NEW YORK STATE | Office of Mental Health

High Fidelity Wraparound

Eligibility and Care Management Requirements

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Introductions

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Agenda

1. High-Fidelity Wraparound Background
2. High-Fidelity Eligibly Criteria
3. Care Management Requirements
4. Disenrollment from High-Fidelity Wraparound

High Fidelity Wraparound Background

High Fidelity Wrap Background

- High Fidelity Wraparound (HFW) - An evidence-based intensive team planning practice model intended to provide coordinated, comprehensive, holistic, youth and family driven care to meet the complex needs of children, youth and families who have multiple system involvement and who may experience serious mental health or behavioral challenges.

- HFW has been proven successful with children/youth with Serious Emotional Disturbance (SED) who have significant mental health needs, including cross-system needs, that have led to the child/youth being admitted to or at imminent risk of long-term hospitalization or out-of-home placement and treatment.

HFW Background

- NYS was awarded SAMHSA Systems of Care Expansion Grants in 2016 and 2020 to pilot HFW within the HHSC program.
- 763 youth have been served to date.
- Currently 16 HHSC CMAs providing HFW at 24 agency locations.

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High Fidelity Wraparound Eligibility

HFW Eligibility Criteria

To be eligible to enroll in HFW, the child/youth must meet each of the following criteria:

1. Health Home Serving Children (HHSC) Enrolled/Eligible through SED OR two (2) Mental Health (MH) diagnosis

   AND

2. Age 6-21 years old upon HFW enrollment

   AND

3. The child/youth's acuity is determined to be Complex (High) based on the Child Adolescent Needs and Strengths (CANS-NY) assessment

   AND

HFW Eligibility Criteria

4. A. Within the last year, the child/youth (A) has been involved with and transitioned from one (1) of the below programs, service, or facilities **and/or** (B) is currently receiving or enrolled in at least one (1) of the following services or programs and is expected to transition back to their community with the new 30 days:
    - Out-of-home care and treatment (e.g., State psychiatric center, psychiatric inpatient hospital, Residential Treatment Facility, Children's Community Residence, Residential Substance Use Disorder (SUD) Treatment, Juvenile Justice Residential Placement, Residential Treatment Center, etc.)
    - Intensive care/treatment for SED (e.g., Partial Hospitalization, Children's Day Treatment, Youth Assertive Community Treatment (ACT), Home and Community Based Services (HCBS) Waiver with K3 code (enrolled under SED))
    - Two (2) or more crisis responses due to mental health challenges (e.g., emergency room visit, mobile crisis response, Children's Crisis Residence, Home Based Crisis Intervention (HBCI), Mobile Integration Team (MIT)
    - Foster Care placement (QRTP, VFCA, etc.)

OR

HFW Eligibility Criteria

4. B. The child/youth is currently going through the application process or on the waitlist for Youth ACT or out-of-home care and treatment (e.g., State psychiatric center, psychiatric inpatient hospital, Residential Treatment Facility, Children's Community Residence (CCR), Residential SUD Treatment, Juvenile Justice Residential Placement, Residential Treatment Center, etc.); or has been found eligible for Residential Treatment Facilities (RTF) level of care.

AND

HFW Eligibility Criteria

5. The child/youth is involved with two(2) or more systems

   - Two (2) or more systems could include: Child Welfare: Child protective services, preventive services, or foster care; Juvenile Justice Services: Arrest, Persons in Need of Supervision (PINS) petition, aftercare, probation, or parole; Complex Health: Chronic and severe medical condition that requires ongoing specialized care; Mental Health: In receipt of a service(s) for a diagnosed mental health disorder; Substance Use: In receipt of a service(s) for a diagnosed substance use disorder; School: 504 Plan(directly related to a BH need), Individualized Education Plan (IEP)/Behavior Plan(directly related to a BH need); Intellectual or Learning Disabilities: In receipt of a service(s) for a diagnosed intellectual/learning disability.

HFW Determination and Screening

- A HFW eligibility screening is integrated within the Uniform Assessment System (UAS) and linked to the CANS-NY assessment. The screening is automated and will only appear if the CANS-NY Care Coordination level of support determines that the child/youth meet Complex (High) acuity, if not already enrolled in HFW.

- If the child/youth is determined Complex acuity, a question regarding if the child/youth have an SED or two (2) MH will need to be answered to trigger the HFW screening questions. The screening is a series of questions that the care manager will be prompted to answer to determine eligibility based on the HFW Eligibility Criteria, noted above.

- The care manager must answer these questions to determine HFW eligibility and have supporting documentation (verification of SED/two (2) MH diagnosis, verification of service utilization within the last year) to support the responses at the time of completion or be able to provide the supporting documentation prior to HFW transition. The CANS-NY assessment cannot be finalized until the HFW screening is completed.

HFW Determination and Screening

- The child/youth's HFW eligibility result will be determined upon completion of the screening and finalization of the CANS-NY and will be displayed on the HFW Eligibility line of the "Assessment Outcomes" section of the UAS.

- If the eligibility result is "No, not eligible" then the child/youth does not meet the criteria for HFW, and services should continue with the current Health Home care manager.

- If the eligibility result is "Yes, eligible", then the child/youth is determined eligible for HFW, and action must be taken by the HH care manager to the HFW process and is dependent upon HFW availability.

- The eligibility determination produced from this assessment will remain valid for one (1) year. The eligibility determination does not need to be removed from the UAS if the child/youth and/or family caregiver choose not to participate with HFW.

- HHs and CMAs should have policies and procedures in place to guarantee that supporting documentation is on file for a child/youth prior to enrollment in HFW. In addition to supporting documentation a signed HFW agreement form must be completed prior to enrollment.

Care Management Requirements

Care Management Requirements

In addition to receiving care management services that meet the requirements outlined in "Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations", children/youth and families enrolled in HFW receive:

- The required caseload ratio for HFW is one (1) full-time equivalent (FTE) HFW Certified HHSC Care Manager to ten (10) HFW recipients. HFW Certified Care Managers must be supervised by a HFW Certified Supervisor. A HFW Certified Supervisor can supervise up to 5 HHSC care managers. This can be a combination of HFW-certified Care Managers and traditional HHSC care managers.

- Timely Engagement and Planning
  - To meet fidelity requirements, initial contact with the child, youth, and family occurs within three (3) days of case assignment, and the first in-person contact occurs within ten (10) days. The initial Child & Family Team Meeting (CFTM) is held within 30 days of the first in-person meeting, where the initial plan of care (POC) is created. Additional CFTMs occur monthly, with no greater gap than 35 days.

Care Management Requirements

- Intensive care coordination
  - At least four (4) completed core services/month, including one (1) Child and Family Team Meeting (CFTM). Each of the four (4) core services must include contacts with the enrolled child/youth/caregiver . CFTMs are structured to involve the child/youth and caregivers in leading the development, implementation, and monitoring of their POC, fostering collaboration among the family, natural supports, and service providers to address the family's needs and strengths.

- Multi-system support and service coordination.
  - A Child and Family Team (CFT) is formed with family, friends, community members, and service providers selected by the child/youth and family. The team develops and monitors a single POC that is holistic and individualized to the specific needs of the child/youth and family. The care manager facilitates monthly CFTMs and ensures ongoing communication among team members. Natural and community supports play a key role, and strategies are implemented within the child/youth's and family's community whenever possible. All team members share responsibility for their tasks to meet the needs of the child/youth and family.

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Care Management Requirements

- Individualized service planning.
  - Planning is driven by the child/youth's and family's culture, strengths, interests, and skills. The child/youth family's perspective are central to decision-making and problem-solving. A Family Vision is created to define desired outcomes, and a Family Story documents the child/youth's and family's experience, guiding the CANS-NY assessment and service planning. Services focus on addressing prioritized underlying needs, and progress is regularly reviewed to adjust the care plan as needed. Transition skills, such as planning, advocacy, maintaining supports, tracking progress, and crisis management, are incorporated from the beginning of the process to support the child/ youth and family in transitioning successfully from HFW.

- Access to family and child/youth peer support.
  - HFW care management agencies (CMAs) must provide or have a demonstrated partnership with Child and Family Treatment and Support Services (CFTSS) State designated providers of Youth Peer Support and/or Family Peer Support Services to be able to refer and connect children/youth and families enrolled in HFW.

Care Management Requirements : Reassessment and Continued Enrollment

- HFW is a short-term intervention that is implemented across four (4) phases of effort. While the time it takes for each child/youth and family to complete the four (4) phases is individualized to them, the average length of stay is between ten (10) and eighteen (18) months.

1. Engagement: relationships are established, the strengths, needs, and supports of the child/youth and family are identified, and the tone is set for teamwork and team interaction.

2. Plan Development: facilitate the Child & Family Team (CFT) in the creation of the initial plan of care addressing the family's needs and choices.

3. Plan Implementation: ensure the plan of care is being implemented as intended, and that the CFT is monitoring and reviewing progress at every CFTM. Facilitate the CFT to update and revise the plan when needed.

4. Transition: share progress, celebrate successes and accomplishments, and plan for a purposeful transition from HFW.

Care Management Requirements : Reassessment and Continued Enrollment

- Each phase focuses on supporting an effective planning process to empower the child/youth and family to reach their goals.

- The CANS-NY assessment supports POC development and provides a standardized approach to monitoring progress. **For those reasons, the CANS-NY reassessment is completed every six (6) months for children/youth enrolled in HFW.**

- However, the CANS-NY is not used to determine continued eligibility for HFW. Once a child/youth is enrolled in HFW, they remain enrolled regardless of the changing CANS-NY acuity rating. The acuity rating of the child/youth may drop from Complex at initial enrollment to either Intense or Standard acuity at subsequent reassessments and the child/youth may remain enrolled until completing the four (4) phases and graduating or choosing to disenroll.

- Once a child/youth has completed the four phases and graduated, they should not remain enrolled in HFW, as their progress and needs have evolved.

Care Management Requirements : Disenrollment

- A child/youth and family officially graduate from HFW upon completion of the four (4) phases of the model.
- At times and for various reasons, a child/youth and family may decide they no longer want to participate in this voluntary program prior to graduation. Once the child/youth and their family have indicated that they would like to graduate or disenroll, the HFW CM must inform the Lead HH and conduct an early reassessment of the CANS-NY, as HFW program requires a discharge CANS-NY.
- The HFW CM will choose “Significant Life Event” and “Discharge from High-Fidelity Wraparound” as the reason code for this assessment. Then the HFW CM will disenroll the child/youth from the HFW and HH program following the current “Member Disenrollment From the Health Home Program” policy.
- If the child/youth and family would like to remain in Health Home program, then the HFW Supervisor, and Lead HH (Current HFW CMA) will coordinate a step-down to another CM/CMA for Health Home only for care management.

Questions

Contact

Contact info:

Any questions should be submitted to OMH.HFW@OMH.NY.GOV

Office of Mental Health