

Iowa REACH Implementation Team Meeting

October 2026



Health and
Human Services



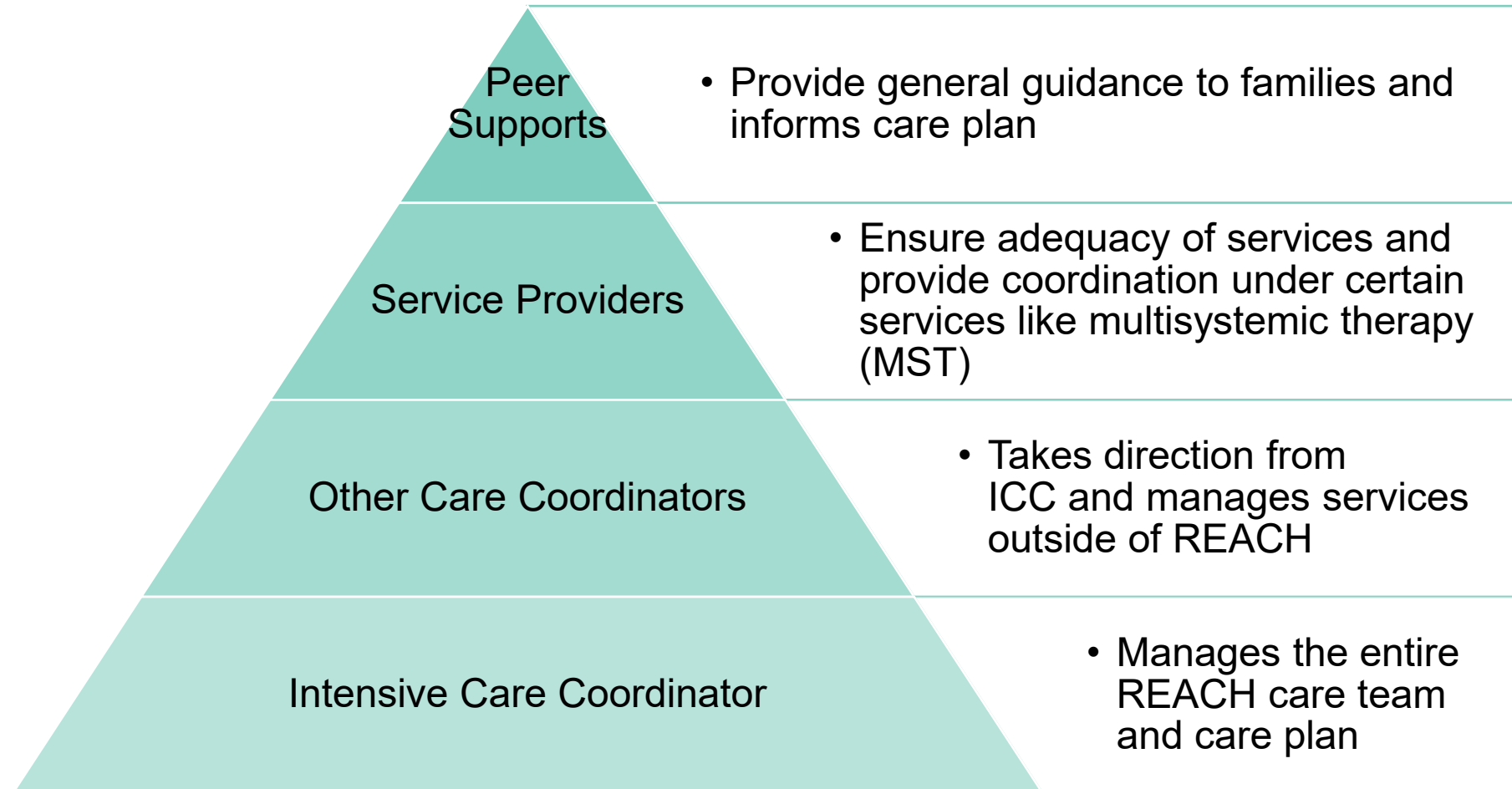
Agenda

- ▶ Intensive Care Coordination Roles
- ▶ Member Transitions

Provider Roles in Care Coordination

Roles involved with ICC

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



Roles and Responsibilities

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

* Also called "case managers"

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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.

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?

Managing Transitions

Transition Periods During REACH

- ▶ Youth enrolled in REACH may experience distinct care transitions including:
 - Accomplishing care goals and moving to lower-level services
 - Aging out of REACH services
 - Developing more intensive care needs that cannot be handled in the home and community
- ▶ While we know these transitions require distinct care, today we want to focus on common elements that make transitions successful

What makes a successful transition?

Think back to a time that you experienced or facilitated an especially successful care transition. What made it successful?

- ▶ Members: What made you feel confident about next steps? Did you feel empowered to participate in leading your care?
- ▶ Referring providers: What tools and knowledge helped you facilitate the transition?
- ▶ Receiving providers: What activities made you feel confident taking on the case?

Now think about a bad experience. Are there any pitfalls we need to be sure to avoid in REACH transitions?

Framework for successful transitions

- ▶ REACH follows the [principles of high-fidelity wraparound](#), which has four distinct phases ending in transition
- ▶ The transition phase of wraparound includes consistent activities for the Care Planning Team which are facilitated by the Intensive Care Coordinator, including:
 - Developing a transition plan at least 90 days before ending services
 - Ensuring essential professional and natural supports are in place
 - Equipping the family with necessary skills and necessary resources from their ICC
 - Formal documentation of achievements and lessons learned

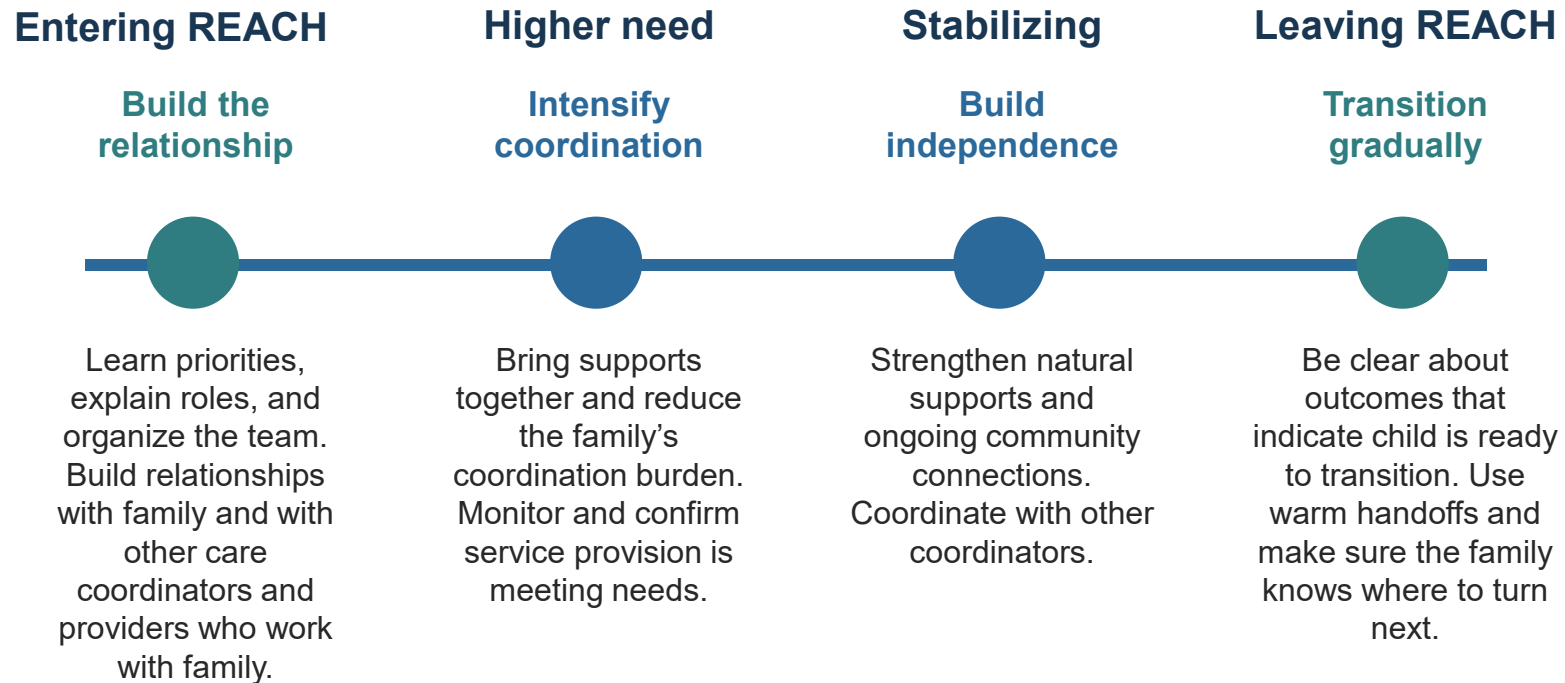
Subcommittee feedback on successful transitions

► **From the subcommittees, we also know that transitions should include:**

- Establishing care goals and a unique transition plan from the first meeting
- Early engagement of new providers as members begin reaching goals, potentially through new case managers joining Care Planning Team meetings
- Flexibility for members to ramp services up and down as needed until they see consistent improvement
- Member education on new services and warm handoffs

Preparing for Transition Throughout Services

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 challenges might receiving providers or MCOs face when managing a child who has recently been discharged from REACH services?
- ▶ What documents or activities might reduce this burden?
- ▶ Of the strategies we've discussed, which is the most essential for ensuring a smooth transition and needs to be done regardless of challenges?