Scott – Medicaid	Britt Miller – Child Welfare
Val Johnson – DBH	Michelle Schildhauer – DBH	Youth Member	Possible Tribal Representation	Janet Hoeke – Parent from Region 4
Raini Bowles – Parent from Region 4	Andrea Emmons – Liberty	Wendy Seagraves – Ada County Juvenile Court Services	Mellisa Carlson – Heritage in Northern Idaho	Dr. Lyons – Praed
David Garret or Community Health Center Representative	Kelly Keele – Provider	Tori Torgrimson – Family Health Services	Brhe Zolber – St. Luke's Children's Center for Neurobehavioral Medicine	Matt Johansen – Optum Idaho
Jane Hart – Parent from Region 4	Amanda Davison – Parent from Region 4	Sara Bennett – Parent from Region 2	Dan Hall – Shoshone-Bannock Tribes	Jennifer Dickison, Kootenai Tribe

Roles and Responsibilities

Co-Chairs	Manage the group by organizing sub-groups, setting goals and objectives, facilitating meetings, and tracking progress, liaison with IGT Executive Committee, etc.
Workgroup administrative support	Support the documentation and scheduling of the larger One Kid One CANS Workgroup, assist in writing/producing memos & reports; liaison between the Department and stakeholders.

Sub-group leads, if needed	Organize the projects their respective sub-group is assigned to, facilitate the workgroup meetings, as well as recruit workgroup members to fulfill specific roles within that group.
Participants	Represent the needs/views of their respective stakeholder group and contribute their personal expertise and judgment. Attend CANS intro/training, make themselves available for meetings, contribute to group discussions and to developing work product, and complete volunteer assignments on time.
Praed Representative	Provide guidance to workgroup members on CANS design and implementation in Idaho.

Primary Objectives

Objective One: Streamline the CANS

Make the CANS easier to use and less time-consuming while maintaining the core purposes of determining eligibility for YES, improving communications among families and providers, and measuring and guiding treatment. This objective will rely heavily upon experts, including the Division of Behavioral Health, Medicaid, Optum, and Praed.

Steps to Implement Objective One:

1) The expert(s) will first prepare a report on key purposes for the Workgroup's review and comment.
2) With knowledge obtained from the Workgroup's review and comment, the experts will develop a CANS modification proposal or proposals to present to the Workgroup for review and comment. Having the benefit of the Workgroup's feedback, the experts will refine their proposal for presentation to IGT and subsequently to IDHW.
3) Assuming the modified CANS is approved, DBH, Medicaid, possibly FACS, and the MCO responsible for the IBHP will draw up a roll-out plan for adopting the new tool statewide. That plan would benefit from input by the Workgroup and/or IGT.

Step one is basically a research task that could be ready to present to the Workgroup in 30-45 days. Step two is more complicated and could be scheduled for three months with some wiggle room depending upon the availability of necessary experts. Step three —substituting an alternative CANS tool in practice—is the most complicated part of the process. Even if a new certification process is not needed, training and adjusting will be necessary, particularly for youth who already have a CANS. This roll-out could happen in FY 2023-24.

Outcomes and Timelines of Objective One

- Expert's report on Key Purposes…30-45 days
- CANS Modification Proposal…3 months
- An approved CANS Tool with reduced items…6 months
- Roll-out of re-developed tool… FY 23-24
- Evaluate/develop needed training for removed items…FY 23-24

Objective 2: Improve User Experience

Objective two will require the active participation of all the Workgroup members from the start. To begin, there will need to be some substantive training on what the CANS is or should be so that the Workgroup is coming from a shared understanding of the purposes and goals of the CANS. Having established an informed baseline, the next task will be to catalog the existing strengths and challenges of the CANS in practice in Idaho. These two steps should be completed within three months.

Outcomes and Timelines of Objective Two

- Discussion Sessions on actionable strategies… first 3 months
- Decision Point Report…3 months (post work group start)
- Implementation Plan for Solutions…4-6 months (post workgroup start)
- Launch solutions…FY 23-24

Team Operations

Team operations should be determined by the workgroup as established in order to meet the needs of the respective projects.

The workgroup will keep the IGT informed on progress toward the above objectives. Department staff will be responsible for providing status updates to their leadership and advising the Workgroup on pertinent State and Federal policy/contractual limitations.

Frequency of Actiontionable Items by Domain

Wiley T. Turner

2023-02-22

Frequency Tables

This is a random sampling of assessments from 34,410 children, The tables represent the frequency of items that are actionable by domain.

Trauma

Frequency and Percent of Items

Item	Count	Percent	Total Children
Disruption In Caregiving Attachment Loss	9429	27 %	34410
Emotional Abuse	7954	23 %	34410
Medical Trauma	2487	7 %	34410
Natural Manmade Disasters	1245	4 %	34410
Neglect	5292	15 %	34410
Parental Criminal Behavior	5807	17 %	34410
Physical Abuse	4610	13 %	34410

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Item	Count	Percent	Total Children
Sexual Abuse	3459	10 %	34410
Systems Involvement	5129	15 %	34410
Terrorism Affected	76	0 %	34410
War Affected	169	0 %	34410
Witness Community Violence	1019	3 %	34410
Witness Family Violence	7672	22 %	34410
Witness School Violence	1085	3 %	34410
Witness Victim To Criminal Activity	3518	10 %	34410

Child Risk Behaviors

Frequency and Percent of Items

Item	Count	Percent	Total Children
Bullied By Others	4615	13 %	34410
Bullying	1655	5 %	34410
Cruelty To Animals	495	1 %	34410
Danger To Others	2705	8 %	34410
Delinquency	1506	4 %	34410
Exploitation	1271	5 %	27139
Fire Setting	310	1 %	34410
Intentional Misbehavior	3090	9 %	34410
Judgement	6801	20 %	34410
Other Self Harm	2004	6 %	34410
Runaway Flight Risk	1243	4 %	34410
Self Mutilation	2232	6 %	34410
Sexual Aggression	273	1 %	34410
Sexual Reactive Behavior	600	2 %	34410
Suicide Watch	1692	5 %	34410

Child Behavioral/Emotional Needs

Frequency and Percent of Items

Item	Count	Percent	Total Children
Adjustment To Trauma	9974	29 %	34410
Anger Control	11993	35 %	34410
Anxiety	15374	45 %	34410
Attachment Difficulties	4343	13 %	34410
Attention Concentration	13241	38 %	34410
Behavioral Regressions	1784	5 %	34410
Conduct	2705	8 %	34410
Depression	10935	32 %	34410
Eating Disturbance	2300	7 %	34410
Emotional Physical Reg	16770	49 %	34410
Impulsivity	11836	34 %	34410
Mood Disturbance	7668	22 %	34410
Oppositional Behavior	8550	25 %	34410
Psychosis	752	2 %	34410
Somatization	2313	7 %	34410
Substance Use	1430	4 %	34410
Triangulation Manipulation	4343	13 %	34410
Trumatic Grief Separation	4845	14 %	34410

Strengths

Frequency and Percent of Items

Item	Count	Percent	Total Children
Community Life	14732	43 %	34410
Coping Skills	20361	59 %	34410
Cultural Identity	6521	19 %	34410
Educational Setting	9402	30 %	31783
Family	8250	24 %	34410
Interpersonal	13574	39 %	34410
Invovement With Care	8628	25 %	34410
Legal Permanency	3427	10 %	34410

Item	Count	Percent	Total Children
Optimisim	12121	35 %	34410
Peer Influences	10395	30 %	34410
Relationship Performanece	4984	14 %	34410
Resilience	12646	37 %	34410
Spiritual Relegious	14976	44 %	34410
Talents Interests	8102	24 %	34410
Use Of Free Time	9710	28 %	34410
Vocational	2521	33 %	7709

Life Functioning

Frequency and Percent of Items

Item	Count	Percent	Total Children
Activity Daily Living	4910	14 %	34410
Develop Intellectual	3905	11 %	34410
Family	12537	36 %	34410
Legal Issues	3501	10 %	34410
Living Situation	6185	18 %	34410
Medical	1937	6 %	34410
Physical	1024	3 %	34410
Recreational	5573	16 %	34410
School Achievement	8053	25 %	31815
School Attendance	3585	11 %	31303
School Behavior	6167	20 %	31317
Sexual Development	1133	3 %	34410
Sleep	9674	28 %	34410
Social Functioning	11128	32 %	34410

Culture

Frequency and Percent of Items

Item	Count	Percent	Total Children

Item	Count	Percent	Total Children
Identity	1078	3 %	34410
Language	568	2 %	34410

Transition to Adulthood

Frequency and Percent of Items

Item	Count	Percent	Total Children
Access To Child Care And Or Respite	188	8 %	2470
Educational Attainment	3081	23 %	13281
Financial Resources	1442	18 %	8004
Independent Living Skill	2430	19 %	12542
Intimate Relationship	1101	18 %	6144
Job Functioning	779	15 %	5356
Medication Compliance	1654	17 %	9851
Parenting Role	279	10 %	2872
Residential Stability	863	8 %	10227
Tran To Adult Services System	882	21 %	4175
Transportation	1295	14 %	9331
Treatment Involvment	1730	13 %	13685

Current Caregiver Strengths & Needs

Frequency and Percent of Items

Item	Count	Percent	Total Children
Caregiver Resources D Access To Child Care And Or Respite	4593	13 %	34410
Caregiver Resources D Culture Congruence	494	1 %	34410
Caregiver Resources D Developmental	250	1 %	34410
Caregiver Resources D Family Stress	11885	35 %	34410
Caregiver Resources D Financial Resources	4150	12 %	34410
Caregiver Resources D Involvment With Care	1642	5 %	34410
Caregiver Resources D Knowledge	3015	9 %	34410
Caregiver Resources D Marital Partner Violence	1051	3 %	34410

Item	Count	Percent	Total Children
Identity	1078	3 %	34410
Language	568	2 %	34410

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Caregiver Resources D Involvment With Care	1642	5 %	34410
Caregiver Resources D Knowledge	3015	9 %	34410
Caregiver Resources D Marital Partner Violence	1051	3 %	34410

Item	Count	Percent	Total Children
Restricted Interest	1114	29 %	3905
Self Expression Strength	1787	46 %	3905
Sensory	1474	38 %	3905
Sexual Behavior	265	7 %	3905
Solitary Palyfullness Strength	688	18 %	3905
Special Education	1824	55 %	3336
Temperament Emot Responsiveness	2551	65 %	3905
Transitions	2012	52 %	3905

Idaho Children's Mental Health
Child and Adolescent Needs and Strengths 2.0 -- DRAFT

Date:

Assessment Type: Initial ☐ Reassessment ☐ Major Life Event ☐ Exit/Discharge ☐

Child's Name: Child's Gender: M ☐ F ☐ T ☐

Child's Race/Ethnicity:

Caregiver Name: Relationship to the Child:

Assessor Name:

For the **Life Functioning Domain**, use the following categories and action levels:

0 No current need; no need for action or intervention.

1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

3 Need is dangerous or disabling; requires immediate and/or intensive action.

LIFE FUNCTIONING DOMAIN

Family Functioning	0 ☐	1 ☐	2 ☐	3 ☐	School Behavior	0 ☐	1 ☐	2 ☐	3 ☐
Living Situation	0 ☐	1 ☐	2 ☐	3 ☐	School Achievement	0 ☐	1 ☐	2 ☐	3 ☐
Social Functioning	0 ☐	1 ☐	2 ☐	3 ☐	School Attendance	0 ☐	1 ☐	2 ☐	3 ☐
Developmental/Intellectual	0 ☐	1 ☐	2 ☐	3 ☐	Legal Issues	0 ☐	1 ☐	2 ☐	3 ☐
Medical/Physical	0 ☐	1 ☐	2 ☐	3 ☐	Self-Care/Activ. of Daily Living	0 ☐	1 ☐	2 ☐	3 ☐
Sleep	0 ☐	1 ☐	2 ☐	3 ☐	Cultural Considerations	0 ☐	1 ☐	2 ☐	3 ☐
Sexual Development	0 ☐	1 ☐	2 ☐	3 ☐					

Please write a rationale for any item rated actionable ('2' or '3').

For the **Traumatic/Adverse Childhood Experiences**, use the following categories and action levels:

NO No evidence of any trauma of this type.

YES Child/youth has had experience or there is suspicion that child/youth has experienced this type of trauma—one incident, multiple incidents, or chronic, on-going experiences.

TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES

Sexual Abuse	No ☐	Yes ☐	Criminal Activity	No ☐	Yes ☐
Physical Abuse	No ☐	Yes ☐	War/Terrorism Affected	No ☐	Yes ☐
Neglect	No ☐	Yes ☐	Parental Criminal Behavior	No ☐	Yes ☐
Emotional Abuse	No ☐	Yes ☐	Disruptions in Caregiving/ Attachment Losses	No ☐	Yes ☐
Medical Trauma	No ☐	Yes ☐	Systems Involvement	No ☐	Yes ☐
Family Violence	No ☐	Yes ☐	Other Trauma	No ☐	Yes ☐
Community/School Violence	No ☐	Yes ☐	If yes, describe type:		
Natural or Manmade Disaster	No ☐	Yes ☐			

Please write a rationale for any item rated 'Yes'.

For the **Behavioral/Emotional Needs Domain**, use the following categories and action levels:

0 No current need; no need for action or intervention.

1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

3 Need is dangerous or disabling; requires immediate and/or intensive action.

BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

Adjustment to Trauma	0 ☐ 1 ☐ 2 ☐ 3 ☐		Oppositional Behavior	0 ☐ 1 ☐ 2 ☐ 3 ☐	
Emotional and/or Physical Dysregulation	0 ☐ 1 ☐ 2 ☐ 3 ☐		Conduct (Antisocial Behavior)	0 ☐ 1 ☐ 2 ☐ 3 ☐	
Psychosis (Thought Disorder)	0 ☐ 1 ☐ 2 ☐ 3 ☐		Substance Use	0 ☐ 1 ☐ 2 ☐ 3 ☐	
Impulse Control	0 ☐ 1 ☐ 2 ☐ 3 ☐		Attachment Difficulties	0 ☐ 1 ☐ 2 ☐ 3 ☐	
Attention/Concentration	0 ☐ 1 ☐ 2 ☐ 3 ☐		Eating Disturbances	0 ☐ 1 ☐ 2 ☐ 3 ☐	
Depression	0 ☐ 1 ☐ 2 ☐ 3 ☐		Somatization	0 ☐ 1 ☐ 2 ☐ 3 ☐	
Anxiety	0 ☐ 1 ☐ 2 ☐ 3 ☐		Anger Control	0 ☐ 1 ☐ 2 ☐ 3 ☐	
			Mood Disturbance	0 ☐ 1 ☐ 2 ☐ 3 ☐	

Please write a rationale for any item rated actionable ('2' or '3').

For the **Risk Behaviors Domain**, use the following categories and action levels:

0 No current need; no need for action or intervention.

1 Identified need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.

3 Need is dangerous or disabling; requires immediate and/or intensive action.

RISK BEHAVIORS DOMAIN

Items		Items	
Suicide Watch	0 ☐ 1 ☐ 2 ☐ 3 ☐	Delinquent Behavior	0 ☐ 1 ☐ 2 ☐ 3 ☐
Non-Suicidal Self-Injurious Beh.	0 ☐ 1 ☐ 2 ☐ 3 ☐	Decision Making	0 ☐ 1 ☐ 2 ☐ 3 ☐
Other Self-Harm (Recklessness)	0 ☐ 1 ☐ 2 ☐ 3 ☐	Fire Setting	0 ☐ 1 ☐ 2 ☐ 3 ☐
Danger to Others	0 ☐ 1 ☐ 2 ☐ 3 ☐	Intentional Misbehavior	0 ☐ 1 ☐ 2 ☐ 3 ☐
Sexual Aggression	0 ☐ 1 ☐ 2 ☐ 3 ☐	Bullying	0 ☐ 1 ☐ 2 ☐ 3 ☐
Runaway/Flight Risk	0 ☐ 1 ☐ 2 ☐ 3 ☐	Victimization/Exploitation	0 ☐ 1 ☐ 2 ☐ 3 ☐

Please write a rationale for any item rated actionable ('2' or '3').

For the **Transition Age Youth Domain,** use the following categories and action levels:

0 No evidence of any needs; no need for action.

1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 Need is interfering with functioning; Action is required to ensure that the identified need is addressed,

3 Need is dangerous or disabling; requires immediate and/or intensive action.

TRANSITION AGE YOUTH DOMAIN (Age 16+)

Independent Living Skills	0 ☐ 1 ☐ 2 ☐ 3 ☐	Job Functioning	0 ☐ 1 ☐ 2 ☐ 3 ☐
Transportation	0 ☐ 1 ☐ 2 ☐ 3 ☐	Transition to Adult Services	0 ☐ 1 ☐ 2 ☐ 3 ☐
Parenting/Caregiving Roles	0 ☐ 1 ☐ 2 ☐ 3 ☐	Accessibility to Child Care	0 ☐ 1 ☐ 2 ☐ 3 ☐
Medication Adherence	0 ☐ 1 ☐ 2 ☐ 3 ☐	Financial Resources	0 ☐ 1 ☐ 2 ☐ 3 ☐
Treatment Involvement	0 ☐ 1 ☐ 2 ☐ 3 ☐	Residential Stability	0 ☐ 1 ☐ 2 ☐ 3 ☐

Please write a rationale for any item rated actionable ('2' or '3') or 'Yes'.

For the **Risk Behaviors Domain**, use the following categories and action levels:

0 No current need; no need for action or intervention.

1 Identified need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.

3 Need is dangerous or disabling; requires immediate and/or intensive action.

RISK BEHAVIORS DOMAIN

Items		Items	
Suicide Watch	0 ☐ 1 ☐ 2 ☐ 3 ☐	Delinquent Behavior	0 ☐ 1 ☐ 2 ☐ 3 ☐
Non-Suicidal Self-Injurious Beh.	0 ☐ 1 ☐ 2 ☐ 3 ☐	Decision Making	0 ☐ 1 ☐ 2 ☐ 3 ☐
Other Self-Harm (Recklessness)	0 ☐ 1 ☐ 2 ☐ 3 ☐	Fire Setting	0 ☐ 1 ☐ 2 ☐ 3 ☐
Danger to Others	0 ☐ 1 ☐ 2 ☐ 3 ☐	Intentional Misbehavior	0 ☐ 1 ☐ 2 ☐ 3 ☐
Sexual Aggression	0 ☐ 1 ☐ 2 ☐ 3 ☐	Bullying	0 ☐ 1 ☐ 2 ☐ 3 ☐
Runaway/Flight Risk	0 ☐ 1 ☐ 2 ☐ 3 ☐	Victimization/Exploitation	0 ☐ 1 ☐ 2 ☐ 3 ☐

Please write a rationale for any item rated actionable ('2' or '3').

For the **Transition Age Youth Domain,** use the following categories and action levels:

0 No evidence of any needs; no need for action.

1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 Need is interfering with functioning; Action is required to ensure that the identified need is addressed,

3 Need is dangerous or disabling; requires immediate and/or intensive action.

TRANSITION AGE YOUTH DOMAIN (Age 16+)

Independent Living Skills	0 ☐ 1 ☐ 2 ☐ 3 ☐	Job Functioning	0 ☐ 1 ☐ 2 ☐ 3 ☐
Transportation	0 ☐ 1 ☐ 2 ☐ 3 ☐	Transition to Adult Services	0 ☐ 1 ☐ 2 ☐ 3 ☐
Parenting/Caregiving Roles	0 ☐ 1 ☐ 2 ☐ 3 ☐	Accessibility to Child Care	0 ☐ 1 ☐ 2 ☐ 3 ☐
Medication Adherence	0 ☐ 1 ☐ 2 ☐ 3 ☐	Financial Resources	0 ☐ 1 ☐ 2 ☐ 3 ☐
Treatment Involvement	0 ☐ 1 ☐ 2 ☐ 3 ☐	Residential Stability	0 ☐ 1 ☐ 2 ☐ 3 ☐

Please write a rationale for any item rated actionable ('2' or '3') or 'Yes'.

For the **Strengths Domain**, use the following categories and action levels:

0 Well-developed, centerpiece strength. May be used as a focus of an intervention/ action plan.

1 Identified and useful strength. Strength will be used ,maintained, or built upon as a part of the plan. May require effort to develop into a centerpiece strength.

2 Identified but not useful. Strength has been identified but require building or development efforts before it can be effectively utilized as part of a plan.

3 No current strength identified. Efforts may be recommended to develop a strength in this area.

STRENGTHS DOMAIN

Family Strengths	0 ☐	1 ☐	2 ☐	3 ☐	Community Life	0 ☐	1 ☐	2 ☐	3 ☐
Interpersonal	0 ☐	1 ☐	2 ☐	3 ☐	Relationship Permanence	0 ☐	1 ☐	2 ☐	3 ☐
Educational Setting	0 ☐	1 ☐	2 ☐	3 ☐	Resilience	0 ☐	1 ☐	2 ☐	3 ☐
Vocational	0 ☐	1 ☐	2 ☐	3 ☐	Involvement with Care	0 ☐	1 ☐	2 ☐	3 ☐
Coping and Savoring Skills	0 ☐	1 ☐	2 ☐	3 ☐	Use of Free Time	0 ☐	1 ☐	2 ☐	3 ☐
Optimism	0 ☐	1 ☐	2 ☐	3 ☐	Peer Influences	0 ☐	1 ☐	2 ☐	3 ☐
Talents and Interests	0 ☐	1 ☐	2 ☐	3 ☐	Cultural Identity	0 ☐	1 ☐	2 ☐	3 ☐
Spiritual/Religious	0 ☐	1 ☐	2 ☐	3 ☐					

Please write a rationale for any useful strength ('0' or '1') or strength to build ('2' or '3').

Survey and Feedback Results

One Kid One CANS Workgroup Survey

What Concerns do you have regarding CANS user experience in Idaho?

Response: What concerns do you have regarding CANS user experience in Idaho?	Via	Created At
The experience is getting in the way of getting the most out of the instrument	pollev.com/kylehanson1	##########
the 14 plus rule prevents many of us from releasing the cans	pollev.com/kylehanson1	##########
Items mirror each other and redundant	pollev.com/kylehanson1	##########
Redundant, retraumatizing, too long with 5 SED kids, not used by all providers,	pollev.com/kylehanson1	##########
sometimes it is done as a checklist	pollev.com/kylehanson1	##########
Keeps some providers from accepting medicaid	pollev.com/kylehanson1	##########
many do not show a narrative, and we do not usually have access to their CDA	pollev.com/kylehanson1	##########
CANS are not shared so not trauma informed	pollev.com/kylehanson1	##########
It is overly burdensome. There are other assessments that do a better job than the CANS at identifying needs and strengths. This is not a peer reviewed tool nor is it evidence based practice.	pollev.com/kylehanson1	##########
Most families have no idea why the CANS would be beneficial	pollev.com/kylehanson1	##########
Parents don't get a copy or agreement/understanding of the CANS before it is finalized	pollev.com/kylehanson1	##########
input is cumbersome	pollev.com/kylehanson1	##########
the repetition of questions. Does not feel useful at all as we capture all the same information in the CDA. Could be doing therapy and not logging into ICANS	pollev.com/kylehanson1	##########
Families unaware of what it is	pollev.com/kylehanson1	##########
It is causing provider administrative burden and has been cited as a primary reason why providers no long see children for services.	pollev.com/kylehanson1	##########
providers are not consistent with their ratings/responses	pollev.com/kylehanson1	##########
That it doesn't allow for there to be one CANS, is repetitive and focuses on checking the boxes correctly not how this helps	pollev.com/kylehanson1	##########
CANS and CDA are not integrated	pollev.com/kylehanson1	##########
Providers not rating similarly	pollev.com/kylehanson1	##########
The disorganization between all the different agencies and the usefulness for families	pollev.com/kylehanson1	##########
Multiple CANS, lack of appropriate and meaningful training for both providers and families.	pollev.com/kylehanson1	##########
the narrative does not carry over	pollev.com/kylehanson1	##########
ICAN, just doesn't work.	pollev.com/kylehanson1	##########
Not stream lined.	pollev.com/kylehanson1	##########
1. the system is not set up for true collaboration between providers	pollev.com/kylehanson1	##########

What ideas do you have to improve the CANS user experience?

Response: What ideas do you have to improve the CANS user experience?	Via	Created At
The billable model of pay for performance needs to change.	pollev.com/kylehanson1	##########
use Crisis Assessment Tool for crisis instead of CANS	pollev.com/kylehanson1	##########
No all patients are being seen in an outpatient clinic	pollev.com/kylehanson1	##########
let us bill for a phone call! to do the CANS with parents	pollev.com/kylehanson1	##########
improve understanding of what CANS is and how it is not a discovery tool.	pollev.com/kylehanson1	##########
Combine the CDA and CANS in a way that will work with different EHRs	pollev.com/kylehanson1	##########
free training that is collaborative between agencies (DBH, Medicaid) and the IBHP to help providers with best practices, TA for ICANS, hear feedback, etc	pollev.com/kylehanson1	##########
CANS shortened version to be used for youth crisis centers	pollev.com/kylehanson1	##########
Compensation for collateral contacts and time it takes to complete documentation.	pollev.com/kylehanson1	##########
Decrease services required to have a CANS done beforehand.	pollev.com/kylehanson1	##########
Shorter version used as screening for possible need of more in-depth services for those children not initially showing a higher level of care	pollev.com/kylehanson1	##########
improve the CANS administrative input and access for providers to see their patient's CANS	pollev.com/kylehanson1	##########
shorten CANS items	pollev.com/kylehanson1	##########
make it a standard that WE all use the YES/NO for trauma section	pollev.com/kylehanson1	##########
system similar to data exchange for all to access	pollev.com/kylehanson1	##########
reduce who does the CANS	pollev.com/kylehanson1	##########
Decrease number of items on CANS and/or extend review window	pollev.com/kylehanson1	##########
To provide better training for providers and families.	pollev.com/kylehanson1	##########
Reduce the Liberty CANS to the minimum amount of information required to determine eligibility.	pollev.com/kylehanson1	##########
use the CANS 50	pollev.com/kylehanson1	##########
1 shared EHR to put CDA in that links to CANS items.	pollev.com/kylehanson1	##########
integrate the CDA and CANS	pollev.com/kylehanson1	##########
1. Narrative carries over	pollev.com/kylehanson1	##########
Reduce the number of items on the CANS and move to completing on an annual basis, not every 90 days.	pollev.com/kylehanson1	##########
Less questions on the CANS, do it once a year	pollev.com/kylehanson1	##########

Compiled Results of Identified Issues and Subgroup to Address

IDENTIFIED ISSUES	*Communications, Portability/Confidentiality, Training, Streamlining (Continue with CDA/CANS - Practice and Policy Issues)
The experience is adverse	T,S*
the 14 + rule prevents releasing the cans	P
Items mirror each other	S
Redundant	T,P
Retraumatizing	T, S
Too much for multiple kids	T, S, P
Not used by all providers	T, P, C
Sometimes it is done as a checklist	T, S, C
Keeps some providers from accepting medicaid	S, T, C
Many do not show a narrative	T, C, S
We do not usually have access to their CDA	T
CANS are not shared so not trauma informed	T, P, C
It is overly burdensome.	S, T, P, C
There are other assessments that do a better job than the CANS at identifying needs and strengths.	T, S
This is not a peer reviewed tool nor is it evidence based practice.	T, C
Most families have no idea why the CANS would be beneficial	T, C
Parents not allowed to reach agreement/understanding of the CANS before it is finalized	T, P
Parents not given a copy of finalized CANS	T, P
Input is cumbersome (ICANS)	T, S
The repetition of questions. Does not feel useful at all as we capture all the same information in the CDA.	S, T
Could be doing therapy and not logging into ICANS	P
Families unaware of what it is	T, C
It is causing provider administrative burden.	S, T
Providers are not consistent with their ratings/responses	T,
That it doesn't allow for there to be one CANS, is repetitive and focuses on checking the boxes correctly not how this helps	T, P
CANS and CDA are not integrated	S, T
Providers not rating similarly	S, T, P
The disorganization between all the different agencies and the usefulness for families	C, P, T
Lack of appropriate and meaningful training for both providers and families.	T
ICAN, just doesn't work.	P, S, T
Not streamlined.	S
The system is not set up for true collaboration between providers	P, T (how to do narrative well, not starting over)
Yearly training, testing, and entering materials is sometimes difficult.	T, S (schoox)
Difficult to find staff to ask questions about clients.	T, P (CFT and collateral)
CANS viewed as "extra work"	S, T, P, C
Not recognizing benefit of CANS for both providers and families.	T
The time spent on assessments, updates, and documentation hinders evidence based practice research.	S, T, P, C
CANS reporting timelines seem to be a disruption to families.	T, S
Unbillable work such as CANS training, re-certs, 90-day reviews.	T, S
Alerts, CANS, assessments make it difficult to recommend other providers that have high caseloads	S
Paperwork overwhelming, redundant, and extremely frustrating to track.	S, T
Paperwork, CANS and threat of audits.	S, T, C
Requirement to complete CANS for youth is professionally insulting.	T, C
Creates barriers to services	S, P, T
CANS should replace any required yearly reviews.	S
Shorter follow-up version for 90 day review.	T
CANS eliminated for outpatient psychotherapy.	C, S
90 day reviews take away from the clinical aspects of tx.	S, T
90 day reviews are redundant and should be every 180 days.	S, T
Concerns that CANS being pushed on adults.	
Initial CANS takes 1-1.5 hrs with parent.	S, T
CANS update 2 hrs per client.	S, T
Parents complain they are "in a meeting to review something" too often.	T, S, C
Providers talk to parent about child as though child isn't present.	T
Children being required to be present for entire CANS.	
Providers not preparing family for expectations and leaving kids traumatized.	T
Providers viewing CANS on complaint and problem tracking vs. assessment on Strengths and Needs	T, C
ICANS set up to lose information if ICANS isn't updated every 90 days.	P
Providers penalized if CANS not done/inputted within specific time frames.	P
Is there a way, without violating privacy, for all community providers who work with the kiddos to have access to the iCANS system? That way they can add comments on the system. Creating different sections to avoid violating privacy but where the information is available for the people who need to see changes in the child overtime.	
EHR concerns and SS #	Portablity

Subgroup Roster

Streamlining the CANS

Name and Organization	Contact:
Brhe (St. Luke's outpatient clinical director)	Brhe Zolber <zolberb@slhs.org>
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Stephenie or Tori (Family Health Services in Twin)	shebert@fhsid.org Tori Torgrimson <ttorgrimson@fhsid.org>
Shawna (owner of Children Support Services in Idaho Falls, original CANS workgroup member)	Shawna TenEyck <shawnatcss@gmail.com>
Mellisa (clinician and QA for Heritage in CDA)	Mellisa Carlson <maCarlson@myheritagehealth.org>

Training Subgroup

Kim (Parent co-chair of OK1C)	Kimberly Hokanson <gkhokanson@gmail.com>
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Portability Subgroup

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Communication Subgroup

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OK1C Subgroups Initial Draft

Objective 1: Streamline the CANS – facilitated by Dr. Lyons (Matt, Mallory, Francesca, Val, Andrea, Raini, Kim and Wendy)

- CANS takes a long time

Objective 2

Training

- How to complete more easily (updated FAQ with videos)
- Concerns with frequency of updates
- Combine with other appointments
- Strengths based - Care when gathering information with youth present

Confidentiality vs Portability

- Transferring from one agency to another – other ICANS concerns
    - 100 day start over, Trauma Domain – Yes, No
- Feasibility of platform that is immediately accessible (Idaho Health Data Exchange)
- *Youth Crisis and Assessment Centers, hospitals*
- Providing a hard copy to families (Starts with Liberty)

Communications

- Website review **-**Currently spread across YES, TCOM, and ICANS
- Format for CANS Collaboratives or Lunch and learns
- YouTube channel or other on demand opportunities.

One Child One CANS Portability

What are some easy to implement suggestions (could be implemented in the next 6 months)?

A. Every family gets a copy every time! (training and advertising to providers)

B. Work with Liberty to make providing the annual CANS a part of the standard policy

C. ICANS consent for referral process needs advertising/training to providers. Share information on what to do if the other provider won't release the information.

D. Updated ICANS informed consent form (add DOB other identification form, not a SS#)

E. ICANS FAQ – clarifying information on DHW sharing (treatment, payment, and healthcare operations)

What are some long-term ideas for improving CANS access and information sharing?

A. Access to CANS is set to provide verified access for those whom parents have provided access, with audit function to ensure access is appropriate. There are already significant punishments for accessing information you are not allowed to access via HIPAA - loss of licensure and 50K per violation. Parents (and youth old enough) should have access to their own electronic records. Ideally an EHR – that has instant access upon consent from the parent/youth. (similar to Idaho Health Data Exchange). Parents shouldn't be responsible for transferring/consenting between providers but should have the option/easy access.

B. Information from CDA and CANS crosses over/auto populate to avoid redundant typing.

C. ICANS – narrative carries over to updates and bubble ratings do not disappear at 100 days. Updated CANS automatically populates with current CANS so providers can simply update the selection and narratives as appropriate.

D. Creating a new client process needs to be simplified to avoid duplicate records in ICANS. Prompts regarding merging clients are confusing. Also should be able to unmerge if a mistake is made. Need to be able to easily link by verifying information. Unique ID process that is utilized and eliminates need for SSN. Would still need to verify DOB, address, etc.

E. Clarifying guidance or protocol for sharing with schools, probation, court, caseworkers etc. that are not providers. Particularly during crisis. (addendum to FAQ?)

F. Drop down diagnosis codes in ICANS align with ICD or DSM 5 (i.e. Autistic Disorder, SUD codes)

G. ICANS due dates for updates need to be based on last update not just 90, 180, 270 from initial CANS.

One Child One CANS Training

Training Subgroup will review current curriculum for certification, in practice and supervision trainings. Ideas for improvement and launch of in practice and supervision trainings. How can we involved parents and engage others in training efforts

Review and improvement of current training curriculum (could be implemented in the next 6 months)?

☐ More training to emphasize how CANS is not a separate assessment

☐ Parent Education – Youtube videos, handouts, resources to be given by providers. Remove "series of questions" from current CANS for Families video. Explain benefits of CANS with parent involvement

☐ Sequel to CANS in 15 Minutes -> How to do an Update in 5 Minutes. Title may need re-worked.

☐ Revamp the training to explicitly state what the CANS is and why it is useful to providers. Clear directions on who can be certified in CANS. (student/professional, masters/bachelors, discipline)

☐ Investigate the differences between our current trainings and Praed's current trainings

☐ Re-education for those who were already trained.

What are some long-term ideas for improving CANS training?

☐ Offer CEU's for trainings

☐ Include parent voice in trainings through a variety of means. Live parent perspective if possible.

☐ Develop and implement CANS 101

☐ Implement CANS in Practice Training and include what the CANS is used for (decision support)

☐ Direct Parent Education

☐ On-Demand Segments for Refreshing knowledge

☐ Condense the trainings

☐ Tech support for provider – Live person to talk to

☐ Agency Process and Owner Training

☐ Live Trainings

☐ Community Stakeholder Training – Broad (primary care providers, education, and legal)

☐ Funding for Providers or Families if trainings are required

☐ Fix the interface and train on how to use it in performing the CANS

☐ Implement CANS in Supervision Training

☐ Using other trainings as recertification training.

☐ Interrater reliability training added to Supervision Training

☐ Mentoring/QA example for providers

One Child One CANS Communication

Communication Subgroup will address current websites, videos, documents and how they can be organized and updated. Consider options for future videos, handouts, flyers, newsletters etc. Gather ideas for collaborative meetings or other efforts to engage stakeholders in TCOMWhat are some easy to implement suggestions (could be implemented in the next 6 months)?

- ☐ Streamline and clean up the ITI website
- ☐ The YES website has a lot of information about the CANS, but it's spread through various pages. We could create a CANS specific page/section to house all the materials.
- ☐ Provide a DBH contact info for parents who are unsure of what the CANS is and want to talk or email directly with a human – websites are confusing, and many parents don't have the time to wade through all the content, and just want to talk to someone real. *A designated number to the TCOM Program Specialist in DHW for families and the community.*
- ☐ Consider creating a CANS "myth vs. fact" one-pager that is on the YES website that can also be printed out and used by providers to address some common misconceptions, i.e., that providers are incentivized financially by Optum to due multiple CANS on the same kiddo.
- ☐ Reach out to Optum to see what marketing opportunities they can provide related to the CANS.
- ☐ Work with IDHW communications to get the word out about the CANS: IDHW Facebook, all IDHW newsletters, etc. (talk to other programs trying to market IDHW initiatives such as TFC and foster parent recruitment).
- ☐ Ask parents what they feel is missing or what we could explain better or in more detail. Fill in those gaps.
- ☐ Have a CANS focus group, and the primary task is to ask about marketing/ rebranding of the CANS.

What are some long-term ideas for improving CANS collaboration and communication?

☐ The ICANS system seems like it could use some updates to make it more user friendly. May be out of our hands, but it's something we could suggest to whoever has that power.

☐ More training for providers on the benefits of collaboration. I have heard there may be something in the works for providers to be paid for the time they consult with each other on a client's CANS and care. That may help as well.

☐ Provide streamlined communications and basic training for internal IDHW staff about the CANS.

☐ Ensure the messaging and process guidance documents relayed by the EHR (currently ICANS) matches the spirit and intent of the CANS.

☐ Update documents and videos to reflect any changes coming out of the One Kid One CANS work and replace any outdated information.

One Kid One CANS Meeting Notes


One Kid One Cans Meeting.docx


One Kid One CANS Notes. 1.18.23.docx


OK1C Meeting Notes 2-8-23.docx


OK1C notes 3.8.23.docx


OK1C notes 4.12.23.docx


OK1C notes 5.10.23.docx


OK1C notes 6.14.23.docx