Intensive Care Coordination Subcommittee Meeting

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IOWA Health and Human Services

Agenda

- Service Components
- Providers
- Public Comment

Service Components

Assessment

Settlement Agreement

- Care planning process includes:
  - completing a strengths-based, needs driven, comprehensive **assessment to organize and guide the development of a Care Plan and a risk management/safety plan**;
  - an assessment process that determines the needs of the child for **medical, educational, social, behavioral health, or other services**;
  - an ICC that may also include the planning and coordination of urgent needs before the comprehensive assessment is completed;
  - further assessments that are provided as medically necessary and in accordance with best practice protocols.

Subcommittee Feedback

- Assessments should reflect a family's needs and not just produce a score
- Assessments should occur at least once a year to document changing needs and adjust the care plan
- However, we should be mindful of over-assessment
- The care plan should include clear goals and a path out of care based on assessment results

Planning and Development of a Person-Centered Plan

Settlement Agreement

- The care planning team (CPT) process will include:
  - having the care coordinator use the information collected through an assessment, to **convene and facilitate the CPT meetings**;
  - having the CPT develop a child-guided and family-driven PCP that **specifies the goals and actions** to address the medical, educational, social, mental health, and other services needed by the child and family; and
  - ensuring that the care coordinator works directly with the child, the family, and others significant to the child to **identify strengths and needs** of the child and family, and to **develop a plan** for meeting those needs and goals.

Subcommittee Feedback

- Overall, this is similar to the role care coordinators currently fill in Iowa
- Initial outreach should be tailored to the family, including asking about their wants and needs and informing them specifically about relevant services
- It can be difficult to involve providers in care planning if they cannot bill for it

Referral, Monitoring, and Related Activities

Settlement Agreement

- The care coordinator will:
  - **work directly with the child and family** to implement elements of the Person Centered Plan (PCP);
  - **prepare, monitor, and modify the PCP** in concert with the CPT and determines whether services are being provided in accordance with the PCP; whether services in the PCP are adequate; and whether there are changes in the needs or status of the child and, if so, adjusts the PCP as necessary, in concert with the CPT; and
  - actively assists the child and family to **obtain and monitor the delivery of available services**, including medical, behavioral health, social, therapeutic, and other services

Subcommittee Feedback

- Access after referral can be a challenge
- Referrals should have a closed loop that confirms whether families were able to access services
- HHS should be mindful that monitoring rules are not burdensome to families

Transition

Settlement Agreement

- The care coordinator will:
  - develop a transition plan with the CPT, and implement such plan when the child has achieved the goals of the PCP; and
  - collaborate with the other service providers and agencies on behalf of the child and family.

Subcommittee Feedback

- The state should ensure there are transitional providers and services available
- There should be a clear process for transition aged youth, including
  - Clear information about how processes and services change in adulthood
  - Connection with adult services before the child turns 18

Discussion

- Is there anything else we haven't discussed that we'll need to do to reach the goals of the settlement agreement?

- Are there other commonly delivered intensive care coordination services in Iowa that we should consider discussing?

Providers

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Principles for ICC Providers

- There should be clear roles, including an assigned "lead" coordinator to reduce duplication and ensure accountability

- Care coordinators and providers should prioritize relationship-building, consistent communication, and follow-through

- Any team member can become a trusted contact for families

Potential Care Coordinators

- **REACH intensive care coordinator**
  - Could require additional training, such as trauma-based care training, for these providers
- **Existing case managers and social workers**
  - May have a strong existing relationship and understanding of the youth and family's needs
- **Peer supports**
  - Have a personal relationship with members and should inform care planning
  - May have an informal coordination role connecting families to support services
- **Other providers**
  - Trusted providers may become key contacts for families

Discussion

- How should the "lead" care coordinator be identified?
- Will the same person organize all aspects of care coordination, including assessment, care plan development, referral and monitoring, and transition?
- What supports will care coordinators need to deliver effective services?

Public Comment

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