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: 10/15/2025

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

- Jenny Erdman
- Will Linder
- Derek McComas
- Ginger Kozak
- Nicki Enderle
- Kati Swanson
- Kim Cronkleton
- Katie Fuller
- Daron Harris
- Stephen Mandler
- Amy Berg-Theisen
- Sara Richardson
- Tresa Stearns
- Nikki Thomson
- Addie Kimber
- Sari Reiter

Agenda Topic and Items

- Intensive care coordination service components
    - Assessment: The group reviewed the settlement agreement care coordination requirements. Per the settlement agreement, an assessment must be completed to drive the care plan. HHS facilitated a discussion on how the recommended assessment tool, the CANS, can drive the care plan.
        - Participants noted that the CANS is not sufficient to drive a care plan by itself, and that clinical referrals, social history, and other factors are important to consider outside the assessment score.
        - Participants discussed the need for ongoing assessment to continue shaping the care plan. Participants agreed that it makes sense to perform assessments every 6 months, with additional assessments if there are major changes in the member's circumstances or clinical status
    - Person-centered care planning: Intensive care coordination will also include development of a child-guided, family-driven, person-centered plan. HHS described current subcommittee feedback on this service, and facilitated discussion on additional considerations from the subcommittee.
        - Participants recommended that care planning should involve both the family and the treatment team, and that families should have autonomy to make decisions about their treatment plan.
        - A participant noted that it can be challenging to gather the whole team for care planning.
            - To address this, another participant mentioned a system in the UK called "Team Around the Family" where the family appoints one individual whom they feel the most connected with to lead care planning and be a negotiator

for the family. This could allow families to be represented even if they cannot meet with all providers.

- Participants suggested that this could be the role of a peer support provider or a care coordinator if they can build a strong relationship with the family.

- Participants noted the importance of including social determinants of health in the care plan. Often, families face significant challenges beyond their child's behavioral health needs. This may look like connecting families to resources or being cognizant of families' situations when doing care planning.
- Participants agreed that care coordinators should meet the family where they are at and tailor their work to a family's unique needs and goals.
- Participants noted that REACH care coordinators should have lower caseloads than other case managers so that they have capacity to build rapport with families and can facilitate 'warm handoff' introductions to necessary services

- Referral and Monitoring: Under the settlement agreement, the care coordinator will work with the family to implement elements of the person-centered plan, monitor it as needed, and assist the family to obtain available services. HHS facilitated discussion on how to enhance referrals in REACH.
    - Participants confirmed that there should be a closed-loop referral process where the care coordinator confirms a family is able to access the services they need. With lower caseloads, closed loop referrals should be more feasible.
    - Participants raised that services must be available for referrals to be successful. If providers and services are not available, member progress will be slow. Coordinators will also be hesitant to recommend services that may not be available.

- For example, in-home family therapy is not widely available in the state. Families sometimes request respite services so they can receive service and maintain their spot on the waiver, even thought they do not need respite services. If other services were more available, this wouldn't happen.

- Participants recommended that case management check-ins occur more than monthly due to the intensity of needs for REACH participants.
- Participants suggested that the care plan should be revisited roughly every 6 months. This should include a simple check-in with providers about whether they believe services are still needed.
    - This check-in should be a conversation and not a form for providers and families to fill out. Currently, form requirements can sometimes cause services to expire even if a provider has verbally suggested the member should continue receiving services.

- Transition: HHS facilitated discussion on how care coordinators can ensure a successful transition out of REACH.
    - Participants noted that it can be challenging to find providers currently, which may make transitions out of REACH harder. A strong provider network or community can help facilitate a wide and strong safety net for families. It is best if providers can directly contact each other to discuss referrals.
        - A participant recommended that there is a warm handoff to the care coordinator who will take over after REACH services end. This care coordinator could then connect the family to new services, instead of the family being overwhelmed with introductions to new providers from their intensive care coordinator as REACH services end.

        - Participants also recommended a long runway for youth who will be aging out of REACH. This should include early conversations with youth about the types of services they can access as they get older. One participant noted that some older teenagers may distance themselves from their families, so it is important to start early discussions with youth who are 16 and older.
- Public Comment
    - None.