NYS Systems of Care

Project Overview for HHSC

February 21, 2018

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New York's System of Care Expansion Grant

Awarded

October 2016 - September 2020

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Project Goal

NYS SOC will integrate evidence-based High Fidelity Wraparound (HFW) within NYS' Medicaid Health Homes Serving Children (HHSC)

Piloting the Integration of HFW in Health Homes Serving Children

- The NYS SOC pilot provides the opportunity to evaluate if using the HFW process for the highest of the high needs children eligible for Health Home will significantly improve outcomes.
- Will provide data for stakeholders, including Managed Care Plans, to assess the value of the HFW process as the State moves toward Value Based Payments and Health Home rates are negotiated between the Plans and Health Homes.
- Provides opportunity to develop best practices for integrating HFW process in the Health Home and under the implementation of the Children's Behavioral Health and Health Medicaid Redesign.

Project Outcomes

- Formalize a State training model to **Support** HFW
- Build County Capacity to **Provide** HFW
- Enhance Statewide Workforce Development to **Replicate** and **Sustain** HFW

Year One Recap

- Staffing
- Infrastructure Building
- Collaborative Partnerships
- Protocols & Procedures
- National Technical Assistance & Learning
- Cultural & Linguistic Appropriateness Standards (CLAS)
- Service Delivery
- Training & Certification Model Development

SAMHSA System of Care

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Systems of Care

- Rooted in a ***philosophy, set of values, and a framework*** through a coordinated network of ***community-based*** services and supports
- Organized to meet the ***physical, behavioral, social, emotional, educational, and developmental*** needs of children and their families
- ***Youth and family guide the process***
- Supports are effective, build on the ***strengths*** of individuals and those that care about them, while addressing each person's ***cultural and linguistic*** needs
- ***Promoting wellness*** of children and youth across their lifespan

Systems of Care

- ***Multi-system sharing*** of resources and responsibilities
- ***Array of necessary and appropriate services and supports***
- ***Collaboration*** across systems and traditional funding silos
- ***Engage and support families*** in raising their children with health and resilience
- Helps children, youth, and families ***achieve success*** at home, in school, in the community, and throughout life

Systems of Care Values

1. Family driven
2. Youth guided
3. Community-based
4. Culturally and linguistically competent
5. Individualized and community based
6. Evidence based and community defined practices

Systems of Care

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High Fidelity Wraparound (HFW)

- a structured, team-based process that uses an evidence-based, nationally-recognized model that partners with families to use their voice and strengths to develop a family-driven plan that promotes self-advocacy.

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10 Principles of High Fidelity Wraparound

1. Family Voice and Choice
2. Team based
3. Natural supports
4. Collaboration
5. Community based
6. Culturally competent
7. Individualized
8. Strengths based
9. Unconditional
10. Outcome based

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NYS Systems of Care Organizational Structure

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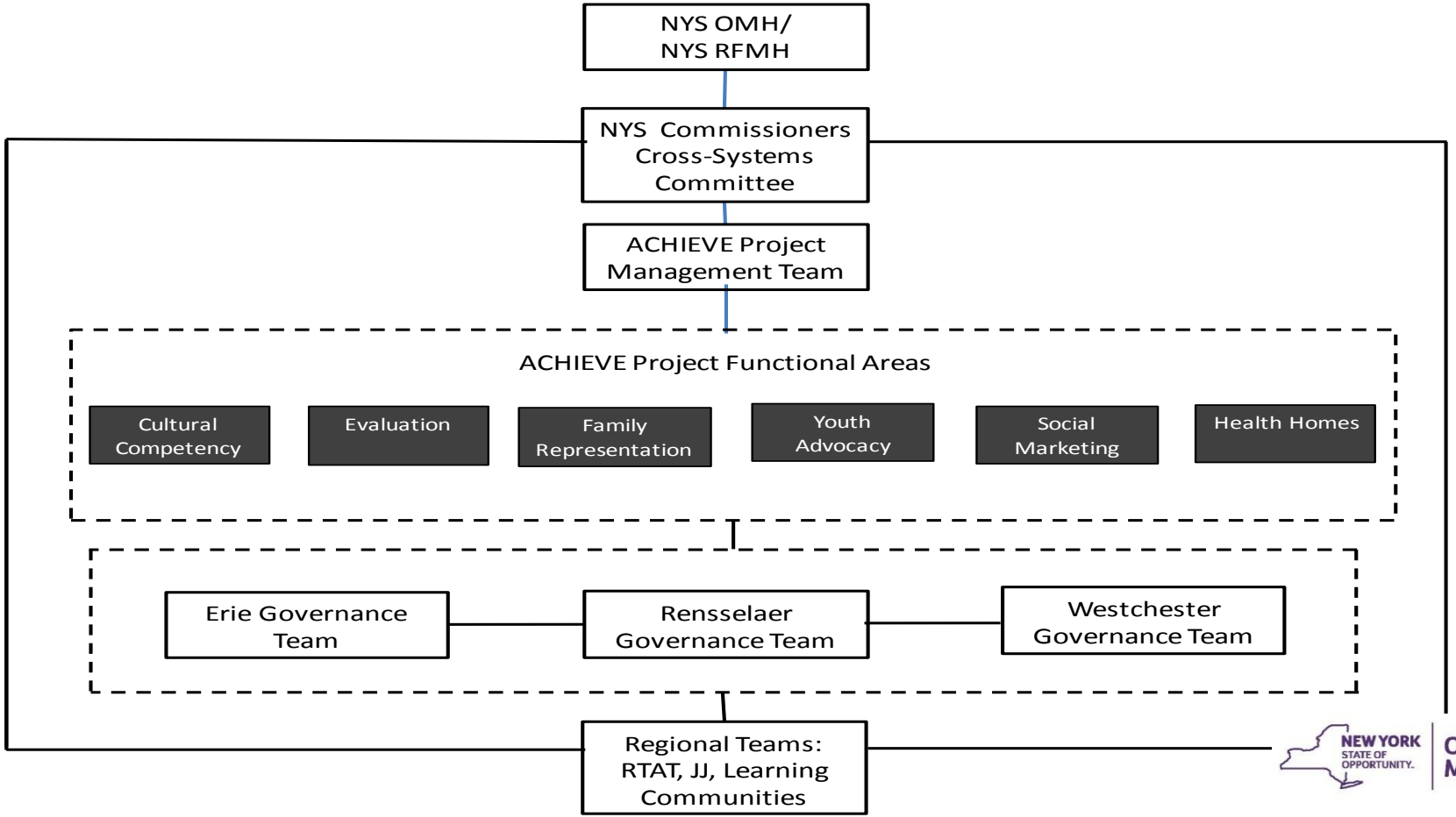

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Original Pilot Counties' Partners

County	Health Homes	Designated Wraparound CMA
Erie	CHHUNY Encompass Oishei Healthy Kids	New Directions Youth & Family Services
Rensselaer	CHHUNY CNYHHN Encompass	County Mental Health Department
Westchester	CCC CCF	MHA of Westchester and Westchester Jewish Community Services

Expansion Pilot Counties' Partners

County	Health Homes	Designated Wraparound CMA
Cayuga	CHHUNY CNYHHN Encompass Health Home Greater Rochester Health Home Home Network	Cayuga Counseling Services
Chautauqua	CHHUNY Encompass Health Home Oishei Healthy Kids	Chautauqua County Department of Mental Hygiene
Orange	CHHUNY Community Health Care Collaborative	Access
Rockland	CHHUNY Community Health Care Collaborative	MHA of Rockland

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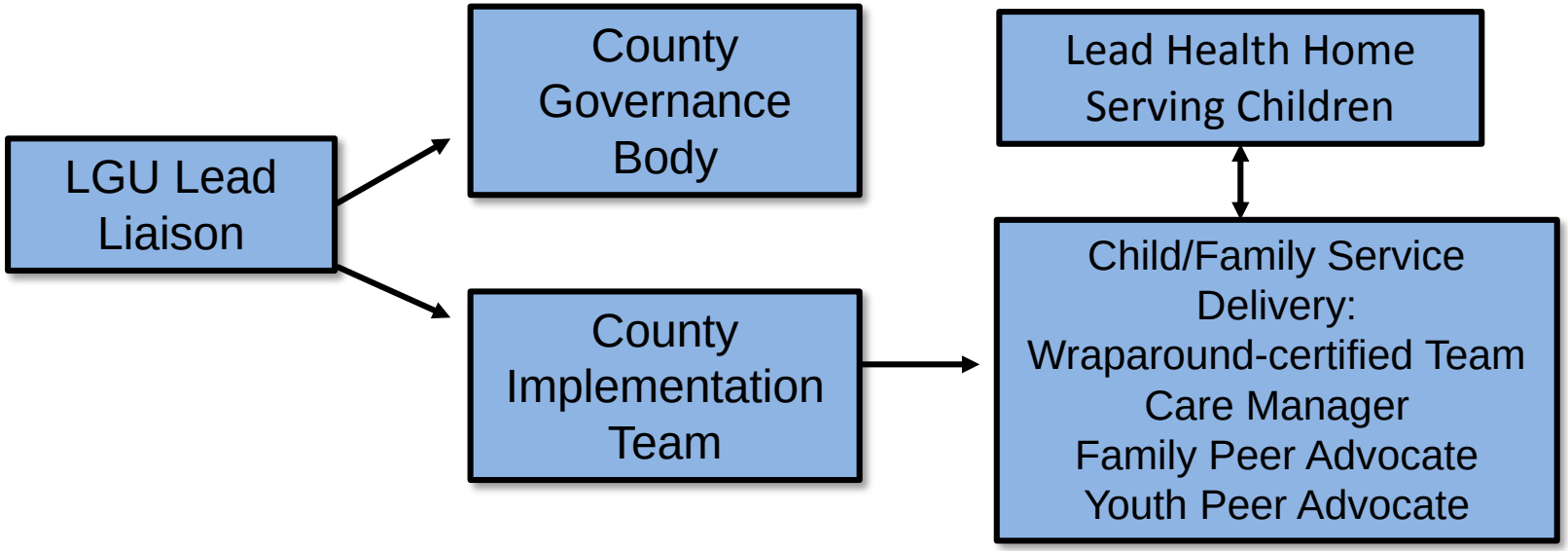
2018 County Additions

- Anticipated to add 3-5 new counties prior to October 2018 (pending SAMHSA approval)
- Selection process to involve HHSC, DOH and LGUs
- Letters to existing pilot counties' CMAs in process

County Structure



NYS Team Model:
Care Management using Wraparound

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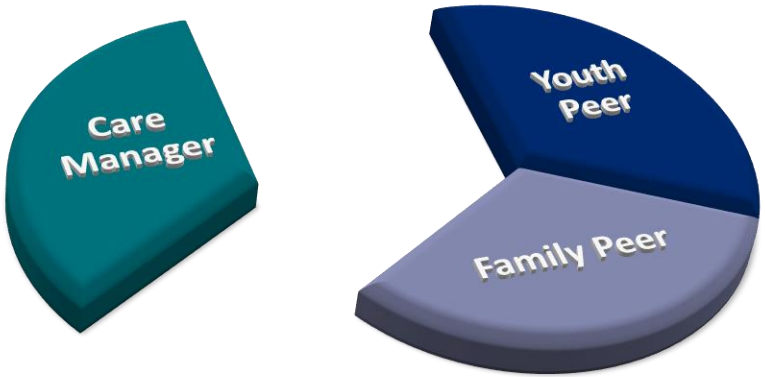
Team Model:
A new approach

- The team moves together as a unit.
- Work within the team is **not** a service.
- Wraparound is a process.

NYS Team Model:
Care Management using Wraparound



- Responsible for CANS NY
- Eligibility
- Plan of Care
- Coordinating and Documenting Work Towards Progress on ALL Goals
- Accountability for Commitments made
- Lead team to serve within principles

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NYS Team Model: Youth Peer Advocacy using Wraparound

- Assist youth to understand process
- Serve as equal member of team, offer Youth Peer Support Services where/when needed
- Offer lived experience perspective to convey message of hope, wellness and recovery
- Contribute to Plan of Care
- Keep youth voice and vision for their future in front

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NYS Team Model: Family Peer Advocacy using Wraparound

- Assist family to understand process
- Serve as equal member of the team, offer Family Peer Support Services where/when needed
- Offer lived experience perspective to convey message of hope, wellness and recovery
- Contribute to Plan of Care
- Keep family vision in front

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NYS Systems of Care

Training and Certification Design

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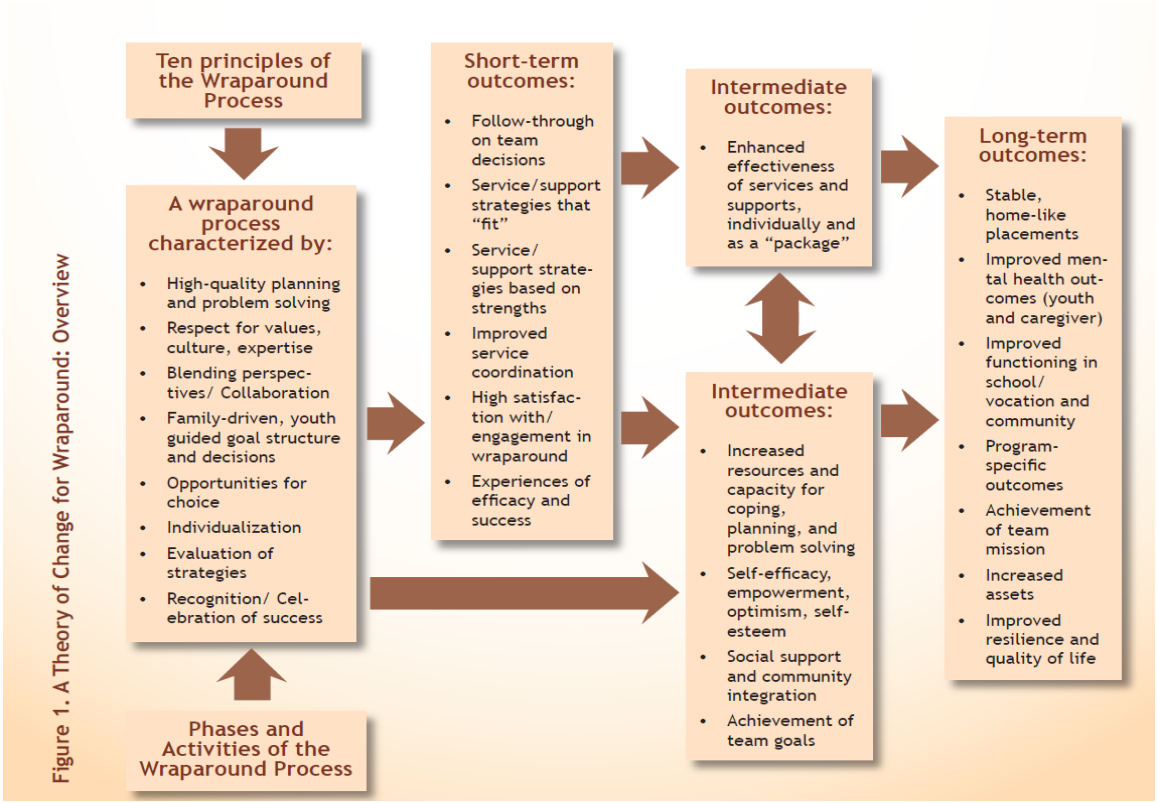
What is Wraparound?

- Wraparound is an **intensive, individualized care planning and management process**.
- The Wraparound *process* aims to achieve positive outcomes by providing a **structured, creative and individualized team planning process** that results in plans that are **more effective and more relevant** to the child/youth and family.
- Wraparound plans are **holistic** and designed to meet the identified needs of caregivers and siblings and to **address a range of life areas.**

Wraparound = Practice Model



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NATIONAL WRAPAROUND INITIATIVE

RIGOROUS RESEARCH ON WRAPAROUND'S EFFECTIVENESS

SUMMARY DOCUMENT

OCTOBER, 2017

The number of studies that have evaluated Wraparound's effectiveness by rigorously comparing the outcomes of youth and families that received Wraparound to a similar group of youth and families that did not has grown

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NWI PHASES OF WRAPAROUND

Phase 1: Engagement
Phase 2: Plan Development
Phase 3: Plan Implementation
Phase 4: Transition

NYS Wraparound Certification Requirements

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NYS SYSTEMS OF CARE WRAPAROUND CERTIFICATION REQUIREMENTS

Certification Components

The New York State Office of Mental Health announces the PILOT program for ***NYS Systems of Care Wraparound Certification.*** In this learning-collaborative model, all partcipants will have the opportunity to learn as a group and receive individualized coaching and technical assistance.

- This training is by invitation only for project funded staff working within the pilot counties serving project identified children and families.
- Upon completion of all required components of the Institute, participants will receive official notice of "*NYS Wraparound Certified*" status in their role of **Care Manager, Youth Peer Advocate or Family Peer Advocate**.
- Supervisors of project funded staff must also participate to support their staff in this endeavor. Supervisors must attend classroom training November 1-2, 2017 and participate in a monthly Supervisor's Implementation Call.

Date of Training	Title/Topic	Supervisor's 9am-11am via Webex
November 1-2	Overview of NYS Wraparound Certification	
December 5-8	Foundations of Wraparound	Dec. 15
January 9-10	Documentation of Wraparound	Jan. 12
February 6-7	Cultural Structural Competence/ Health Habitus	Feb. 9
March 13-14	Enhancing CFT Skills	March 16
April 10-11	Trauma Informed Wraparound	April 13
May 8-9	Transition Begins with Hello	May 11

Requirements

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Required Certification Components	Frequency/timeframe
Live Classroom Skills Clinics	15 days over 6 months
Topic Specific TA Sessions	At least 3
Role Specific TA Sessions	At least 2
Team Specific Coaching	At monthly Implementation Team meetings. Must attend at least 4.
Team Case Presentation	In a live classroom session
Audio Recordings	Submit and review with coach at least 3 over the 6 months
Documentation Requirements	Complete web based training, case specific documentation will be reviewed by coaching team over the 6 months.

Requirements

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CASE PRESENTATION GUIDE

County _____

Family "Name" _____

How was family described to you?

Describe the process of how you first engaged with the family:

What was uniquely offered by each member of the team during the enagement process with the family?

Summary of Family Timeline:

Describe the initial work in engagement to come alongside of the family to reframe their family story?

List the Functional Strengths present in the family:

Describe the process of eliciting the family vision from each member.

Summarize the overall Family Vision

Coaching Plan

- Outlines most critical skills for the position and categorizes them as a strength or an area for development.
- Documents strengths discovered from professional history that can be leveraged to aid in development.
- Coach will support team member in discovering areas that need development by asking open ended questions:

Has the team member always struggled in this area?

Can he/she remember a time when it was not so much of a challenge?

What would be different if the team member mastered this skill?

NYS Certified Wraparound Coaching Plan

Employee Name		Role	
Coach Name			
Date of Meeting		Follow up	

Most Critical Skills/Competencies for this role:	Strength	Developmental Area

Employee Strengths that can be leveraged in Wraparound Process:

Developmental Area	Strategy	Activities	Success Measure

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Coaching Plan

- The team member will brainstorm and decide on a strategy to implement.
- Strategy is broken down into individual concrete action steps that can be implemented and recorded.
- Success is measured by the team member progression in mastering the skill.

NYS Certified Wraparound Coaching Plan

Employee Name		Role	
Coach Name			
Date of Meeting		Follow up	

Most Critical Skills/Competencies for this role:	Strength	Developmental Area

Employee Strengths that can be leveraged in Wraparound Process:

Developmental Area	Strategy	Activities	Success Measure

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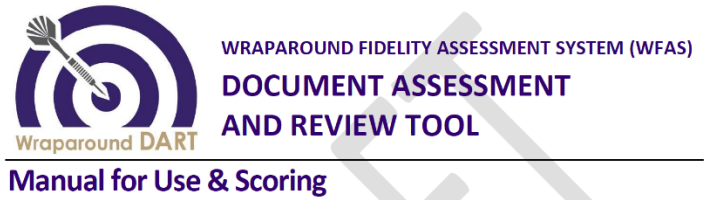
Documentation

Independent Documentation will be required for each member of the Facilitation Team for NYS Wraparound.

Purpose:
Fidelity to the Model
Research
Service Improvement



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Fidelity Measures

Activity	Timeframe
First Contact with Family	Within 3 days of referral or case assignment
First Face to Face contact with Child/Youth and Family	Within 10 days of referral or case assignment
First Crisis/Risk Management/Safety Plan completed	At first face to face meeting with child/youth and family
First Strengths, Needs and Culture Discovery/Family Narrative Completed	Within 20 days of first face to face meeting with the child/youth and family
First Child and Family Team Meeting	Within 30 days of first face to face meeting with the child/youth and family
First Plan of Care Completed	Within 35 days of first face to face meeting with the child/youth and family
Date of each additional Child and Family Team Meeting	Within 35 days of the previous Child and Family Team Meeting

NYS Wraparound Engagement Tracker

- Designed to capture Quality and Quantity
- Pages and Fields created for adherence to standards of high quality practice
- User-Friendly
- Resource for the Child/Youth and Family

Tracking Form

- Care Manager adds text to “gray” fields.
- Organizes dates and activities of wraparound process
- Sheet calculates deadlines automatically
- Basic information: names and dates are then auto-populated throughout workbook

NYS Certified Wraparound Engagement Tracker

Child/Youth Name	Brian Williams
NYS Certified Wraparound Family Peer Advocate Name	Daphnne Brown
NYS Certified Wraparound Youth Peer Advocate Name	Bianca Logan
Caregiver	Jennifer Williams
Caregiver	Robert Williams
Date of Referral or Case Assignment (MM/DD/YYYY	11/24/2017

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43063

Activity to Complete	Deadline to Complete	Date Completed	Over/ Under	If over deadline (items in red), please explain
Date of First Contact with Family Within 3 days of referral or case assignment	11/27/2017	11/26/2017	-1	
Date of First Face to Face Contact between Care Manager, Youth and Family Within 10 days of referral or case assignment	12/4/2017	12/7/2017	3	

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Contact/Documentation Organizer

- "Dashboard" to document dates of contact with family
- Resource to quickly see what paperwork is necessary in each phase of Wraparound

NYS Certified Wraparound Contact/Documentation Organizer

Family Contacts	
Date of First Contact with the Family	11/26/2017
Date of First Face to Face Contact with the Family	12/7/2017
Date of First Child and Family Team Meeting	12/26/2017
Informal Support %	43%
Date of Second Child and Family Team Meeting	1/22/2018
Informal Support %	0%
Date of Third Child and Family Team Meeting	2/15/2018
Informal Support %	43%

Phase One-Engagement	
Documentation to Complete	Date Completed
Crisis/Safety Plan	12/7/2017
Family Story Family Strenghts Family Needs Family Vision	12/5/2017
CANS-NY	
Support Identification	11/29/2017
Informal Supports	0.00%
Meeting Minutes	

Phase Two-Planning	
Documentation to Complete	Date Completed
Ground Rules	
Revised Strengths	
Revised Needs	
Team Mission Statement	
Initial Plan of Care	1/25/2018
Crisis/Safety Plan	
Meeting Minutes	

Phase Three-Implementation	
Documentation to Complete	Date Completed

Phase Four-Transition	
Documentation to Complete	Date Completed

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YPA and FPA Documentation

Independent Documentation will be required for each member of the Facilitation Team for NYS Wraparound.

Purpose:

Study of Role

Time Spent billable vs. non-billable

Medicaid billing in 2020

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YPA and FPA Documentation

NYS Wraparound Family/Youth Peer Advocate Progress Note

Child/Youth/Family Name	
Peer Name	
Agency	

Date:	Work Start Time:		
	Work End Time:		Billing Units:
	Total Time (Duration):		

Work Location:		Type of Communication:	
	Office		Face to Face
	Home		Phone Call
	Community		Text

Type of Work Delivered:				
	Engagement, Bridging and Transition Support	Non Billable		Documentation Review
	Self-Advocacy, Self-Efficacy and Empowerment			Attend Child and Family Team Meeting
	Community Connections and natural Supports			Facilitation Team Meeting
	Parent Skill Development			Preparation for Peer Meeting
	Medical Assistance			Relationship Building with Peer
	Collateral Contact			

Which Goal or Goals does this contact support?

Description of work provided:

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Target Population

Pilot Capacity for Families Served

	Year 1	Year 2	Year 3	Year 4
Chautauqua	0	10	10	10
Erie*	7	20	20	20
Rensselaer*	0	17	20	20
Rockland	0	10	10	10
Westchester*	7	20	20	20
New York City	0	10	20	20
Cayuga	0	10	10	10
Orange	0	20	20	20
Total	14	117	130	130

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NYS SOC – High Fidelity Wraparound
TARGET CRITERIA

In order for a child/youth to enroll in SOC in a designated County and receive High Fidelity Wraparound intervention, ***s/he has been determined:***

- ❑ Health Home eligible by the NYS Health Home Serving Children criteria under the single qualifying condition of Serious Emotional Disturbance (HHSC SED Definition), including enrollment in Medicaid; **OR**

- ❑ Health Home eligible by the NYS Health Home Serving Children criteria under the qualifying condition of Serious Emotional Disturbance (HHSC SED Definition) but Medicaid-ineligible and cannot enroll in Health Home.

NYS SOC – High Fidelity Wraparound
TARGET CRITERIA

AND *s/he* must meet the following criteria:

- ❑ Be between the ages of 12 and 21; **AND**
- ❑ Live in the community in a designated pilot County in settings allowable by HH guidelines. Children/youth may be at imminent discharge from out of home or out of state placement at the time of NYS SOC referral, when engagement may begin 30 days before discharge; **AND**
- ❑ Be willing to participate in NYS SOC and the HFW process; **AND**
- ❑ Is involved with two or more service systems in the last 6 months (e.g., child welfare, special education services, juvenile justice, mental health and/or substance use); **AND**
- ❑ Have a CANS-NY Health Home score of high acuity;

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NYS SOC – High Fidelity Wraparound
TARGET CRITERIA

AND *s/he* demonstrates documented evidence of:

- ❑ Being in crisis and in emerging/imminent risk of out-of-home placement, due to challenges living in the home and community; **OR**
- ❑ Returning to their home and community from out-of-home placement; **OR**
- ❑ Inpatient hospitalization (mental health, substance use or physical health) within the past 6 months; **OR**
- ❑ Multiple (i.e., two or more) inpatient hospital stays, emergency room use and/or CPEP/crisis services in the last 6-12 months.

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Enrollment Flow: HH Enrolled Children/Youth

HHSC identifies enrolled child that would benefit from Wraparound

HH CM sends referral & recent CANS scoring sheet to SPOA

SPOA makes NYS SOC eligibility determination & confirms eligibility with HHCM

HHCM contacts designated Wraparound agency and coordinates transfer, if necessary

Wraparound certified CM begins engagement, strengths discovery, and helps to identify goals and child/family team members

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Enrollment Flow:
NYS SOC Eligible/HH Eligible Children/Youth

Stakeholder identifies child that would benefit from Wraparound

SPOA reviews referral information, conducts a CANS-NY and determines NYS SOC eligibility

SPOA makes direct referral to designated Wraparound Agency, which assigns a Wraproud certified CM

Wraparound certified CM opens enrollment segment in MAPP

Wraparound certified CM begins engagement, obtains consents and enrolls in HH, completes strengths discovery, and helps to identify goals and child/family team members to develop plan of care

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NYS SOC Evaluation

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Research Questions

- How is HFW being implemented?
- What is the cost of becoming trained & certified?
- Is implementation adhering to the NYS Wraparound model?
- Is the NYS Wraparound model working well?
- How is HFW integrated within Health Homes?
- What adjustments are needed to improve the integration of HFW into Health Homes?
- How is HFW impacting families?

Evaluation Activities

- Training Modules
- SOC Infrastructure Development
- Implementation of NYS SOC
- Youth and Family Experience
- Youth and Family Outcomes
- Team Meeting Fidelity to Wraparound Model

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Additional Project Foci

- Sustainability Ad Hoc Committee
- Peer Planning & Workforce Development
- Social Marketing Planning & Implementation

Contact NYS SOC Co-Directors

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