NYS Systems of Care
Project Overview for HHSC
February 21, 2018
New York’s System of Care Expansion Grant

Awarded

October 2016 - September 2020
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
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

- Cultural and Linguistic Competence
- Community Based
- Youth-Guided
- Family-Driven

- Youth
- Mental Health
- Child Welfare
- Caregivers
- Juvenile Justice
- Primary Care
- Community
- Education
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.
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
NYS Systems of Care
Organizational Structure
# Original Pilot Counties’ Partners

<table>
<thead>
<tr>
<th>County</th>
<th>Health Homes</th>
<th>Designated Wraparound CMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erie</td>
<td>CHHUNY, Encompass, Oishei Healthy Kids</td>
<td>New Directions Youth &amp; Family Services</td>
</tr>
<tr>
<td>Rensselaer</td>
<td>CHHUNY, CNYHHN, Encompass</td>
<td>County Mental Health Department</td>
</tr>
<tr>
<td>Westchester</td>
<td>CCC, CCF</td>
<td>MHA of Westchester and Westchester Jewish Community Services</td>
</tr>
</tbody>
</table>
## Expansion Pilot Counties’ Partners

<table>
<thead>
<tr>
<th>County</th>
<th>Health Homes</th>
<th>Designated Wraparound CMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cayuga</td>
<td>CHHUNY CNYHNN Encompass Health Home Greater Rochester Health Home Home Network</td>
<td>Cayuga Counseling Services</td>
</tr>
<tr>
<td>Chautauqua</td>
<td>CHHUNY Encompass Health Home Oishei Healthy Kids</td>
<td>Chautauqua County Department of Mental Hygiene</td>
</tr>
<tr>
<td>Orange</td>
<td>CHHUNY Community Health Care Collaborative</td>
<td>Access</td>
</tr>
<tr>
<td>Rockland</td>
<td>CHHUNY Community Health Care Collaborative</td>
<td>MHA of Rockland</td>
</tr>
</tbody>
</table>
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

LGU Lead Liaison

County Governance Body

County Implementation Team

Lead Health Home Serving Children

Child/Family Service Delivery:
- Wraparound-certified Team
- Care Manager
- Family Peer Advocate
- Youth Peer Advocate
NYS Team Model: Care Management using Wraparound
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
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
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
NYS Systems of Care
Training and Certification Design
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

Figure 1. A Theory of Change for Wraparound: Overview

Phases and Activities of the Wraparound Process

Ten principles of the Wraparound Process
- High-quality planning and problem solving
- Respect for values, culture, expertise
- Blending perspectives/collaboration
- Family-driven, youth-guided goal structure and decisions
- Opportunities for choice
- Individualization
- Evaluation of strategies
- Recognition/celebration of success

A wraparound process characterized by:

Short-term outcomes:
- Follow-through on team decisions
- Service/support strategies that "fit"
- Service/support strategies based on strengths
- Improved service coordination
- High satisfaction with engagement in wraparound
- Experiences of efficacy and success

Intermediate outcomes:
- Enhanced effectiveness of services and supports, individually and as a "package"

Intermediate outcomes:
- Increased resources and capacity for coping, planning, and problem solving
- Self-efficacy, empowerment, optimism, self-esteem
- Social support and community integration
- Achievement of team goals

Long-term outcomes:
- Stable, home-like placements
- Improved mental health outcomes (youth and caregiver)
- Improved functioning in school/vocation and community
- Program-specific outcomes
- Achievement of team mission
- Increased assets
- Improved resilience and quality of life
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.
NWI PHASES OF WRAPAROUND

Phase 1: Engagement
Phase 2: Plan Development
Phase 3: Plan Implementation
Phase 4: Transition
NYS Wraparound Certification Requirements
Chapter 9: NYS Wraparound Certification Requirements

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

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

<table>
<thead>
<tr>
<th>NYS Certified Wraparound Coaching Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name</td>
</tr>
<tr>
<td>Coach Name</td>
</tr>
<tr>
<td>Date of Meeting</td>
</tr>
<tr>
<td>Most Critical Skills/Competencies for this role:</td>
</tr>
<tr>
<td></td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Employee Strengths that can be leveraged in Wraparound Process:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Developmental Area</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coach Name</td>
<td></td>
</tr>
<tr>
<td>Date of Meeting</td>
<td>Follow up</td>
</tr>
</tbody>
</table>

Most Critical Skills/Competencies for this role:

<table>
<thead>
<tr>
<th></th>
<th>Strength</th>
<th>Developmental Area</th>
</tr>
</thead>
</table>

Employee Strengths that can be leveraged in Wraparound Process:

|                     | |
|---------------------| |

<table>
<thead>
<tr>
<th>Developmental Area</th>
<th>Strategy</th>
<th>Activities</th>
<th>Success Measure</th>
</tr>
</thead>
</table>
Documentation

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

**Purpose:**
- Fidelity to the Model
- Research
- Service Improvement
## Fidelity Measures

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

<table>
<thead>
<tr>
<th>Activity to Complete</th>
<th>Deadline to Complete</th>
<th>Date Completed</th>
<th>Over/Under</th>
<th>If over deadline (items in red), please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of First Contact with Family Within 3 days of referral or case assignment</td>
<td>11/27/2017</td>
<td>11/26/2017</td>
<td>-1</td>
<td></td>
</tr>
<tr>
<td>Date of First Face to Face Contact between Care Manager, Youth and Family Within 10 days of referral or case assignment</td>
<td>12/4/2017</td>
<td>12/7/2017</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
• "Dashboard" to document dates of contact with family
• Resource to quickly see what paperwork is necessary in each phase of Wraparound

### Contact/Documentation Organizer

**NYS Certified Wraparound Contact/Documentation Organizer**

<table>
<thead>
<tr>
<th>Family Contacts</th>
<th>Phase One-Engagement</th>
<th>Phase Two-Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of First Contact with the Family</strong></td>
<td><strong>11/26/2017</strong></td>
<td><strong>Date Completed</strong></td>
</tr>
<tr>
<td><strong>Date of First Face to Face Contact with the Family</strong></td>
<td><strong>12/7/2017</strong></td>
<td><strong>Family Story</strong></td>
</tr>
<tr>
<td><strong>Date of First Child and Family Team Meeting Informal Support %</strong></td>
<td><strong>43%</strong></td>
<td><strong>Family Needs</strong></td>
</tr>
<tr>
<td><strong>Date of Second Child and Family Team Meeting Informal Support %</strong></td>
<td><strong>0%</strong></td>
<td><strong>Support Identification</strong></td>
</tr>
<tr>
<td><strong>Date of Third Child and Family Team Meeting Informal Support %</strong></td>
<td><strong>43%</strong></td>
<td><strong>Informal Supports</strong></td>
</tr>
</tbody>
</table>

### Phase Three-Implementation

<table>
<thead>
<tr>
<th><strong>Date Completed</strong></th>
<th><strong>Meeting Minutes</strong></th>
</tr>
</thead>
</table>

### Phase Four-Transition
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
YPA and FPA Documentation

### NYS Wraparound Family/Youth Peer Advocate Progress Note

<table>
<thead>
<tr>
<th>Child/Youth/Family Name</th>
<th>Peer Name</th>
<th>Agency</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Work Start Time:</th>
<th>Work End Time:</th>
<th>Total Time (Duration):</th>
<th>Billing Units:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Work Location</th>
<th>Type of Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Home</td>
<td>Phone Call</td>
</tr>
<tr>
<td>Community</td>
<td>Text</td>
</tr>
</tbody>
</table>

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

Which Goal or Goals does this contact support?

Description of work provided:
Target Population
## Pilot Capacity for Families Served

<table>
<thead>
<tr>
<th>Region</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chautauqua</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Erie*</td>
<td>7</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Rensselaer*</td>
<td>0</td>
<td>17</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Rockland</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Westchester*</td>
<td>7</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>New York City</td>
<td>0</td>
<td>10</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Cayuga</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Orange</td>
<td>0</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14</td>
<td>117</td>
<td>130</td>
<td>130</td>
</tr>
</tbody>
</table>
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, \textit{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; \textbf{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.
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;
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.
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
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 Wraparound 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
NYS SOC Evaluation
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
Contact information
NYS SOC Evaluation Team:

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518-442-3798

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518-442-5346

Tom LaPorte
tlaporte@albany.edu
518-437-3696

Center Director:
Rose Greene
rgreene@Albany.edu
518-442-5774
Additional Project Foci

• Sustainability Ad Hoc Committee
• Peer Planning & Workforce Development
• Social Marketing Planning & Implementation
Contact NYS SOC Co-Directors

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