Meeting Notes

Division: Department of Health and Human Services, Iowa Medicaid

Meeting Topic: REACH Implementation Team: Intensive Care Coordination Subcommittee

Facilitator: Jenny Erdman, HHS

Date: 09/17/2025

Time: 4:00 PM

Location: Virtual

Meeting Objectives

Implementation Team meetings create the opportunity for key stakeholders to facilitate and support the adherence to the Iowa REACH Initiative Implementation Plan objectives and activities and to provide coordinated oversight and recommendations to ensure the success of the Iowa REACH Initiative.

Meeting Participants

- Amy Berg-Theisen
- Daron Harris
- Ginger Kozak
- Gretchen Hammer
- Jenny Erdman
- Kati Swanson
- Katie Fuller
- Kim Cronkleton
- Marisa Cullnan
- Mindy Williams
- Nicki Enderle
- Sara Richardson
- Tresa Stearns

Agenda Topic and Items

- Eligibility for the highest tier of care coordination services

  - Participants discussed risk factors and indicators of a high need for intensive care coordination, including PMIC history, family history with substance use, incarceration, child abuse or allegations, issues at school, or special needs such as a 504 IEP.
  - Participants discussed commonalities among youth and families who benefit from intensive care coordination.
    - One participant mentioned involvement in the foster care system, particularly families with failed adoptions or children who were adopted young and encounter challenges during adolescence, who often end up at PMIC or in shelters. Another participant identified children who are not permitted to attend school due to mental health challenges and are kept at home often benefit from intensive care coordination.
    - Another participant shared that when acuity is lower, patients are more likely to take advantage of services that are provided. When a case is more critical or acute, patients take advantage of services less due to a number of barriers: poverty, family history mental health struggles, level of consistency to access care, etc.
- Accessing care coordination following assessment
  - Iowa HHS provided an overview of REACH eligibility criteria and the recommended Child and Adolescent Needs and Strengths (CANS) assessment tool.
  - Participants discussed the best ways to connect folks to services following an assessment that meets the eligibility requirements.
    - One participant uses the CANS assessment in a different state to facilitate home visiting in a rural area and foster personal relationships with the entire family.
    - Another participant has seen the most success with a warm handoff or when providers make connections directly. Families trust their home visitors and making direct connections can foster trust in the new service.
    - Another participant explained that sometimes referral services act as a barrier themselves when they require a lot of clicks to get information. There should be a direct number or point of contact to improve accessibility.
  - Participants discussed how folks are currently connected to care coordination for urgent needs when they are enrolled but have not had an assessment.
    - One participant has a rotating provider on-call seven days per week. They do not turn away urgent or crisis calls in the absence of an assessment or paperwork; they try to find out more about the needs to see what can be done prior to the assessment.
    - Under PMICs (psychiatric medical institutions for children), a case manager manages the client's transition in and out of the facility. Upon

discharge, there is an automatic BHIS request for authorization. At this point, someone connects with the family to help their transition home and connect them with new providers.

        - Another participant identified that mobile crisis services might meet this need. Someone can get immediate crisis intervention at an outpatient mental health clinic that maintains open evaluation times for urgent cases.
    - Every young person who will access REACH services needs a CANS assessment to be completed. Participants discussed whether the CANS assessment provides sufficient information to inform intensive care coordination engagement, or whether additional assessment would be required to determine intensive care coordination services.
        - One participant noted that REACH eligibility states that the consumer must be diagnosed with a serious emotional disturbance and that CANS cannot make a diagnosis, therefore supports another assessment for to inform intensive case coordination.
        - Participants expressed interest in a portal that allows care coordinators to see CANS scoring, expressing that it would be a great way to track progress.
        - One participant noted that this is similar to the process for behavioral health intervention services (BHIS), which requires a strengths and difficulties questionnaire is required every 3 months to reauthorize the client. The new score is included in the treatment plan to record progress.
- Elements of care coordination services
    - Participants discussed how the state could operationalize a service that moves through care tiers to align with a child's needs.
        - One participant shared that the previous intensive case management model had one coordinator serve a client through all levels of service, which was a main benefit of the program.
        - Another participant shared that retention is good for folks who know they are switching services, but not for folks who are switching case management support providers.
        - Participants agreed that a care coordinator should follow a family through care tiers, but it would be nice for coordinators to have a maximum number of families according to the intensity of needs. The state may be able to look to Illinois for more operational details from their case management program.
    - Participants discussed the role of the care coordinator in engaging the family about potential services, organizing providers, and drafting the initial care plan.
        - The care coordinator should be in charge of drafting the care plan. Under the current system, coordinators receive a referral from a clinician with suggested BHIS goals. These goals may differ when they are seen in a clinical setting versus at home.

- The coordinator will then communicate with providers during treatment to adjust the care plan in accordance with what is working and what new needs are coming up.