New York State Systems of Care

Systems of Care 101: Part I

This training and all materials are products created via Cooperative Agreement #5H79SM063413-03.
Outcomes for Today

• Explore what a System of Care is, including the core values and principles

• Understand NYS Systems of Care history, along with family and youth peer movements

• Identify our community strengths in utilizing the SOC framework
Introductions

Name
Organization
Role
One functional strength
What do you know about SOC?
Children’s System Transformation

New York State is transforming its publicly funded care management, behavioral health, child welfare, juvenile justice and intellectual/developmental disabilities systems.

The Systems of Care approach can assist in connecting all systems under a shared framework for philosophy adoption, collaboration, integration and problem solving.
Understanding Systems of Care

https://youtu.be/6WIIIGkli_0
Systems of Care Defined

“A broad flexible array of effective services and supports for a defined, multi-system-involved population, which is organized into a coordinated network, integrates care planning and care management across multiple levels, is culturally and linguistically competent (or responsive), builds meaningful partnerships with families and with youth at service delivery, management, and policy levels, has supportive management and policy infrastructure, and is data-driven”.

Mental Health

Child Welfare

Youth

Family driven
Youth guided

Community-based
Culturally and linguistically competent
Individualized
Evidence-based and community defined practices

Caregivers

Primary Care

Community

Education

Juvenile Justice
Effective Systems of Care…

…needs organized leadership, decision-making, and oversight:
• provided through a group or team effort,
• comprised of those persons who hold a shared vision for what needs to be done, can identify and eliminate barriers, including gaps in services
• can communicate information so services are not duplicated and needs are met more efficiently, and
• have the ability and resources to make those things happen.
The SOC Approach is NOT...

...an exact “model” to be replicated

...a “program” that provides a service

...a “treatment or clinical intervention”

...in itself Wraparound, but will help to build it
The SOC Approach IS...Simply put – how a community takes care of its own

- An organizational framework for system reform
- A value base for systems and service delivery
- A guide to implement – unique to each state, tribe, territory, community
- Adaptable - approach based on context and environment
- Flexible for innovation
- Applicable for different
  - age groups (early childhood, youth and young adults of transition age)
  - levels of need (serious conditions, at risk)
  - cultural groups
Why System of Care?

It is proven to achieve the following outcomes:

- Promoting wellness of children and youth across their lifespan
- Multi-system sharing of resources and responsibilities
- Array of necessary and appropriate services and supports
- Collaboration across systems and traditional funding silos
- Engaging and supporting families in raising their children with health and resilience
Most importantly…

Because All Children are Our Children!
You may be thinking: “How did we get here?”

Let’s look at the History of Systems of Care as it evolved alongside Wraparound and the Peer Support Movement...
VIDEO:
History of Systems of Care, Wraparound, and the Peer Movements in NYS!

https://youtu.be/LExPUr_t1_w
SOC Components

**Philosophy**
Values and principles that provide the foundation for service systems.

**Services and Supports**
Interventions with youth and families at the service delivery level. These are consistent with the SOC values.

**Infrastructure**
Governance, financing, partnerships, and CAPACITY for planning, evaluation, quality improvement, and workforce development.
SOC Core Values

The Systems of Care Philosophy comes from these Core Values.

Family Driven
Youth Guided
Community Based
Culturally and Linguistically Competent
Individualized
Evidence-based and Community Defined Practices

These core values must guide our efforts to infuse the Systems of Care philosophy into our infrastructure, services, and supports.
Core Value: Family Driven

• Assumes and asserts that **families are the experts** in their lives, their needs and their goals. They, not the service provider or expert, **must be the ones to decide** what they need.

• As recipients of service, family members and caregivers **must be represented and have a voice** on policy, management and service delivery levels **for all children** in the community.
Family Driven Care

Family driven promotes four changes in the way children/youth are served

1) increased focus on families,

2) provision of services in natural settings,

3) greater cultural sensitivity, and

4) a community-based system of care (Knitzer, 1993).
Core Value: Youth Guided

...means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation.
A Youth-Guided Community has:

- An open minded viewpoint and there are decreased stereotypes about youth.
- Prioritized youth involvement and input during planning and/or meetings.
- A desire to involve youth
- Begun stages of partnership with youth.
- Begun to use language supporting youth engagement.
A Youth-Guided Community has:

- Taken the youth view and opinion into account.
- A minimum of one youth partner with experience and/or expertise in the systems represented.
- Begun to encourage and listen to the views and opinions of the involved youth, rather than minimize their importance.
- Created open and safe spaces for youth.
- Appropriate incentives are provided to youth. This includes youth participation in the program as well as those who serve on boards or provide training.
Core Value: Community Based

- Children, youth and young adults should have a community-based network of services available to them in more normative and less restrictive settings.
- Decisions about the mix of services to be offered, service coordination mechanisms, and use of resources are made at the local level.
Core Value: Culturally & Linguistically Competent

• Agencies, programs and services are **responsive** to the cultural, racial and ethnic differences of the populations they serve.

• Communities **address the structural barriers and value differences** encountered by ethnic minorities.

• Children and families served within their own **unique and specific contexts**.
Core Value: Individualized

- Meet the **unique needs** of a given child and family.
- **Approach** to services is **flexible**.
- **Wraparound process** one of the most significant practice-level approaches to **individualized planning** and service delivery.
Core Value: Evidence Based and Community Defined Practices

• Important to provide effective, evidence-informed clinical interventions, services and supports to improve outcomes.
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SOC Philosophy

PRINCIPLES

• Broad array of effective supports and services
• Individualized, Wraparound Practice Approach
• Least restrictive, clinically appropriate setting
• Family and youth partnerships at all levels
• Care Management for coordination at services level
• Cross-agency collaboration
• Developmentally appropriate services for both young children and for youth in transition to adulthood
• Link with mental health promotion, prevention, and early identification
• Continuous Accountability

Philosophy

Values and principles that provide the foundation for service systems.
SOC Components

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SOC Infrastructure

Strategic Framework
Roadmap for Systems Change

- Implementing policy, admin. and regulatory changes
- Developing and expanding services and supports, care management and individualized approach
- Providing training, TA and coaching
- Generating support and an advocacy base
- Creating or improving financing strategies
Systems of Care

Governance

• Decision-making at a policy level that has legitimacy, authority and accountability
• Policies set collaborative practices at policy and service levels
• Requires structure, and process, in addition to clarity about to population of focus
• Not to be confused with systems management, the day-to-day operational decision-making
Required Leadership

• Visionary Leaders

• Process Leaders

• Preparing for Transitions
Family and Youth Leadership

- Parent Engagement & Participation
- Training & Mentorship
- Participant Supports
- Privacy & Confidentiality
- Evaluating Strategies for Family & Youth Involvement
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Array of Services and Supports

• Implement and sustain a broad array of home and community based services and supports that are individualized, coordinated, family driven, youth guided, and culturally and linguistically competent.
SOC Services and Supports - Coordinated Care

• SOCs typically work with children receiving multiple services from multiple systems
• Intensive care management is critical to effectiveness of services, less intensive care coordination with lower levels of need
• Dedicated, full-time intensive care management with low ratios for children and families with multiple issues, stressors, and multi-system involvement
• Term “care management” vs. “case management” based on individuals preference for not being referred to as “cases” to be “managed”

SOC Services and Supports

- Coordinated Care

- Support one plan of services even when multiple systems are involved, may be more detailed plans for different providers
- Support the goals of continuity and coordination of services over time and across systems
- Encompass families and youth as partners in managing services and supports
- Utilize a strength-based focus that incorporates use of natural supports

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Next Steps

• Insert any local training information for Part II or other relevant training or updates for participants
Facilitator Contact Information
If dividing this presentation into two sessions, SOC 101, Part II begins here.

Consult facilitator notes for further explanation.
New York State Systems of Care

Systems of Care 101: Part II

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- Complete a System of Care framework review
- Review local SOC infrastructure
- Review available care coordination
- Review local services and supports, with access points
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• Care Management for **coordination at services level**
• Cross-agency **collaboration**
• Developmentally appropriate services for both **young children** and for **youth in transition to adulthood**
• Link with mental health **promotion, prevention, and early identification**
• Continuous **Accountability**
Local SOC Infrastructure

Detail local structures that align with SOC (e.g., executive leadership/cabinets, SPOA committees, CCSI Tier 2 committees, etc.) – functions or responsibilities, who sits on them, how is family/youth participation formalized/supported
Care Coordination in SOC

• Health Home
• Non-Medicaid Care Management
• Fill in other specific case/care management models in community
Health Homes Serving Children

- NYS DOH Health Homes Serving Children
- Comprehensive, Coordinated Care Management

Health Home Serving Children (HHSC)

The New York State Health Home Program was launched in 2012. While children who meet the Health Home eligibility requirements have been eligible for Health Home enrollment since that time, it has been the intent of the State to work with existing Health Homes and other providers to tailor New York State’s Health Home Model to better serve children and to recognize the important differences in the approach to care management and planning for children and adults. The links below provide important information, guidance, and presentation materials that have been developed by the State, e.g., the New York State Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services in consultation with Health Homes, Managed Care Plans, children’s advocates, and other stakeholders to tailor the Health Home model to better serve children. The Health Home Serving Children (HHSC) program was launched in December 2016, with 16 Health Homes designated to serve children. Of the 16 designated Health Homes, 13 of these Health Homes were already serving adults. Visit our Find a Health Home page to locate a Health Home by county and to access contact information for each Health Home.

Recent Updates

Note: Items will be moved into its respective subject area below after 6 months.

- New Requirements to Attend In-Person CANH-NT Training – May, 2018 – Updated December, 2018 (PDF)
- 1/21 Final In-person Transition Training Schedule
- Mandated Background Check Requirements for HCBS Providers and Health Homes – Updated November 2018 (PDF)
  - Background Check Guidance for HCBS Providers – November 2018 (PDF)
- DRAFT Children’s Health Home Transition Rates – effective January 1, 2018
- CANH-NT Training Forced Progression Announcement – October 15, 2018
Local Health Homes & Care Management Agencies

Fill in local list
Services and Supports

Home and Community Based Treatment and Support Services

- Assessment and evaluation
- Individualized “wraparound” service planning
- Intensive care management
- Outpatient therapy –individual, family, group
- Medication management
- Intensive in-home services
- Substance use intensive outpatient services
- Mobile crisis response and stabilization
- Family peer support
- Youth peer support
- Respite services
- Therapeutic behavioral aide services
- Therapeutic mentoring
- Behavior management skills training
- Youth and family education
- Mental health consultation
- Therapeutic nursery/preschool
- School-based behavioral health services
- Supported education and employment
- Supported housing
- Transportation

Out-of-Home Treatment Services

- Therapeutic foster care
- Therapeutic group home care
- Residential treatment services
- Inpatient hospital services
- Inpatient medical detoxification
- Crisis stabilization services
Local Services and Supports
Children’s Mental Health System – The Big Picture

- Inpatient psychiatric centers and units, State and Community operated
- Residential Treatment Facilities
- Community Residences
- Crisis Residences
- Teaching Family Homes
- Outpatient Mental Health Clinics
- School Based Mental Health Clinics
- Day Treatment
- Home and Community Based Services (HCBS)
- Healthy Steps
- Project TEACH
- NYS Systems of Care Initiative
- Health Homes Serving Children (care management)
- Family Peer & Youth Peer Support Services
- Child and Family Treatment Supports & Services (CFTSS)
- And other special initiatives
Accessing Mental Health Services

Single Point of Access (SPOA)

SPOA Children’s Coordinator: (Insert your info here)

Universal Referral Form
Role of SPOA/LGU

- Children's Mental Health services contact/lead
- Conduct local outreach/education to inform community of available county resources
- Lead in county for questions or needs for children's MH services
- Trouble shooter for assisting with challenges for access to services
- Helping families and providers to navigate multiple child-serving systems
- Identification of available county resources for families and providers
- Identify service gaps/needs
- Receive referrals, request for services that are local, county or State-Funded
Accessing (insert type of service)

- Instructions: You may want to duplicate this slide to indicate entry points for
  - basic needs benefits
  - child welfare,
  - juvenile justice,
  - substance use,
  - School districts
  - and other local services
Regional Resources
Regional Offices: FTNYS ~ YP! ~ OMH

- Regional Offices of Families Together
  - Regional Parent Advisors
  - Regional Families Together in New York State Chapters
- Regional Offices of Youth Power
  - Regional Youth Partners
  - Regional Teams
- Regional Field Offices of NYS OMH

https://www.ftnys.org

YOUTH POWER!
Amplifying youth voice and peer advocacy

http://www.youthpowerny.org

https://www.omh.ny.gov/omhweb/aboutomh/fieldoffices.htm
Regional Youth Justice Teams are regional teams of juvenile justice stakeholders including representatives from local government agencies, service providers, the judiciary, community organizations and youth and families who have been justice involved. The teams were created to further implement New York State's strategic plan for juvenile justice. Each team meets on a quarterly basis to share best practices, identify areas for practice improvement and provide input to state policymakers. If you are interested in becoming part of a regional team, contact the team liaison in your region.

http://www.criminaljustice.ny.gov/ofpa/jj/jj-index.htm
The Regional Planning Consortium (RPC) is where collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical healthcare can occur in a way that is data informed, person and family centered, cost efficient and results in improved overall health for adults and children in our communities.

The RPC is a network of 11 regional boards comprised of stakeholders who work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend priorities for reinvestment of Medicaid savings.

http://www.clmhd.org/rpc/
Regional Technical Assistance Teams (RiTATs) are teams that are comprised of representatives from many different systems and are vital to our cross-systems work. Currently there are five regional technical assistance teams in New York State: Central New York, Hudson River, Long Island, New York City, Western New York.

The RiTATs:

• **act as liaisons** between the Council on Children and Families (CCF) and county teams;

• **identify** regional barriers and address creative solutions;

• **provide** cross-systems training and technical assistance on local and regional levels; and

• **promote services** that are family-driven, youth guided and culturally and linguistically competent.

Regional Team Leaders participate in monthly calls, and assist in coordinating training and technical assistance events throughout the year.

https://www.ccf.ny.gov/
CTAC and MCTAC: New York University McSilver Institute for Poverty Policy & Research

The Community Technical Assistance Center of New York (CTAC) and the Managed Care Technical Assistance Center of New York (MCTAC) are a training, consultation, and educational resource center serving all behavioral health agencies in New York State.

- **CTAC** provides training and support on quality improvement strategies -- including training on specific clinical skills and evidence-based practices.
- **MCTAC** works in conjunction with New York State to provide technical assistance to all behavioral health agencies in New York State in preparation for the transition to Medicaid managed care.

https://www.ctacny.org/
Next Steps

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