Iowa REACH Implementation Team Meeting

9/9/2026

IOWA Health and Human Services

Agenda

- REACH updates
  - What we're learning through current stakeholder engagement
  - How feedback is shaping REACH implementation
  - Where additional infrastructure and support are needed
  - Key priorities as we move toward implementation
- Intensive Care Coordination Roles

REACH Updates

Multiple Workstreams Moving Forward

REACH implementation is advancing across several interconnected areas, and these workstreams are increasingly linked as we prepare for statewide implementation.

Stakeholder engagement & feedback

Ongoing engagement with plaintiffs' counsel and system partners. Draft documents were submitted for review, and the team is now working through their feedback internally.

Model refinement

Continuing to clarify key components of the REACH model, for example, clarification of ICC roles, and the decision to fold behavior modeling, skill-building, and family education into the core ICC position.

System alignment

Mapping REACH against existing systems and models, including Systems of Care, the Intercept model, and HOME, to identify overlap and reduce duplication.

Cross-department coordination

Keeping REACH aligned with broader Medicaid and policy changes, including HOME state plan changes, habilitation/CCO changes, and capitation updates.

Feedback Is Helping Refine the Model

Our internal review found:

- Feedback from plaintiffs' counsel has been largely positive
- Broad alignment with the direction of the REACH documents
- Relatively few areas of misalignment
- Real opportunities to better explain the rationale behind key decisions

Areas discussed with plaintiffs' counsel:

- Practice model naming
- ICC caseload and staffing guidance
- Service definitions - specifically around skill-building
- Due process and appeal rights
- Other family protections

What this means for implementation

We have submitted documents to plaintiffs' counsel as part of the federal settlement and met internally to review the counsel suggestions. Clear, documented explanations for our decisions will be important as REACH moves forward.

ICAN Training: Building a Sustainable Approach

Iowa Comprehensive Abilities and Needs assessment — Current focus: translating training requirements into an operational process.

Questions we're working through

- How should ICAN training be structured internally?
- What will certification look like?
- How do we prepare our staff, and support provider partners?
- What infrastructure is needed as participation grows?
- How do we maintain consistency across providers and locations?

Implementation implication

We've met with the Praed Foundation and the University of Chicago to gain insight and develop a clear, sustainable training approach, essential for quality and consistency as REACH expands statewide.

REACH Must Fit Within the Larger System

REACH will intersect with existing systems, programs, and referral pathways. We're continuing to map REACH against:

Systems of Care	**The Intercept model**	**Existing referral pathways**
Related programs and services	**Medicaid policy changes**	**Capitation changes**

Why this matters — this work can help us:

Identify overlap and gaps • Clarify roles and responsibilities • Streamline referrals • Reduce duplication
• Improve coordination across systems

A concrete example: the Youth Villages Intercept crosswalk

The grant-funded Youth Villages Intercept program starts in January. We've decided to build a crosswalk between REACH, Systems of Care, and Intercept as an educational tool to spot overlap and improvement areas. Successful implementation depends not only on how REACH works internally, but on how it connects to everything around it.

Building a Fidelity Model

Ensuring REACH is implemented as intended, while allowing for local context. We're working with CEBH at the University of Iowa and exploring the University of Iowa Behavioral Health Center of Excellence for ICC training and fidelity monitoring, to develop a REACH fidelity model.

- Define the core components of REACH that should be consistently implemented
- Develop a shared understanding of high-fidelity implementation
- Support providers and partners as they build and sustain REACH practices
- Distinguish essential model elements from areas where flexibility may be appropriate
- Identify opportunities for ongoing monitoring, feedback, and improvement
- Create a framework for understanding variation across settings statewide

Key takeaway

Fidelity isn't a rigid, one-size-fits-all model. It's about consistently keeping the elements that make REACH effective, while recognizing differences across communities, organizations, and implementation contexts.

What These Lessons Suggest for Implementation

Three priorities are emerging:

Across all three: continue creating opportunities for feedback and adjustment.

1

Clarity

- Clear model definitions
- Clear expectations and roles
- Clear communication about decisions and timelines

2

Capacity

- Adequate staffing
- Training and certification
- Resources for providers and implementation partners

3

Coordination

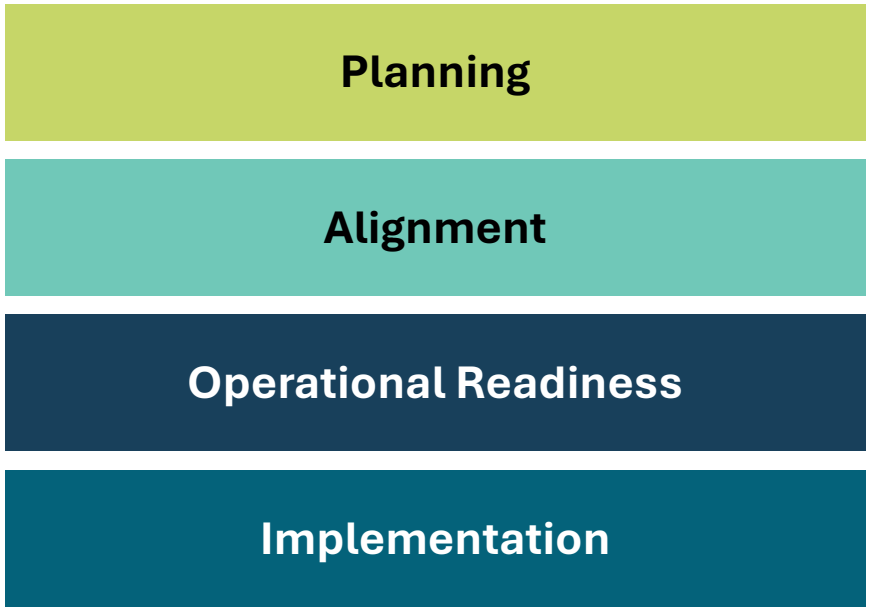
- Strong connections with existing systems
- Consistent cross-department communication
- Clear referral pathways and system interfaces

What's Coming Next

Near-term priorities:

- Present our progress and responses to plaintiffs' counsel
- Continue refining REACH documents and implementation decisions
- Advance ICAN training and certification planning
- Continue REACH / Systems of Care / Intercept mapping
- Coordinate with other departments as Medicaid policy changes progress
- Prepare potential community providers as early-adoption REACH providers
- Continue engaging partners to identify implementation needs

Overall Direction



What Do We Need to Get Right?

We'd like the Implementation Team's perspective:

What are you hearing?

- Do these themes align with what you're hearing from partners?
- Where are you hearing something different?

What should we anticipate?

- Where do you see the biggest implementation challenges?
- What questions or concerns are likely to emerge?

What support is needed?

- What will providers and communities need to feel prepared?
- Where might additional training, communication, or capacity be needed?

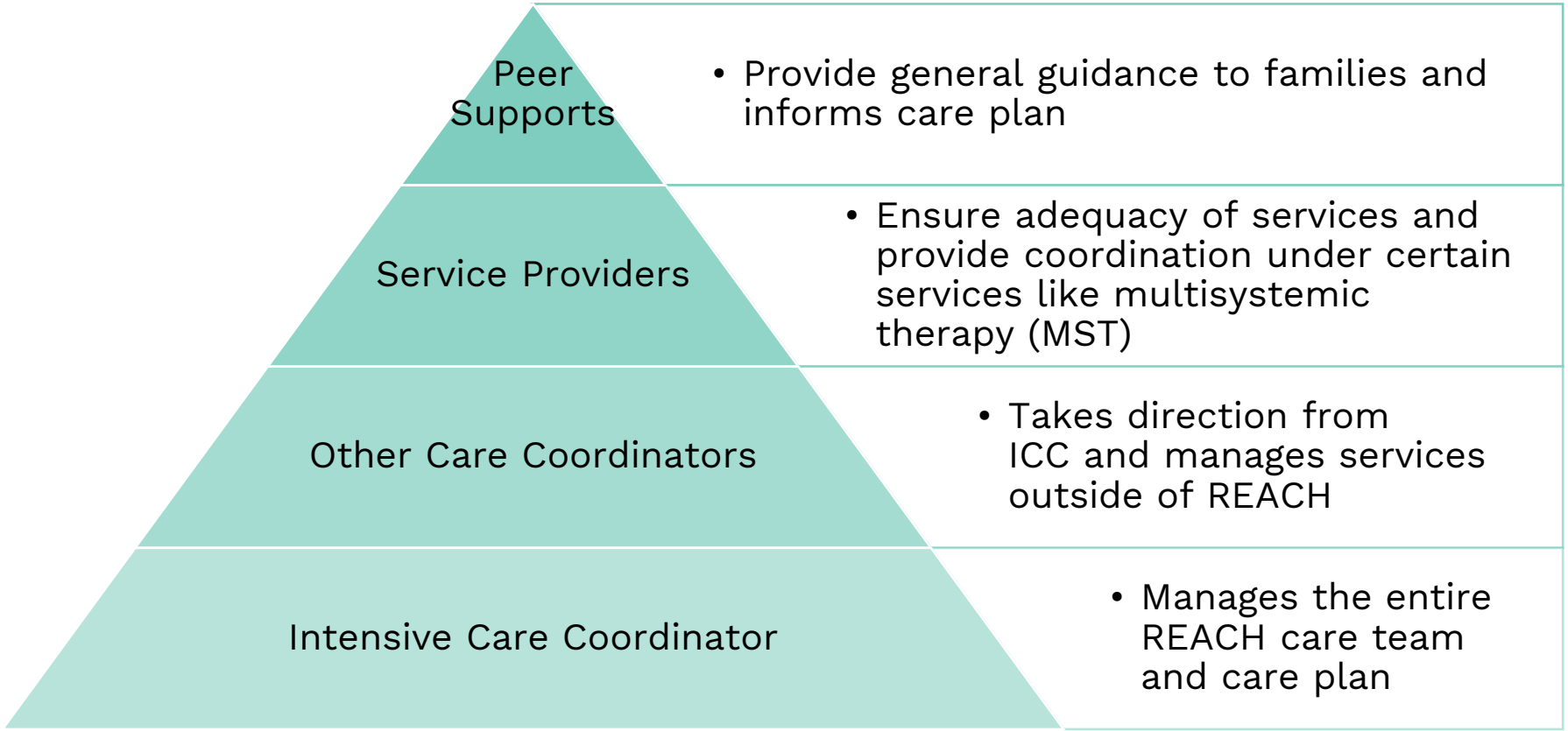
What should we focus on now?

- What should REACH prioritize before implementation?
- Are there stakeholders or system connections we should engage more deeply?

Intensive Care Coordination Roles

Roles involved with ICC

Each team member brings different expertise, but youth and families should experience one coordinated team.



Role Responsibilities

* Also called “case managers”

Intensive Care Coordinator

- Builds and facilitates the Care Planning Team
- Coordinates the individualized plan of care across systems and providers
- Helps clarify roles, reduce duplication, and identify gaps
- Maintains a whole-family view of strengths, needs, and goals
- Monitor whether services are being provided and meeting the child’s need.
- Plan and coordinate transitions, including discharge, return from out-of-home placement, or movement to a lower level of care.

Other Care Coordinators*

- Coordinate services outside of REACH under direction of the Intensive Care Coordinator
- Meets other programs' documentation requirements on behalf of individual
- Raises potential concerns to ICC
- Contributes to the REACH individualized plan
- Helps members transition out of REACH and is a trusted connection throughout care

Peer / Family Support

- Brings lived experience and helps families feel heard and understood
- Strengthens youth and family voice and choice in team decisions
- Provides practical support navigating services and systems
- Supports transitions and helps families build confidence

Service Providers

- Deliver treatment and supports identified in the plan of care
- Share progress and observations with the team
- Coordinate with the ICC and other providers to reduce fragmentation
- Adjust services as youth needs and goals change

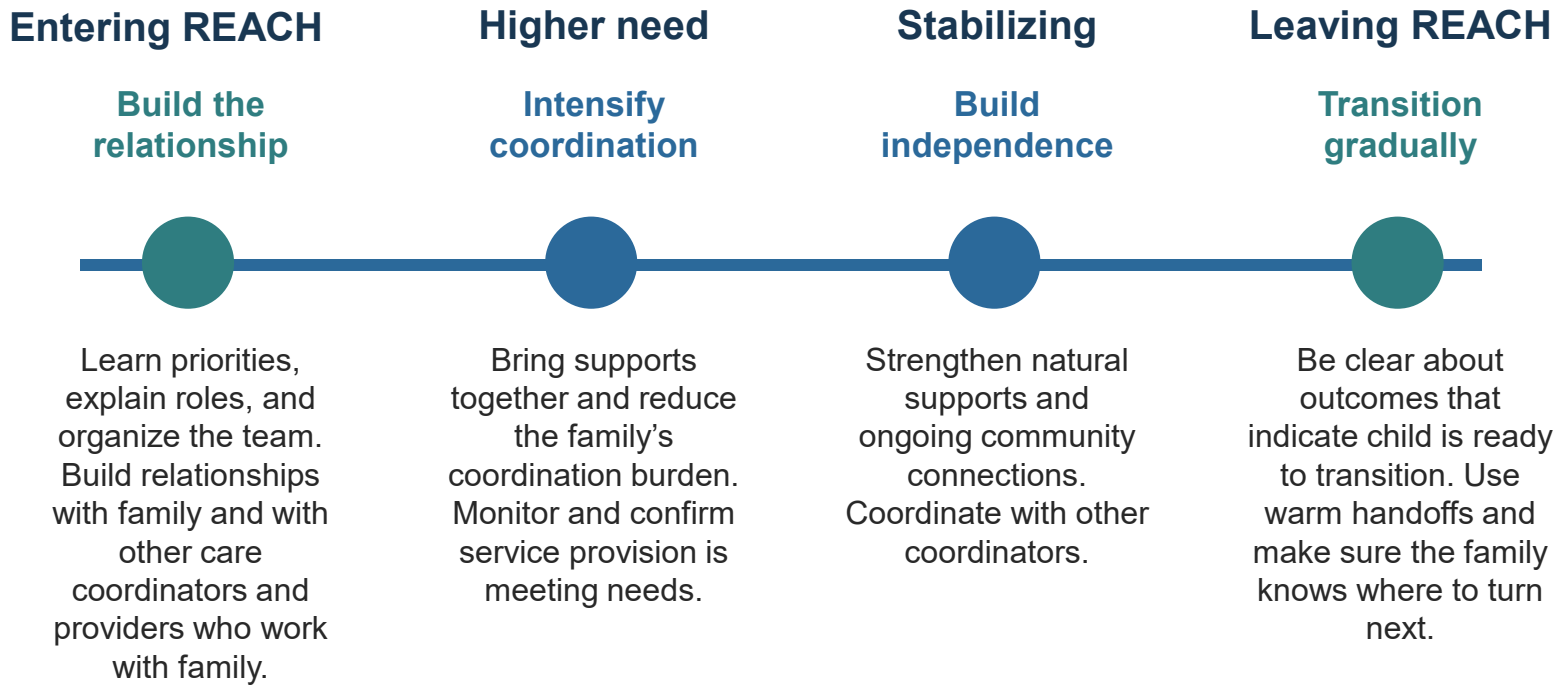
Principles for ICC to Develop Trust with Children and Families

1	**Listen first**	Learn what matters to the youth and family, including strengths, priorities, existing supports, and past experiences with services.
2	**Be clear**	Explain the ICC role, what REACH can and cannot do, and how the family can shape goals and team membership.
3	**Follow through**	Do what was promised, communicate when plans change, and help resolve barriers across systems. Delegate to other coordinators when appropriate.
4	**Collaborate**	Use the Care Planning Team to make decisions with the youth and family. Involve trusted providers, community members, and other care coordinators.
5	**Prepare together**	Talk about transitions early so changes in support feel planned and predictable rather than abrupt. Make sure other coordinators and providers are involved and ensure warm handoffs.

Consistency, transparency, and follow-through help the ICC become a trusted partner, not just another person involved in care.

ICC Support During Transition

Transitions can preserve trust when the ICC relationship changes gradually and families know what comes next.



Ramping down from care is an actively planned process with the family, not a sudden loss of support.

Discussion

- What other responsibilities should definitively belong to the ICC to reduce confusion?
- What should youth and families hear at enrollment so they know who to contact for different needs?
- What would an ICC need to do consistently to earn and maintain a family's trust?
- How can we ensure that members still have a strong coordinated network even as they transition out of REACH?