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System of Care Implementation in New York State: Prepared for the NYS Conference of Local Mental Hygiene Directors, Inc.

Center for Human Services Research, University at Albany

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Acronyms

CCF	Council on Children and Families
CFTSS	Children and Family Treatment and Support Services
CHSR	Center for Human Services Research
CLMHD	NYS Conference of Local Mental Hygiene Directors, Inc.
C-SPOA	Children's Single Point of Access
C-YES/CYES	Children and Youth Evaluation Services
DCS	Department of Children's Services
HCBS	Home- and Community-Based Services
HFW	High Fidelity Wraparound
HHSC	Health Homes Serving Children
HHCM	Health Home Care Management
LHD	Local Health Department
MCO	Managed Care Organization
MRT	Medicaid Redesign Team
NYS	New York State
OMH	NYS Office of Mental Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SOC	System of Care
TA	Technical assistance
TA Network	TA Network at the Institute for Innovation & Implementation, University of Maryland School of Social Work

Executive Summary

Introduction

The concept of System of Care (SOC) is a framework with values and principles to guide the field in reforming child-serving systems, services, and supports to better meet the needs of children and youth with or at risk for mental health challenges and their families. The framework includes: 1) a clear philosophy to guide service delivery, 2) an infrastructure to guide services and supports for children, and 3) a broad range of services and supports (Stroul, Blau, & Friedman, 2010, Stroul, 2002).

Methods & Analysis

This report describes the results of two project activities: 1) analysis of quantitative and qualitative data from the SOC Survey, with the goal of identifying areas of strength and challenge in SOC implementation in New York State (NYS); and 2) in-depth qualitative data collection on specific domains of interest, with the goal of providing additional data on these domains to supplement webinar materials and inform SOC development conversations.

Analysis of survey data focused on subscale mean scores and proportions of high and low implementation for individual items. Analysis of interview data focused on extracting data that was relevant to the four selected domains of interest and identifying common and unique themes.

Key Findings & Conclusions

Interesting findings emerged across the data sources that point to successes and challenges in SOC implementation in NYS. Because the survey was collected in early 2020 and the interviews were completed in late 2021, the themes presented likely demonstrate persistent SOC-related successes and challenges in NYS that were extant prior to and persist during COVID-19.

Counties developed cultures of providers that champion the spirit of the SOC philosophy. Many counties and providers in NYS have done well at incorporating and prioritizing SOC values and principles into their work, as reflected in both the survey and interviews.

Individualized care was a strength in NYS. Individualized care items were among the highest scoring on the survey, and individualized care coordination was often reported to be sustainably funded throughout the interviewed counties. NYS counties have been particularly effective at implementing this SOC principle.

Family-driven care emerged as another strength in NYS. The family-driven subscale of the survey was among the most highly and consistently implemented SOC components in NYS. Interviews also revealed that many counties have processes in place to value and incorporate family input.

Counties had structures in place to facilitate a coordinated, cross-system approach to care. Many survey responses reflected counties' strong implementation of a coordinated approach. In addition, interviews revealed that counties often had multiple, regularly scheduled cross-systems meetings to facilitate this approach to care.

- **Counties faced difficulties building SOC infrastructure**. Securing sustainable funding and means to successfully build the infrastructure is essential to support well-functioning SOCs. Infrastructure survey items were rated as less implemented, and interviewed counties reported that SOC infrastructure components often lacked funding.

- **Counties encountered provider vacancies and turnover**. Survey short answer and interview responses pointed to challenges counties faced with provider vacancies and turnover. Counties would likely benefit from guidance and sustainable funding and other strategies to support the attraction and retention of qualified providers so that they are able to continue to serve families as effectively as possible.

- **Rural communities had unique challenges**. Rural counties expressed that SOC development strategies and standards often were not feasible for them to implement. Rural counties would benefit from guidance on creative and rural-specific solutions.

- **Counties had difficulty adjusting their SOCs to fit within the Health Homes Serving Children (HHSC) framework**. NYS recently implemented HHSC to facilitate care for youth and their families. Understandably, there has been confusion related to how this new infrastructure fits within the SOC infrastructure. Because of this uncertainty, counties reported that there are separate SOCs for Medicaid versus non-Medicaid youth. Guidance on how to integrate HHSC within SOCs, so that there can be one holistic SOC, would be beneficial.

Overall, counties found ways to successfully implement many aspects of SOC with their existing resources and skills. Counties were especially creative in finding new solutions to advance their SOCs and serve families given the restrictions in place due to COVID-19 (e.g., using videoconferencing to enhance collaboration and family-driven care). The webinars and technical assistance (TA) offered by the New York State Conference of Local Mental Hygiene Directors, Inc. (CLMHD) and TA Network at the Institute for Innovation & Implementation, University of Maryland School of Social Work (TA Network) are an important next step to give counties the tools they need to overcome challenges and further develop their local SOCs.

Introduction

Systems of Care

The concept of SOC is a framework with values and principles to guide the field in reforming child-serving systems, services, and supports to better meet the needs of children and youth with, or at risk for, mental health challenges and their families.

An SOC is defined as:

> A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. (Stroul, Blau, and Friedman, 2010)

The framework includes:

1. a clear *philosophy* to guide service delivery
2. an *infrastructure* to guide services and supports for children
3. a broad range of *services* and *supports* (Stroul, Blau, & Friedman, 2010, Stroul, 2002).

More specifically, the SOC *philosophy* includes the core values of being family- and youth-driven, being community-based, and offering culturally and linguistically competent systems and services. In addition to core values, guiding principles include a comprehensive service array, individualized care, provision of services in least restrictive settings, interagency collaboration and care coordination, evidence-informed practices and practice-based evidence, linkage with mental health prevention and early identification, accountability, and developmentally appropriate services for all ages: infants through young adults and their families (Stroul et al., 2010).

The *infrastructure* of an SOC includes structures and processes for system management and accountability, strategic planning, financing, management of high needs populations, defined entry points to care, an extensive provider network, data management and quality improvement, interagency partnerships, partnerships with youth and family organizations and leaders, strategic communication and marketing, and workforce development (Pires, 2010; Stroul & Le, 2017; Stroul, Dodge, Goldman, Rider, & Friedman, 2015).

Finally, an SOC also provides an array of *services* and *supports* for children, youth, and young adults with Serious Emotional Disturbance (SED) and their families. This array is comprised of options that are available in home and in the community, including community-based treatment interventions along with inpatient and residential interventions with linkages to community services (Stroul, et al., 2015; Stroul, Blau, & Larson, 2021). Building upon the SOC values and principles, evidence-based practices and culture-specific interventions are also widely available (Stroul, Blau, & Larson, 2021).

The SOC framework has recently been updated to include broadening the SOC to serve a wider population, including youth with substance use challenges and those involved with child welfare and/or juvenile justice systems. Adjustments were also made in emphasizing a broader array of services and supports with a set of core services in place, including the use of an intensive High Fidelity Wraparound (HFW) care coordination process. The SOC framework emphasizes the need to evaluate the effectiveness at both the system and service levels. In addition, in a well-functioning SOC, the SOC is widespread within the child-serving system and support is provided between communities and the state (Stroul, Blau, & Larson, 2021).

Project Background

Individual counties and communities across New York State (NYS) have received financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) to build and expand SOCs for many years. Although this funding has helped state and local communities have put many strategies into place to develop their SOCs, additional support for some components is needed.

NYS has also received state-level SOC Expansion grants for the past five years, beginning in 2016. These grants aided in the development of extensive infrastructure and provided ongoing support to expand and sustain the implementation of the SOC philosophy over the course of the grant and beyond. The statewide grants facilitated NYS Office of Mental Health (OMH) becoming a leader in SOC and guiding local SOC development throughout the state.

CLMHD, in partnership with OMH, sought to gain more insight into local SOCs statewide regarding best practices and challenges related to implementation. This information is essential to provide technical assistance (TA) on how to better serve children to ultimately improve outcomes for children with emotional, social and behavioral needs, and their families.

The goals of this project were to:

- acquire a more comprehensive understanding of local children's systems, including the coordination of major changes to the children's system and identification of best practices and specification of challenges to system-building and meeting family needs, and
- provide data on topics of interest to supplement webinar materials and inform conversations around these SOC topic areas.

This report is based on two data sources. The first was a statewide SOC survey, implemented in February 2020 by the Center for Human Services Research (CHSR). This survey provided both quantitative and qualitative data and was an informative first step in understanding local SOC development in NYS. Components with greater and lesser implementation were identified based on scores on quantitative items and themes that emerged from qualitative short-answer responses.

The second data source was interviews with county SOC leaders, conducted in fall 2021, to gain more specific information about implementation strategies and challenges. Topic areas of interest were identified by CLMHD with input from the project team and included:

- county cross-systems efforts to promote/strengthen the SOC;
- whether and how counties collect cross-systems data to drive cross-systems planning;
- whether and how counties blend and/or braid funding to support system of care (e.g., county tax levy, state aid, preventive services, grants, Family First Preservation Act, MRT, OMH Reinvestment); and
- whether and how counties are funding, supporting, and sustaining SOC components (e.g., wraparound facilitation, care coordination, evidence-based practices, family/peer support, crisis services, infrastructure, flexible service dollars, school-based efforts).

Findings in this report will help inform the Building Effective Children's Systems Webinar Series, facilitated by Denise Sulzbach[1] and Sheila Pires,[2] designed to provide TA to communities strengthening their SOCs. This webinar series consists of eight webinars, between October 2021-May 2022.

1 Deputy Director, The TA Network, The Institute for Innovation & Implementation University of Maryland School of Social Work

2 Managing Partner, Human Service Collaborative

2020 SOC Implementation Survey

Survey Introduction

OMH contracted with CHSR to administer the SOC Implementation Survey to SOC representatives throughout NYS to analyze the degree of SOC implementation at the county level. The survey was first administered in the winter of 2019, with an additional administration in winter 2020; the data presented in this report reflect the second administration.[3]

The SOC Implementation Survey was designed to examine SOC knowledge, gaps, and needs statewide. It was primarily comprised of the Rating Tool for Implementation of the SOC Approach for Children, Youth, and Young Adults with Behavioral Challenges and Their Families, which is designed to "assess progress in a community or region implementing the system of care approach for children, youth, and young adults with behavioral health challenges and their families" (Stroul, Dodge, Goldman, et al., 2015). The subscales of the tool reflected the major components of the SOC framework and the principles highlighted in the philosophy, infrastructure, and services and supports.

The survey included the following sections:

- SOC & HFW knowledge and prioritization (added to tool by CHSR),
- overall assessment of SOC implementation,
- strategic plan for the SOC approach,
- service delivery guided by the SOC approach,
- system infrastructure based on the SOC approach,
- commitment to the SOC philosophy and approach, and
- general thoughts on SOC (short answer responses, added to tool by CHSR).

Method

Sample

All Children's Single Points of Access Coordinators (C-SPOAs) of NYS were asked to provide a list of individuals who were meaningfully involved in their county SOC. The intent of this sampling strategy was to include representatives from all the child-serving systems in the county who would be most knowledgeable on SOC activities. Contact lists of potential survey participants were facilitated by OMH through feedback from C-SPOAs, the Health

3 The full report on the 2020 survey can be found here: https://www.albany.edu/chsr/Publications/SOC_Implementation_Report_2020_final.pdf.

Home Coalition, and existing SOC contact lists. Representatives from 53 counties and New York City[4] received the survey.[5] The survey was distributed to a total of 1071 individuals across the state; the number of individuals who received the survey per county varied widely, with a range from one to 48.[6] Responses were collected between February 5 and March 2, 2020. A total of 609 people answered at least some items of the survey, though 61 exited the survey before reaching the SOC implementation items. As such, usable data was received from 548 respondents, resulting in a 51% response rate.

Analysis

CHSR completed new analyses to identify more specific areas for improvement to help CLMHD target their SOC support efforts. Data were assessed in several ways to identify areas of strength and areas in need of improvement. Three additional analyses are included in this report:

1. Additional subscale descriptive analyses (e.g., low/high overall means, county by county variation to indicate high versus low consistency in implementation),
2. Items with fewer/greater ratings of extensive and substantial implementation, and
3. Strategies and challenges mentioned in the short answer responses.

Identification of relatively strong and challenging domains and items were addressed by examining descriptive statistics of subscales and individual items. Particular attention was paid to whether aspects of SOC had been implemented "substantially" or "extensively," as this level of implementation is ultimately the goal of the SOC initiative.

For most items on the survey, there was a substantial proportion of "don't know" responses. Because "don't know" responses may be indicative of communication challenges (i.e., aspects of the SOC are implemented but partners don't know about it) or lack of implementation, these responses were incorporated into some analyses, i.e., calculations in which "don't know" responses were treated as the absence of an affirmative response and were included in the denominator against which the percentage of affirmative responses is calculated. Charts showing the percent of respondents reporting "substantial" or "extensive" implementation for survey items are calculated in this manner, where "don't know" responses were considered an indication that the respondent does not believe that the item in question is substantially or extensively implemented. Where means were calculated, "don't know" responses were excluded.

One hundred and eight respondents (19%) responded to a final open-ended question asking whether they had anything else they would like to share. Responses were content-analyzed to identify themes relevant to strategies and challenges to SOC implementation.

Results

The following section of results describe the results of analyses of quantitative and qualitative data from the SOC Survey.

Subscale descriptive analyses

Subscales with the highest and lowest averages provide an indication of areas of greater and lesser implementation in NYS communities. Although the exact wording varied by section, the lowest response option typically indicated

4 NYC responses were considered together as one group, rather than by county.

5 Warren and Washington, and Fulton and Montgomery, were surveyed together because they have combined systems. The four counties who did not directly receive the survey were Allegany, Onondaga, Schenectady, and Schuyler, but some responses for these counties were received via respondents that serve multiple counties.

6 For one county, the 2019 contact list was used because an updated list was not provided in 2020, so this county had a greater number of contacts with 87.

no implementation and was assigned a value of zero, and the highest response option typically indicated high implementation and was assigned a value of four. All subscales averaged a score between two (corresponding with moderate implementation) and three (corresponding with substantial implementation), i.e., implemented moderately or higher.

Table 1 displays the average overall scores on each SOC topic area. Areas with greatest reported implementation (means = 2.63-2.73) were commitment of providers, family-driven approach, use of a least restrictive approach, commitment of youth and family leaders, and use of an individualized, wraparound approach. Areas with greater implementation thus tended to relate to SOC principles expressed in services and supports and commitment of partners, likely reflecting the commitments and efforts of staff. Areas with the lowest reported implementation (means = 2.01-2.10) were existence and use of a strategic plan, availability of out-of-home treatment services, use of a culturally and linguistically competent approach, and SOC infrastructure in place. These areas were the more concrete aspects of SOC development, e.g., plans in place, infrastructure components in place, and services available, which require more planning, assistance, staff time, and finances.

Figure 1 displays the range of responses between the lowest county average and the highest county average on each of the SOC areas. Large ranges may indicate SOC components that were less consistently implemented in NYS communities. Even if the average is higher, if some communities are scoring lower in a certain area, targeted TA may be warranted.

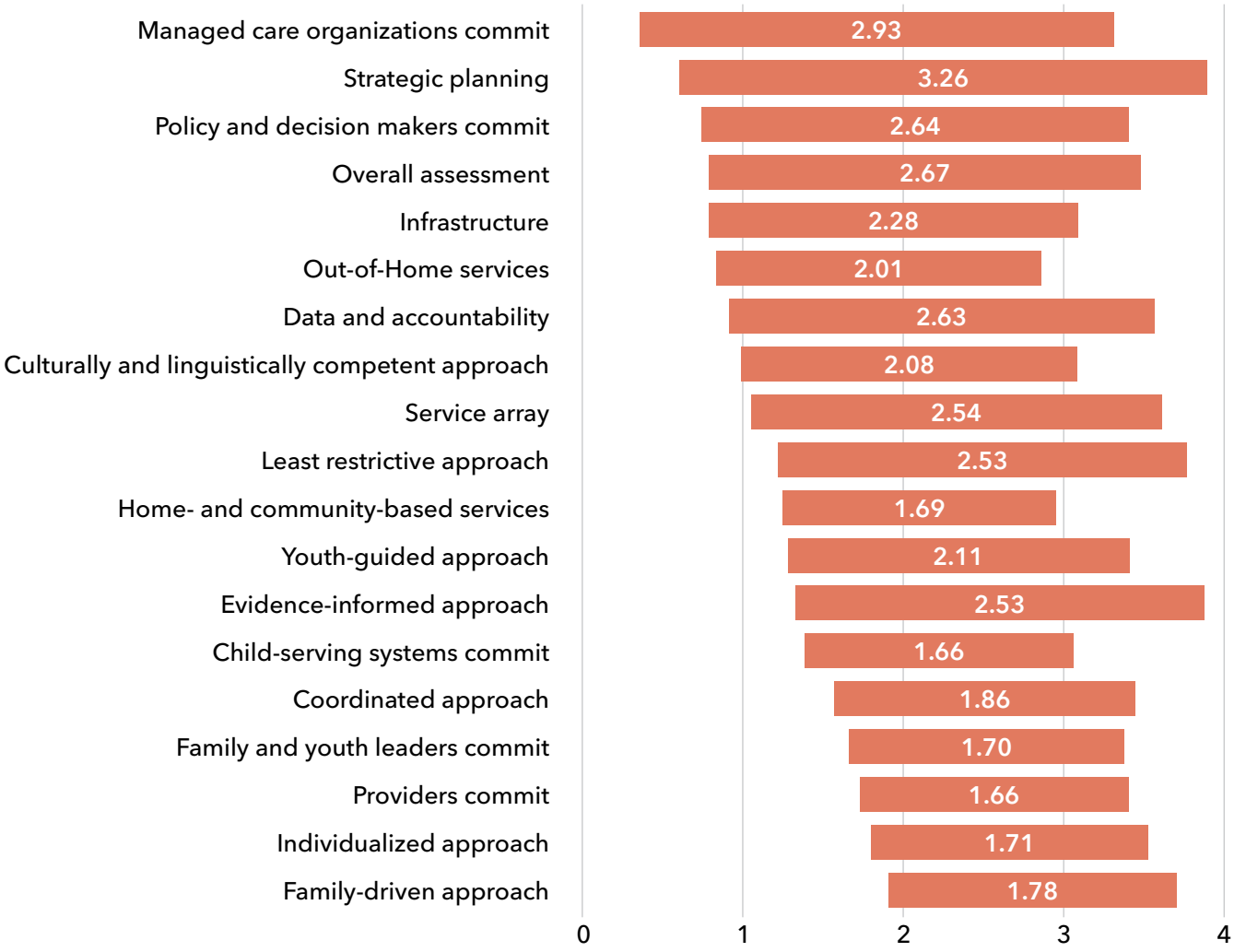
SOC components with the lowest minimum scores include managed care organization commitment, existence and use of a strategic plan, policy and decision maker commitment, overall rating of SOC implementation, SOC infrastructure in place, out-of-home service availability, data and accountability, and use of a culturally and linguistically competent approach. Again, components like developing infrastructure and a strategic plan maybe be more resource-intensive than other SOC areas. The lower commitment of MCOs and policy and decision makers in some counties may be especially problematic because these leaders are often needed to make desired changes in the SOC.

TABLE 1. SOC subscale means (n = 261-420, "don't know" responses excluded)

Category/Subscale	Mean
Strategic planning	**2.01**
Principles	**2.44**
Family-Driven Approach	2.71
Least Restrictive Approach	2.64
Individualized, Wraparound Approach	2.63
Coordinated Approach	2.61
Data and Accountability	2.54
Evidence-Informed Approach	2.39
Youth-Guided Approach	2.23
Service Array	2.11
Culturally and Linguistically Competent Approach	2.07
Services	**2.13**
Home- and Community-Based Treatment	2.18
Out-of-Home Treatment	2.04
Infrastructure	**2.10**
Commitment	**2.41**
Providers	2.73
Family and Youth Leaders	2.63
Policy and Decision Makers	2.35
Child-Serving Systems	2.34
Managed Care Organizations	2.31
Overall SOC Assessment	**2.17**

SOC areas with the highest minimum scores include commitment of providers and youth and family leaders, use of an individualized, wraparound approach, and use of a family-driven approach, which indicates that providers are generally committed to implementing services and supports consistent with SOC values.

FIGURE 1. Range between the lowest county average and the highest county average, by SOC area (n = 261-420, "don't know" responses excluded)



SOC areas with the smallest ranges are more similarly implemented throughout NYS; these components include provider commitment, child-serving system commitment, availability of home and community-based services, family and youth leader commitment, and use of an individualized, wraparound approach. These areas tended to also be areas with high means (see **Table 1**).

SOC areas with the largest ranges are less consistently implemented in NYS, with some communities having higher and other communities having lower implementation; these components include existence and use of a strategic plan, commitment of managed care organizations, overall SOC implementation, policy and decision maker commitment, and use of data and accountability mechanisms. The less consistently implemented components are similar to those with the lowest minimums, pointing to areas where targeted TA would be helpful.

It may also be helpful to combine these metrics. Implementation areas with high county minimums and smaller ranges are those that were consistently more developed and thus need little to no TA. TA would be most efficient if focused on areas with low minimums and small ranges (where more counties are struggling), and, secondarily, areas with low minimums regardless of their range or average (i.e., where at least one county is struggling), as displayed in **Table 2**.

TABLE 2. Summary table, lower and higher implementation areas

		County Minimum Score	
		Low: Areas for improvement	**High: Greater, more consistent implementation**
Score Range	**Small**	• Out-of-Home Treatment Services • Culturally and linguistically competent approach • Infrastructure	• Family-driven approach • Individualized, wraparound approach • Provider commitment
	Large	• Managed Care Organization commitment • Existence and use of a strategic plan	

As such, future TA would benefit counties by focusing on strategies to incorporate MCOs into the SOC, create and implement strategic plans, expand out-of-home treatment services, implement culturally and linguistically competent approaches, and build SOC infrastructure. Counties tend to be more successful implementing family-driven and individualized approaches and maintaining high provider commitment to SOC values and principles.

Items with fewer ratings of extensive and substantial implementation

While the prior analyses focused on overall subscales, this section shifts focus to the items within the subscales. Examining individual items can lead to more specific guidance on areas of strength and difficulty.

The following items are included based on the percentage of respondents indicating that they were "substantially implemented" or "extensively implemented". Individual items with lower levels of extensive and substantial implementation may indicate specific areas that are more difficult to implement and where counties may need assistance, whereas areas with higher levels of extensive and substantial implementation may indicate specific areas that are more successfully implemented already.

Table 3 displays the items where 25% or fewer respondents reported substantial or extensive implementation.[7] These items tended to be about the existence and connectedness of services or SOC infrastructure. Items with the least frequent ratings of substantial and extensive implementation were primarily services: tele-behavioral health services[8], medical detoxification, therapeutic mentoring, and transportation.

All items with low percentages of substantial or extensive implementation also had high percentages of "don't know" responses, which indicates that if the components do exist, key stakeholders may not have been aware of implementation in these topic areas, consistent with a lack of strategic communications within the SOC regarding that topic area.

7 Full data tables of all items located in Appendix A.

8 This survey was implemented in the month prior to New York State On PAUSE (stay at home) orders due to the COVID-19 pandemic; this service is likely more widely available as of this report.

TABLE 3. Items where 25% or fewer respondents reported substantial or extensive implementation, ordered from lowest to highest within subscale sections (n = 401-533, "don't know" responses included)

Services Subscales

Item text	Substantially/ extensively implemented
Tele-behavioral health services	11%
Medical detoxification	13%
Therapeutic mentoring	14%
Transportation	14%
Therapeutic behavioral aide services	20%
Substance use residential treatment	20%
Youth peer support	22%
Crisis stabilization beds	22%
Therapeutic group home care	22%
Supported independent living	22%

Infrastructure Subscale

Item Text	Substantially/ extensively implemented
Structure and/or process for strategic communications/social marketing	15%
Financing for system of care infrastructure and services	17%
Structure and/or process to manage care and costs for high-need populations (e.g., care management entities)	18%
Structure and/or process for measuring and monitoring quality, outcomes, and costs (including IT system) and for using data for continuous quality improvement	19%
Structure and/or process for training, TA, and workforce development	22%
Structure and/or process for partnerships with youth organization and youth leaders	24%

Items from "other" subscales

Item Text	Substantially/ extensively implemented
Flexible funds are available to meet child and family needs not financed by other sources	23%
SOC Commitment of Medicaid system	25%

Items with more ratings of extensive and substantial implementation

Items with a greater proportion of extensive and substantial implementation may indicate areas that have been implemented more successfully. **Table 4** displays items where at least 55% of respondents reported substantial or extensive implementation.

Items with the highest levels of substantially/extensively implemented ratings likely reflect areas that are prioritized and well supported in NYS. These items also tended to have lower percentages of "don't know" responses (i.e., < 20%), which may indicate greater knowledge of implementation of that topic area. Items with more reports of substantial and extensive implementation included mental health system partner commitment, family strengths are incorporated in service planning and delivery, and individualized assessments of child and family strengths and needs are used to plan services and supports.

TABLE 4. Items where at least 55% of respondents reported substantial or extensive implementation, ordered from highest to lowest within subscale sections (n = 401-533, "don't know" responses included)

Individualized, Wraparound Approach to Service Planning and Delivery Subscale

Item text	Substantially/ extensively implemented
Individualized assessments of child and family strengths and needs are used to plan services and supports	58%
Individualized service plans are developed and implemented for each child and family that address multiple life domains	55%

Family-Driven Approach Subscale

Item Text	Substantially/ extensively implemented
Family strengths are incorporated in service planning and delivery	60%
Families have a choice of services and supports	55%
Families have a primary decision making role in service planning and delivery	55%

SOC Partner Commitment

Item Text	Substantially/ extensively implemented
Mental health system	60%
Direct service providers (clinicians and others)	55%

Items from "other" subscales

Item Text	Substantially/ extensively implemented
Coordinated Approach - Basic care coordination is provided for children and families at lower levels of service intensity	55%
Home- and Community-Based Treatment and Support Services (Nonresidential) - Outpatient individual therapy	55%

Survey Short Answer Responses from SOC Participants

Many respondents provided rich responses to the short answer items regarding challenges experienced and strategies developed by their local SOC. A full list of deidentified responses is included in the Appendix B.

Whereas many respondents expressed that their counties, in general, had at least some SOC components in place, some respondents reported specific strides made in their county towards SOC implementation such as successful collaborative efforts. One respondent reported that,

> As an educator in our region, I am very pleased with the interest on the part of all those providing behavioral health services and support in collaborating with educational agencies and family support groups in an effort to improve the care and potential for success of youth in our region.

Another said, "I strongly believe efforts are made to collaborate with systems of care and community providers to ensure the efficiency of the quality of care provided to children and families." Having successful SOC champions and leadership in place was also mentioned, one respondent said, "I think the intention is [sic] our county among SOC leadership is very positive and forward thinking."

Some respondents believed in the SOC philosophy but were less sure of the feasibility of implementing an SOC. In the words of one respondent, "Conceptually the SOC is a solid framework, however the implementation and resources needed to reach a vast number of students impacted by their health and mental health is monumental."

Another respondent elaborated on this feasibility concern by describing state-level barriers that reduce implementation feasibility:

> I have worked in the system for many years and always committed to SOC philosophy and goals however, I have been part of so many work groups and so many conferences/processes to reduce the silo's or barriers between state agencies, that in my opinion have a tremendous influence on local structures because of funding streams and programmatic regulations that can be in conflict between the various human service systems that it is disheartening [sic].

Several respondents also noted they were new to their county or positions and/or were not yet knowledgeable about SOC.

SOC Implementation Challenges

Many comments described challenges that stakeholders faced when trying to implement SOC and problems they perceived with current SOC implementation. Specific challenges are described below.

Lack of Service Availability

One component of SOCs is to have a wide array of services available to help youths and their families. Many comments referenced a shortage of services needed to meet the complex challenges of families within their communities. One respondent explained that "there simply are not many services available. It is not that people don't want to provide them they simply don't exist." Another described how "being a family peer support, I find it hard for families to stay positively engaged as there are fewer and fewer services/programs to help their families."

When services were available, many reported that long waitlists led to delays in receipt of needed services. One explained that "Our mental health organizations are overwhelmed and [have] wait lists." This challenge seemed to be particularly relevant to rural counties. According to one respondent, "SOC is lacking is small rural communities. There are major gaps, or lack of services or no services at all."

Some respondents specified the types of services they would like to be more available in their communities. For example, one stated that "I would like to see increased supports for preschool families and youngsters;" another saw a need for a "local partial hospital program. These families need us to be more available and a flexible system."

Another respondent noted that the lack of services has led to higher-end service use for some youth:

> There is a lack of timely community services and supports available to children with and without Medicaid. This is increasing their level of need and placing children in inpatient settings and residential settings that could potentially be successful in their homes and communities with supportive services.

The availability of services seemed to be a greater issue for rural communities because lack of transportation and travel distance needed to get to services impeded the ability of youth to access services in the region. As one respondent noted, "I think it's important to know that there is a real lack of services in the county and although the services exist in the region, distance is a real barrier for many people."

Staff Shortages/Turnover

Service availability was further hindered by staff shortages and turnover. Staff shortages were prevalent at the direct provider level, according to respondents, with many mentioning challenges related to attracting and retaining skilled providers. As one respondent explained, "The SOC in this county is restricted by the general lack of qualified service providers."

These staff shortages made it challenging to implement services and SOC-related practices and added additional strain to the remaining providers. In the words of one respondent, "In our county there is a significant lack of work force to implement these changes. Mental health clinicians burn out and leave due to the level of stress from high caseloads." Another described "I have observed more people around the table but fewer interventions being delivered due to the complexity of the process and the lack of people to provide the services."

It is important to note also that these responses were collected prior to the COVID-19 pandemic, which likely further increased staffing shortages and additional service provision challenges which may have led to increased strain on remaining staff.

Some also mentioned staff turnover at the key stakeholder level which hindered the implementation of SOC. One such respondent explained that "since we have had a complete turnover of County leaders and have lost the momentum and SOC focus." General lack of staff to effectively implement an SOC was also mentioned: "not enough staff to support the system!!!!!"

Besides providing SOC-necessary services, staffing shortages may have made it more challenging for staff to incorporate the SOC philosophy and values into their work. As one respondent explained, "The challenge remains helping agencies and workers, already over committed and often underpaid, to take time to fully understand." Staff likely do not have time available to take on extra trainings or tasks to help advance their SOCs.

Funding

Respondents also reported lack of funding as a challenge to implementing programs and services necessary to their SOC. One described, "It is very disheartening that the financial state of the SOC is causing regions and agencies across the state to not be able to support these wonderful services. I hope that we can come up with a plan to continue to provide these services to the youth in our care."

In addition, one respondent preferred that some of the funding that goes into larger, short-term initiatives or programs be allocated to county-level, local initiatives and programs:

> I have been in the children's mental health field for many, many years and I have found that the system is so busy trying to find a solution that they change direction too many times. Never giving a plan a time to work. If we had the money that has been spent on different programs and processes we'd have more money to put into programs specifically for peer-run solutions.

Effects of Medicaid Redesign Team (MRT)

MRT was an initiative designed to address underlying health care cost and quality issues in New York's Medicaid program.[9] MRT focused on programmatic changes to the way health care is provided, reimbursed, and managed to maximize quality and efficiency of care. Implementation of Health Homes for Medicaid enrollees was an initiative recommended by MRT.[10]

Many respondents expressed continued adjustment to the Medicaid transformation. One explained that "after going through the large transformation in Children's Mental Health, we have some re-building to do." Some noted that MRT/Health Homes Serving Children (HHSC) was a barrier to, rather than a facilitator of, SOCs; as one respondent noted, "I feel that many responses to questions would have been more favorable to a system of care prior to the recent Medicaid redesign and subsequent changes in service delivery for youth." Some felt the new system was too complex and difficult for families to understand. One asked if, "We as Care Managers, (many of us well-educated and carrying a large student loan debt) struggle to understand this system, how can we expect lay people to understand its complexities?"

Other descriptions also pointed to MRT as a cause of their current challenges. Some reported MRT reduced service eligibility, such as one respondent who said,

> There is also, a group of children that C-YES [Children and Youth Evaluation Services] has determined doesn't meet their level of care and aren't eligible for Medicaid or CFTS [Children and Family Treatment] services but the child and family has determined needing a higher level of support.

Other respondents reported that MRT-related changes led to delays and high family burden when initially connecting to care. One respondent reported, "I have several families who have applied for family of one Medicaid and have been waiting months for decisions and dealing with constant demands for more documentation, intrusive home visits, and questions about personal information."

Another respondent described the delays and barriers to connecting to care more specifically:

> One family I worked with for which I submitted an application on 4/7/19 did not gain approval until 10/19 when the child was placed in a community residence. In that time they were required to provide a year's worth of financial and personal information. This same family and I attended a scheduled meeting with the local Maximus representative and when we arrived we were told that there was not an appointment. Since I had a copy of an email sent to me by CYES, I was able to prove that there was an appointment, but what if I was not there? The family missed work that day, they had all of their documentation ready.

Home- and Community-Based Services (HCBS) and Children and CFTSS are designed to be available to Medicaid-enrolled youth. However, these services face many similar hurdles to the general service challenges listed above, including low availability, lack of staff, and inadequate funding. One frequently mentioned hurdle was reduced service availability and long wait lists: "Families are not adequately being served due to lack of services and long wait lists." Service delays were also attributed to delays in referral processing: "The Health Home folks and the private agencies are over worked and cannot keep pace with referrals. I have found these agencies to be tremendously helpful, supportive and integral. However, they are overwhelmed with number of referrals."

Service availability is further hindered by lack of staff, "I believe many of the HCBS services still do not have enough providers in our county. We lack appropriate higher level of educational services within the county, and although the county utilizes day treatments in the region, it seems as though there are fewer options available."

9 https://www.health.ny.gov/health_care/medicaid/redesign/

10 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Some suggested that low reimbursement rates disincentivized employment within the service provider profession, another factor constraining the supply of services: "CFTSS providers can't hire staff due to rates and regulations and many services are unavailable to the vast majority of people that qualify for the services," and "Agencies are not able to sustain HCBS services due to the reimbursement rate."

Another respondent elaborated on how low rates hindered service provision:

> There is also not enough funding or people hired to provide some of the services that have been allotted to serve the children in our community. One example is the Psychosocial Rehabilitation Service, which does not pay enough to obtain qualified service providers, and still has a waiting list to obtain services.

Another noted that, "CFTSS services are theoretically available in XXX County but provider agencies are having significant difficulty hiring staff due to the low reimbursement rates… In reality, these services are available on a very limited basis."

In addition to reimbursement rates, others felt that the new competitive work climate has led to staff shortages. One respondent said, "the Medicaid redesign became a business for agencies to capture clients for payment. This has resulted in much turnover in staff and to large of caseloads for people to work with."

Others mentioned the burden of new paperwork and logistical requirements affecting the quality of service delivery, saying that "I believe some of the new changes (especially with the health home care management system) has made it difficult to provide quality hands-on services to the children and family served due to the amount of paperwork and layers attached to obtaining and keeping services." Another felt that MRT had negatively affected service quality because it "…watered down available services and spread available resources out more thinly in rural areas."

There were some misgivings connected to MRT-related changes in local child-serving systems, and many counties struggled to build their SOC amidst the MRT-related changes. County leaders would likely benefit from guidance on how to operate an SOC within the HHSC/MRT landscape.

A Different System for Medicaid versus non-Medicaid Youth

Another service issue several respondents described was the development of what one respondent described as "two systems of care:" a private SOC and a Medicaid SOC. Another respondent noted that "whether or not a child has Medicaid would impact many of my answers."

Respondents posited that privately insured youth lacked access to residential care and crisis stabilization services and often fell into eligibility gaps, while services for Medicaid recipients were more widely available because of Medicaid's more comprehensive array of reimbursable services. Thus, whereas some respondents found Medicaid reimbursement to be insufficient, others said private insurance supported even fewer service options. One respondent stated:

> Like other counties with a large non-Medicaid population we seem to be developing a two tier SOC, one for children with Medicaid and one for children with commercial insurance. The services available to children with Medicaid are more diverse, better reimbursed and are able to be accessed earlier in the course of treatment. The SOC for children with commercial insurance, who do not meet HCBS LOC [level of care], is substantially lacking in comparison.

This lack of services for privately insured families has necessitated higher-end service use. As one respondent explained, "There are [sic] a real lack of services for families in crisis and particularly if they have private insurance. Many are spending days in ER rooms with no options for families."

Engaging all Relevant Stakeholders in a Collaborative Manner

A common theme that arose from responses was that all the necessary SOC leaders were not at the table and committed to the SOC. For an SOC to function well, all child-serving systems need to be involved. To have all partners actively involved, they all need to be at the table, communicating, and collaborating effectively. One respondent noted, "Currently there are no parents/caregivers or youth on the SOC committee. Although there are many community providers on the committee, most are not following the SOC approach." Another respondent remarked, "that is part of the problem that system [OPWDD] does not seem to want to engage with or provide services in a system of care." Another respondent explained that:

> LHD's [Local Health Departments] are not invited to the table, as they should be. I had to ask to be invited to the Regional Planning Consortium to gain a better understanding of the Health Homes. However, I am the only LHD representative at the table.

Others struggled to bring new stakeholders into the SOC. One respondent described, "I believe that we started with a good foundation for our local SOC but things slowly died down and new stakeholders (such as hospitals and other local agencies) were not brought to the table so we have the same 8/9 agencies as always."

Even when all the necessary players were present, some counties still experienced challenges with collaboration and communication, expressing that the systems were not functioning in an integrated manner. One respondent mentioned, "I believe we are still functioning in silo's and not as integrated."

Another respondent elaborated:

> The breakdown is in the understanding of roles and responsibility's and how the various agency's can work together to support each other and play their part. It seems each agency operates in a silo rather than with systemic operations to meet the needs of the child/family. The need is to actually develop and function as a network of service and support to each other and the children/ Family's [sic].

Collaboration was hindered by varying commitment in SOC among the partnering agencies. As one respondent noted, "There is unequal participation and commitment to SOC. Some of this is related to expectations regarding immediate improvements and disappointment in slow change or progress." Collaboration was also impeded by communication difficulties such that "there is a lack of communication between service providers where one may have information about a service while others do not."

Strategies Implemented in developing SOCs

Challenges were more prevalent in participants' responses than strategies; however, several strategies were noted as either being already implemented or needed. Strategies were related to collaboration and communication, formal SOC infrastructure, and funding.

Collaboration and communication:

- Be solution- focused while identifying barriers. Maintaining transparency and giving feedback to NYS is essential in growth and quality.
- Obtain input from families and workers on the front lines.
- Facilitate SOC committees or groups that help to facilitate cross-systems work, engaging all levels (e.g., decision makers, service recipients, providers).
- Highlight effective, cross systems SOC work at the NYS level, which would serve as an example and help promote local SOC development.

Formal SOC infrastructure:

- Have a cohesive SOC sustainability plan in place.
- Implement oversight of SOC implementation from an independent source.
- Designate a lead agency to organize SOC efforts.
- Obtain buy-in and investment of decision-makers, i.e., top-down support.
- Incorporate the SOC into existing infrastructure, such as Health Homes, to increase efficiencies, which would improve client outcomes by maximizing existing resources.

Funding:

- Create state funding/funding streams to support the SOC (e.g., fund staff, support peers, offer more services).
- Allow flexibility to use state funding resources creatively.
- Advocate for commercial insurances to cover all services (e.g., crisis stabilization is highly needed).

Survey Data Analysis Summary and Conclusions

SOC Areas with More Implementation in NYS

The survey findings helped to point to areas of SOC that are strengths in NYS.

Provider Commitment to SOC. Though many short answer responses described provider shortages and providers being stretched too thin, provider commitment was amongst the highest rated sections on the survey. Even as existing providers are facing more stressful environments and more burnout, they remained committed to serving families in a manner consistent with SOC philosophy and values.

An Individualized Approach to Children's Services. This subscale was among the highest scoring subscales. Respondents reported high implementation on the item "implementation of individualized assessments of child and family strengths and needs are used to plan services and supports," as well as "individualized service plans are developed and implemented for each child and family that address multiple life domains."

SOC Areas that may Need Additional Support in NYS.

Based on survey findings, the following areas should be examined as areas for additional training and TA to help facilitate local implementation of these SOC components.

SOC knowledge amongst key stakeholders. This survey was targeted to individuals identified by their county C-SPOAs as being important players in the SOC; however, several respondents were new and/or not knowledgeable about SOC. In addition, many survey items had high percentages of "don't know" responses. This information supports the need for ongoing SOC trainings (or access to archived trainings) to reinforce the SOC framework and SOC-related activities for new or less knowledgeable staff. SOCs should consider incorporating basic SOC training at the provider or county level into the onboarding process for those working in the children's systems.

Commitment of leaders and decision makers. Decision makers were perceived as being less committed to SOC. Having SOC champions in leadership is essential to build the infrastructure, services, and programs necessary to maintain and grow an SOC. This group includes MCOs, who determine what services are reimbursable (and therefore available) for participants. SOCs would benefit from guidance and TA around how to incorporate decision makers and MCOs into the SOC.

Creation and execution of SOC strategic plans. Few respondents were aware of their county executing an SOC strategic plan. Counties could benefit from more guidance on creating and executing these plans in a cross-system way so that all relevant SOC stakeholders are involved.

Building SOC infrastructure. Counties had challenges implementing SOC infrastructure components; many of the individual items in the infrastructure subscale were among those rated with lowest implementation. SOCs could benefit from guidance in building:

- a structure and/or process for strategic communications/social marketing;
- financing for system of care infrastructure and services;
- a structure and/or process to manage care and costs for high-need populations (e.g., care management entities);
- a structure and/or process for measuring and monitoring quality, outcomes, and costs (including IT system) and for using data for continuous quality improvement;
- a structure and/or process for training, TA, and workforce development; and
- a structure and/or process for partnerships with youth organization and youth leaders.

Operating an SOC within the HHSC/MRT landscape. Many short answer responses described negative impacts of MRT/HHSC on children's services. Large system changes like this can be challenging to adjust to. Counties need additional guidance on how best to operate their SOC within this structure.

Addressing challenges faced by small, rural communities with fewer services available. Rural communities faced difficulty implementing SOCs due to services being less accessible and/or available. Examples, demonstrations, and specific instructions related to SOC implementation in rural communities would be beneficial.

Identifying and using funding to build and support the SOC. Lack of funding impacted the ability of SOCs to hire staff and provide necessary services and supports. Identifying funding sources that could be allocated to providing these less widely available services and supports would be beneficial:

- tele-behavioral health (likely now more widely implemented due to the COVID-19 pandemic),
- medical detoxification,
- therapeutic mentoring,
- transportation,
- therapeutic behavioral aide services,
- substance use residential treatment,
- youth peer support,
- crisis stabilization beds,
- therapeutic group home care,
- supported independent living, and
- flexible funds.

Creating a level playing field for Medicaid and non-Medicaid youth. Some counties reported that non-Medicaid youth were at a disadvantage when receiving needed services. Counties would benefit from learning what they can do to best serve their non-Medicaid youth.

Getting all the necessary players to the table and working in a truly collaborative way. Some local SOCs were still missing important representative involvement, such as: the OPWDD, service recipients, and hospital representatives. With the changes to the children's system, representatives from HHSC are also important, but their involvement in SOC discussions and decision making was not mentioned. SOCs would benefit from additional information on how to integrate systems (including newer players like HHSC) and reduce siloes.

In-Depth interviews

In-depth qualitative data collection on specific topics of interest was conducted, with the goal of providing additional data on these topics, supplementing webinar materials, and enhancing conversations around these important SOC topic areas.

Sample Selection

Sites were selected for qualitative interviews based on several factors:

1. **High scores on subscales of SOC survey relevant to the domains of interest.** These scores could help identify counties with effective strategies in the domains of interest in place.
2. **Recent SOC grant recipients who are no longer grant-funded.** These sites could help identify strategies that were put into place during the funding period to build SOCs that were sustained post-grant.
3. **Input from the project team.** The team provided additional input based on their familiarity with the SOCs throughout the state, resulting in several adjustments to the sample list.

A full description of the sample selection process is available in Appendix C.

The final sample consisted of the following 16 counties:

- Albany
- Cayuga
- Chautauqua
- Chenango
- Dutchess
- Erie
- Genesee
- Greene
- Monroe
- Nassau
- Orange
- Otsego
- Putnam
- Rockland
- Westchester
- Wyoming

Protocol Development

The interview protocol was developed to address four domains of interest:

1. Cross-systems efforts to strengthen the SOC;
2. Blending/braiding funding to support the SOC;
3. Funding, supporting, & sustaining SOC components; and
4. Collecting cross-systems data to facilitate cross-systems work.

The interview protocol development was led by CHSR, incorporating input from all project partners. The full protocol can be found in Appendix D.

Interview Process

The C-SPOA and Department of Children's Services (DCS) Commissioners were contacted for each of the identified counties. These representatives were asked to identify up to three additional relevant partners to participate in a group interview. They were also asked to select an interview time that worked for their group and to identify stakeholders to complete the funding table portion of the protocol. Up to three emails were sent approximately two weeks apart if no response was received.

Interviews were conducted via Zoom and included a facilitator and a note taker from CHSR. All interviews were recorded where permission was granted. Interviews were restricted to one-hour time slots, and the interviewer asked as many questions as possible during this time, with a focus on asking at least some items in each of the four domains.

The final interview sample included 13 counties (81%): Chautauqua, Chenango, Dutchess, Erie, Genesee, Monroe, Nassau, Orange, Otsego, Putnam, Rockland, Westchester, and Wyoming counties. Interviews were conducted between 9/20/21 and 10/14/21.

Table 5 identifies the characteristics of the counties who participated in interviews. Counties were from the Western (n=5), Hudson River (n=5), Central (n=2) and Long Island (n=1) regions of the state. The range in population size was large, from 39,465 (Wyoming) to 1,351,334 (Nassau), as was the household median income, from $50,272 (Chautauqua) to $116,100 (Nassau). About half (6/13) of the counties were recent SAMSHA System of Care grantees; two were currently funded, and four were recently-funded former grantees whose SAMHSA funding has since lapsed.

TABLE 5. Sample County Characteristics[11]

County	Region	County Population	Median Household Income ($)	Current/recent SAMHSA SOC expansion grantees (2008+)
Chautauqua	Western	126,032	50,272.00	current (2019)
Chenango	Central	46,730	52,002.00	
Dutchess	Hudson River	293,293	81,219.00	
Erie	Western	917,241	58,121.00	
Genesee	Western	56,994	60,524.00	
Monroe	Western	740,900	60,075.00	former (2012)
Nassau	Long Island	1,351,334	116,100.00	former (2008)
Orange	Hudson River	385,234	79,994.00	former (2008)
Otsego	Central	58,701	54,028.00	current (2017/2018)
Putnam	Hudson River	98,532	104,486.00	
Rockland	Hudson River	326,225	93,024.00	former (2016)
Westchester	Hudson River	965,802	96,610.00	
Wyoming	Western	39,465	58,052.00	

11 Region based on OMH regions; population based on the 2020 Decennial Census; SAMHSA grantee status obtained from SAMHSA website 7/19/2021; income based on Annual Resident Population Estimates for States and Counties, July 1, 2020

The number of interviewees within each county interview session ranged from one to seven. The C-SPOA coordinator participated in all interviews. The participation of C-SPOA coordinators was essential given that they have historically served critical functions within county SOCs, including receiving referrals and identifying the best service and support arrangement for multi-system involved children. They were joined by one or more individuals in all but one interview, with four interviews including five or more participants. DCS Commissioners participated in 10 of the 13 interviews. Other attendees were from other child-serving systems such as probation, BOCES, care management agencies, and the Youth Bureau. A complete list of the participants and their roles by county is available in Appendix E.

Data Analysis

Interview notes for each interview were reviewed by a total of three reviewers. Two reviewers extracted data relevant to the four domains of interest and a third reviewer then completed a thematic analysis of the extracted data to identify common and unique themes.

The coding of interview data focused on implementation strategies and challenges in each of the four domains of interest. Due to the emergence of common themes from the two funding-focused domains, these two domains were combined in the findings.[12]

Interview Findings

Domain 1: County cross-systems efforts to strengthen the SOC

County cross-systems efforts to promote or strengthen the local SOC consist of activities intended to promote collaboration among child-serving systems. Collaboration increases the effectiveness of services and supports for youth whom SOCs are designed to serve (i.e., those who have complex mental health needs, are multi-system involved, are at risk of out-of-home placement, and/or have difficulty participating in one or more social setting and their families; these youth will be referred to as "youth with complex behavioral health needs"). Interviewers asked about specific activities, including whether counties:

- established a common mission or vision statement to galvanize and guide multi-system efforts; and
- held cross-systems meetings, including 1) collaborative meetings to discuss individual youth and 2) collaborative meetings to discuss broader child-serving initiatives and oversee system of care policies.

General status

Most counties were unaware of the existence of a multi-system mission or vision statement. However, all respondents said their child-serving systems informally adhered to SOC values and principles.

All counties reported having collaborative meetings to discuss individual youth. C-SPOA coordinators led these meetings, and they consisted of discussions around facilitating access to services for youth with complex behavioral health needs. Several interviewees said family participation in these meetings was necessary because they involved discussion of the services for which families were eligible, with some noting that to exclude families would not be in keeping with the SOC philosophy. However, most counties said family participation in these meetings was inappropriate, with the following reasons provided as rationale:

- These meetings are about "service systems getting our act together." Service system representatives need to discuss service options before presenting these options to families.

12 In addition, data were reviewed for strategies relevant to these webinar topic areas: family engagement and partnership; youth engagement and partnership; equity, cultural, and linguistic competence; collaboration and governance; data and quality measures; financing; and core service components. Summaries of this data were shared with the team but are not included in this report.

- Families face transportation limitations. Not all families have transportation to get to the meetings.
- Involving families is a poor use of their time. In some situations, families that can attend are either forced to sit through the entire meeting, which includes discussions of other families, or must wait to join the meeting until their service options are up for discussion.
- One interviewee said the meetings were "traumatizing" because it places the family in an undignified position whereby they must "beg for services."

In general, counties that did not involve families in C-SPOA meetings said they contacted families before the meetings to identify needs and service preferences and then again after to relate options.

All interviewees said they had strong cross-systems participation in these collaborative meetings to discuss individual youth, though the practice of involving system representatives varied by county. Some counties held meetings with representatives from a plethora of child-serving systems in attendance, whereas others held meetings primarily with mental health providers but invited other child-serving system providers as needed. In addition to mental health providers, most counties reported consistent attendance from child welfare, schools or BOCES, and family and youth peer advocates. Other less common attendees included representatives from juvenile justice and intellectual or developmental disabilities agencies. Two key entities that rarely attended interviewees' collaborative meetings focused on individual youth were HHSC and MCOs.

All counties also reported holding collaborative meetings to discuss broader child-serving initiatives and oversee system of care policies. In general, interviewees described these meetings as focusing on identifying current trends in children's needs, service availability, and emergent programs, often based on evidence from attendees, whether anecdotal or empirical. All counties were specifically asked about whether discussion in these forums led to policy change; none noted such occurrences. Similar patterns of attendance at meetings to discuss systems-level issues were also observed, with HHSC most notably rarely in attendance.

Although not asked about explicitly, all counties also reported conducting care coordination meetings, though the method by which these were conducted varied, with most counties conducting these meetings as part of HHCM. Several also said they offered care coordination meetings through HFW for a limited number of youth through the NYS OMH HFW pilot project and/or care coordination, with some elements of wraparound through which services (e.g., HCBS) were coordinated. One county stated that they offered wraparound for all youth.

Challenges, solutions, and strategies

Use grants and workshops to develop plans to coordinate cross-systems work. Interviews revealed that several counties lacked written mission or vision statements. Because such statements are the foundation for developing plans to galvanize and guide multi-system efforts, counties could benefit from external support to structure forums for developing these statements and plans. Grants could be used to provide financial support for plan development. One county that had external funding to brand their SOC said they had a consultant "come in and lead our meetings and organize everything: [we talked] about what to name the SOC and to come up with a mission, a vision, etc. It was a lot of meetings; a lot of post-it notes; a lot of whiteboards, but we got there."

While it may be effortful to obtain the external funding to support and then execute these types of planning sessions, having plans appears to be associated with more developed SOC implementation (Center for Human Services Research, 2020) and may therefore be worth the investment.

Action Planning Workshops provided by OMH may also assist in the development of plans, as was suggested by one interviewee.

Create stronger linkages between county and state. Interviews also revealed counties' views that state agencies have hampered their local SOC development efforts. Several respondents described a "siloing" effect of state

regulations and New York State's MRT efforts, particularly the latter's introduction of HHSC. As one interviewee put it, state agencies "are siloed so county agencies are siloed."

One interviewee explained that the siloed structure of state agencies produces agency-specific languages and acronyms, which trickles down to the county level, making it difficult for cross-systems communication. Another elaborated on this, saying, "If you want to help families, you have to learn all the acronyms; and sometimes [different child-serving systems] use the same acronyms for different things."

One interviewee said the HHSC model of care coordination "incentivizes kid hoarding" and removes accountability structures, both of which are antithetical to the SOC philosophy. Several C-SPOA coordinators also explained that the emergence of HHSC has restricted the number of referrals they receive because HHSC self-refer.

Although one way to address these issues would be to promote stronger C-SPOA-HHSC coordination, several counties said they don't see the point of involving HHSC in cross-systems meetings. Thus, although state agencies have provided support on coordinating with HHSC, multiple interviewees felt more help was needed. Without stronger support mechanisms between counties and state agencies, particularly around coordinating with HHSC, counties may continue to function in silos and miss out on critical information on a large segment of their service recipients.

Change the structures of system-level meetings to make them more productive. Several counties related that systems-level meetings were not always productive, because, for example, attendance was inconsistent, or participants lacked follow-through or offered too many lofty or expensive ideas. Other counties with similar meeting histories said they enhanced the productivity of meetings by employing one or both of the following strategies:

- **Conduct meetings via Zoom.** Some counties who switched to this mode during the pandemic continued to meet this way and found that it reduced participants' time commitment and increased attendance.
- **Employ workgroups.** Several counties created workgroups around topic areas (e.g., empowerment, community outreach) or populations of youth with specific needs (e.g., youth who have been trafficked). Some of these counties continued to hold the broader systems-level meeting, but less frequently than workgroup meetings. This arrangement was described as leading to more productivity and stronger, more relevant connections.

Use Zoom to engage families in service-level meetings. Several counties expressed cogent concerns about involving families in service-level meetings, as discussed previously. One county found that engaging families in service-level meetings via Zoom addressed several of these concerns by:

- allowing families to call in when they were up for discussion in the meeting, which made efficient use of the family's time, ensured they did not have to hear discussions about other families, and reduced the burden on families associated with attending in person; and
- assuaging families' anxiety by using the Zoom function that displays the speaker instead of displaying all attendees at the meeting, allowing families to see only one person at a time.

Domains 2 & 3: Supporting Systems of Care with diverse, sustainable funding sources

All SOCs need funding to function, but some funding strategies are more reliable than others. Blending and braiding funds are two approaches to diversify funding streams and are recommended strategies to ensure a robust array of services in an SOC (Stroul et al., 2009). Blending pools funds from diverse sources to pay for services, whereas braiding funds coordinates separate funds to pay for services. Accessing sustainable funds is another key strategy to ensure services remain robust and accessible.

To assess the extent to which counties used these funding strategies, all were asked to complete a funding chart to identify each of the funding sources used to fund core components of an SOC (see chart in Appendix D). Interviewees were also asked about current funding strategies and needs.

General status

Counties who completed and shared their funding chart (9/13) tended to fund all or most of the SOC services and supports identified in the chart. Care coordination and mobile crisis services were funded in all nine counties.

Components that tended to be unfunded in some counties were supports with indirect mental health impacts, such as trainings, supported employment, housing support, and infrastructure; services designed to assist families in times of heightened distress, including therapeutic foster care, intensive in-home services, and respite, were also unfunded in some counties.

However, funding was not consistent across counties. Services that had the most diverse funding sources in some counties, including evidence-based practices, youth or family peer support, and primary prevention, went unfunded in other counties. The ability of some counties to fund these services with multiple funding sources may be explained by the ability of these broader service categories to be implemented in multiple settings (e.g., schools, substance use facilities). Smaller, rural counties tended to lack funding for one or more of these service components.

It is important to understand counties' strategies to fund care coordination. Although care coordination is only one component of an SOC, it is one of the most critical; if done well, it can integrate services and supports into a single service package, making service access more efficient and effective. All counties used HHCM, and every county funded such coordination with at least one sustainable funding source (e.g., Medicaid), suggesting care coordination is widely available and is supported through sustainable means. Thus, although several counties expressed misgivings, HHSC may ensure reliable access to care coordination, a critical SOC component for Medicaid-enrolled youth. All but one county said they funded wraparound care coordination. However, only five of the nine counties reported offering HFW through HHCM, which may be a more sustainable and robust approach to wraparound care coordination.

The interviewed counties did not consistently use less sustainable funding sources (i.e., discretionary grants and block grants); instead, they relied primarily on state aid and Medicaid to fund many of their services/supports. They also rarely used funds from juvenile justice or child welfare, though the latter was used in some counties to fund intensive in-home and therapeutic foster care.

Challenges, solutions, and strategies

Identify funding to attract and retain provider workforce. The primary challenge interviewees identified was that their service array was limited due to high turnover and job vacancies, which several attributed to inadequate funding to attract and retain qualified staff. Characterizing this issue, one interviewee said, "I think [mental health service provider] is a really hard career that doesn't pay for its education requirements, and the complexity and traumatic nature of the job."

It was noted that low funding levels for staff cost SOCs more in the long term, due to the need to retrain staff while children's needs go unmet, leading to worse, more expensive outcomes. Identifying opportunities to fund these positions at levels commensurate with training and demands, such as the recent federal funding allocated to strengthen the State's mental health workforce under the American Rescue Plan, may help address provider vacancies.[13]

Develop resources for non-Medicaid population. Several counties noted that the shift to HHSC has created two SOC populations: youth who are enrolled in Medicaid and youth who are not, with the latter having fewer service options. Interviewees said they needed state guidance on funding services to meet this population's needs.

13 For more information, see Supplemental Block Grant and FMAP Funding (ny.gov)

Use mini grants to fund small-scale infrastructure and skill-building opportunities. As noted above, several counties did not fund infrastructure and training. Several interviewees noted that investing in infrastructure and skill-building components is difficult because they often lack targeted funding. However, one county said they made multiple investments with a "mini" grant offered through the NYS ACHIEVE pilot project, including an on-line SOC resource guide, equipment, and a subscription to a University of Maryland Institute for Innovation and Implementation learning community. Some of these resources have lasting utility.

Because these mini grants are one-time opportunities and not sustainable funding, they are most effective when used for one-time needs rather than ongoing needs (e.g., services or staff). One county suggested using this type of funding to develop critical non-service skills (e.g., advocacy, data analysis) in multiple existing staff so these individuals could perform key functions after initial investments. Distributing these skills across multiple staff members also reduces vulnerability to loss of skills in the event of turnover.

Mini grants are less labor-intensive to obtain than those offering greater funding, such as SOC expansion grants, and therefore may be an economical way to enhance infrastructure and staff skill sets.

Identify strategies to sustainably fund key non-service roles. Several counties said they did not have enough funds to support key non-service roles, including data analysts and youth and family advocates in governance roles. Counties were sometimes able to create these roles with grant funds but had to close these positions when grant funding ended. Because these staff needs are ongoing and essential, more sustainable funds need to be identified.

Modify regulations and resources to support rural counties. Rural counties discussed challenges not mentioned by their non-rural counterparts. They felt staffing issues were more pronounced in rural counties. As one interviewee put it, "In a small county, when there is no worker, there isn't a service." Two said the current funding structure for HFW care coordination does not make fiscal sense. One interviewee explained that the combination of having too few staff, the multiple-month training and certification process, and the need to retain a full caseload were cost-prohibitive factors for a rural county. An interviewee also said it is not possible to maintain the "conflict-free case management" model (i.e., where the provider who determines eligibility cannot also provide services) in smaller, rural counties where there is often only one care management agency.

Domain 4: Collecting cross-systems data to drive county cross-systems planning

Although the SOC guiding principles hold that systems should offer evidence-informed services and supports and monitor the effectiveness of these resources through accountability mechanisms (Stroul, Blau, & Friedman, 2010), achieving these goals remains a challenge for many counties. Therefore, it is critical to identify current trends, challenges, and strategies in counties' use of data to guide cross-systems planning. Interviewees were asked about the extent to which and methods for collecting, analyzing, and using data on individual families, identifying overall trends within a single service system, and sharing data to identify trends across systems.

General status

Interviewees reported a wide range of data capacities. Some reported using primarily anecdotal evidence, paper files, or simple spreadsheets, while others reported employing teams of data analysts with specific training in this area. The most often identified data collection activity consisted of tracking referral and service access data to determine the extent to which families are accessing services and the number of openings for new referrals. Some counties also reported conducting primary data collection activities (e.g., needs assessments) and analyzing existing datasets to inform decision-making.

Additionally, several counties said systems-level meetings were often used as forums to share data trends, though most counties did not report conducting these activities. Further, most said they were unable to access data about individual youths from other child-serving systems or merge data from disparate child-serving systems to identify cross-system trends. While building the capacity to perform these data analytic functions is undoubtedly demanding, as an SOC guiding principle it remains a worthy goal.

Challenges, solutions, and strategies

Establish data-sharing mechanisms between C-SPOA and HHSC. Several counties said that since HHSCs emerged, their C-SPOAs began to receive fewer referrals. One county related that they do not receive any information about youth who are served by HHSC unless they are referred for residential placement. One C-SPOA coordinator wondered if youth who bypass C-SPOA are receiving all the available and needed services in the community. With many of the interviewed counties reporting minimal communication between C-SPOAs and HHSC, these information gaps are likely to continue. Counties could benefit from guidance on establishing stronger connections between C-SPOA and HHSC to ensure youth are able to access the services they need. One county did report creating a specific meeting to connect administrators from their care management agencies to C-SPOA and the Local Government Unit to share trends and gather data, which may serve as a model for other counties.

Create a universal consent form to access data on youth served in any child-serving system. Several counties said that one of the primary challenges to accessing data across child-serving systems was that each system adheres to their own protected health information release guidelines (e.g., HIPAA vs. FERPA). One county identified a strategy they used to address this issue: the creation of a universal consent form to be signed by all families who enter any one of their child-serving systems, thereby permitting any child-serving system access to system-specific individual-level information.

Provide guidelines and tools to facilitate data merging across child-serving systems. Until counties are able to merge data across systems, they will not be able to (at least empirically) identify trends in needs and service access issues for multi-system-involved youth. State guidance in this area is needed.

Summary and Conclusions

Interesting findings emerged across the data sources that point to successes and challenges in SOC implementation in NYS. Because the survey was collected in early 2020 and the interviews were completed in late 2021, the themes presented likely demonstrate overarching SOC-related successes and challenges in NYS, that existed prior to the COVID-19 pandemic and have persisted during it.

Counties developed cultures of providers that champion the spirit of the SOC philosophy. Many counties and providers in NYS have done well at incorporating and prioritizing SOC values and principles into their work, as reflected in both the survey and interviews.

Individualized Care was a strength in NYS. Individualized care items were among the highest scoring on the survey and individualized care coordination was often reported to be sustainably funded throughout the interviewed counties. NYS counties have been particularly effective at implementing this SOC principle.

Family-driven care emerged as another strength in NYS. The family-driven subscale of the survey was among the most highly and consistently implemented SOC components in NYS. Interviews also revealed that many counties have processes in place to value and incorporate family input.

Counties had structures in place to facilitate a coordinated, cross-system approach to care. Many survey responses reflected counties' strong implementation of a coordinated approach. In addition, interviews revealed that counties often had multiple, regularly scheduled cross-systems meetings to facilitate this approach to care.

Counties faced difficulties building SOC infrastructure. Securing sustainable funding and means to successfully build the infrastructure is essential to support well-functioning SOC. Infrastructure survey items were rated as less implemented, and interviewed counties reported that SOC infrastructure components often lacked funding.

Counties encountered provider vacancies and turnover. Survey short answer and interview responses pointed to challenges counties faced with provider vacancies and turnover. Counties would likely benefit from guidance and sustainable funding and other strategies to support the attraction and retention of qualified providers so that they are able to continue to serve families as effectively as possible.

Rural communities had unique challenges. Rural counties expressed that SOC development strategies and standards often were not feasible for them to implement. Rural counties would benefit from guidance on creative and rural-specific solutions.

Counties had difficulty adjusting their SOCs to fit within the Health Homes Serving Children (HHSC) framework. NYS recently implemented HHSC to facilitate care for youth and their families. Understandably, there has been confusion related to how this new infrastructure fits within the SOC infrastructure. Because of this, counties reported that there is a separate SOC for Medicaid versus non-Medicaid

youth. Guidance on how to integrate HHSC within SOCs, so that there can be one holistic SOC would be beneficial.

Overall, counties found ways to successfully implement many aspects of SOC with their existing resources and skills. Counties were especially creative in finding new solutions to advance their SOCs and serve families given the restrictions in place due to COVID-19 (e.g., using videoconferencing to enhance collaboration and family-driven care). The webinars and technical assistance (TA) offered by the New York State Conference of Local Mental Hygiene Directors, Inc. (CLMHD) and TA Network at the Institute for Innovation & Implementation, University of Maryland School of Social Work (TA Network) are an important next step to give counties the tools they need to overcome challenges and further develop their local SOCs.

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Appendix A: Item Scores

Item		substantially/ extensively implemented	somewhat/ moderately implemented	not at all implemented	don't know
1	Individualized, Wraparound Approach to Service Planning and Delivery - Individualized child and family teams are used (including family, youth, providers, etc.) to develop and implement a customized service plan	51%	29%	2%	17%
2	Individualized, Wraparound Approach to Service Planning and Delivery - Individualized assessments of child and family strengths and needs are used to plan services and supports	58%	26%	1%	15%
3	Individualized, Wraparound Approach to Service Planning and Delivery - Individualized service plans are developed and implemented for each child and family that address multiple life domains	55%	27%	2%	16%
4	Individualized, Wraparound Approach to Service Planning and Delivery - Services include informal and natural supports in addition to treatment	51%	31%	1%	17%
5	Individualized, Wraparound Approach to Service Planning and Delivery - Flexible funds are available to meet child and family needs not financed by other sources	23%	29%	13%	35%
6	Family-Driven Approach - Families have a primary decision making role in service planning and delivery	55%	31%	1%	12%
7	Family-Driven Approach - Family strengths are incorporated in service planning and delivery	60%	26%	1%	13%
8	Family-Driven Approach - Families have a choice of services and supports	55%	30%	3%	12%
9	Family-Driven Approach - Families have access to peer support	47%	35%	3%	15%
10	Family-Driven Approach - A family organization exists and supports family involvement at the system and service delivery levels	45%	32%	5%	19%
11	Youth-Guided Approach - Youth are active partners in service planning and delivery	37%	39%	6%	18%
12	Youth-Guided Approach - Youth strengths and interests are incorporated in service planning and delivery	50%	33%	3%	15%
13	Youth-Guided Approach - Youth have a choice of services and supports	39%	39%	5%	17%
14	Youth-Guided Approach - Youth have access to peer support	26%	39%	14%	21%
15	Youth-Guided Approach - A youth organization exists and supports youth involvement at the system and service delivery levels	29%	35%	14%	23%
16	Coordinated Approach - Intensive/targeted care coordination with a dedicated care coordinator is provided to high-need youth and families	53%	30%	3%	13%
17	Coordinated Approach - Basic care coordination is provided for children and families at lower levels of service intensity	55%	30%	2%	14%
18	Coordinated Approach - Care is coordinated across multiple child-serving agencies and systems	51%	34%	2%	13%
19	Coordinated Approach - One overall plan of care is created across child-serving agencies and systems (there may be more detailed plans for	37%	35%	9%	19%
20	Culturally and Linguistically Competent Approach - Culture-specific services and supports are provided	30%	43%	7%	20%

Item		substantially/ extensively implemented	somewhat/ moderately implemented	not at all implemented	don't know
21	Culturally and Linguistically Competent Approach - Services and supports are adapted to ensure access and effectiveness for culturally diverse populations	30%	44%	5%	20%
22	Culturally and Linguistically Competent Approach - Providers represent the cultural and linguistic characteristics of the population served	29%	44%	6%	21%
23	Culturally and Linguistically Competent Approach - Providers are trained in cultural and linguistic competence	34%	35%	6%	25%
24	Culturally and Linguistically Competent Approach - Specific strategies are used to reduce racial and ethnic disparities in access to and out-comes of services	29%	37%	7%	27%
25	Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Evidence-informed practices are implemented within the array of services and supports to improve outcomes	42%	37%	2%	19%
26	Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Providers are trained in specific evidence-informed practices and/or evidence-informed practice components	41%	37%	2%	20%
27	Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Best practice guidelines, clinical protocols, and manuals are provided to practitioners	36%	30%	5%	29%
28	Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Fidelity to evidence-informed practices and out-comes is measured	28%	33%	5%	34%
29	Least Restrictive Approach - Utilization of home- and community-based services is increased	51%	29%	4%	16%
30	Least Restrictive Approach - The number of children who are served in settings more restrictive than necessary is reduced	43%	28%	3%	26%
31	Least Restrictive Approach - Utilization of inpatient hospitalization is decreased and it is primarily used for short-term, acute treatment and stabilization when necessary and appropriate	41%	27%	4%	29%
32	Least Restrictive Approach - Utilization of residential treatment is decreased and it is primarily used for short-term lengths of stay to achieve specific treatment goals when necessary and appropriate	39%	28%	5%	29%
33	Service Array - Broad array of home- and community-based services and supports is available	34%	49%	7%	9%
34	Service Array - Array includes or is linked to services and activities to identify behavioral health problems at earlier stages and at earlier ages (e.g., screening in primary care, schools, child welfare, etc.)	33%	46%	4%	17%
35	Service Array - Array includes developmentally appropriate services for young children and their families	34%	47%	5%	15%
36	Service Array - Array includes developmentally appropriate services for youth and young adults in transition to adulthood	30%	50%	7%	14%
37	Data and Accountability - Data are collected regularly on the quality and outcomes of services and supports and are used for continuous quality improvement	28%	33%	4%	34%
38	Data and Accountability - Electronic health records exist	47%	23%	3%	27%
39	Home- and Community-Based Treatment and Support Services (Nonresidential) - Screening for behavioral health needs (e.g., in early care, education, primary care, child welfare, and juvenile justice settings)	43%	44%	2%	10%
40	Home- and Community-Based Treatment and Support Services (Nonresidential) - Assessment and evaluation	47%	43%	1%	9%

Item		substantially/ extensively implemented	somewhat/ moderately implemented	not at all implemented	don't know
41	Home- and Community-Based Treatment and Support Services (Nonresidential) - Individualized service planning (e.g., wraparound process)	51%	37%	3%	9%
42	Home- and Community-Based Treatment and Support Services (Nonresidential) - Intensive care management	43%	40%	5%	11%
43	Home- and Community-Based Treatment and Support Services (Nonresidential) - Service coordination for youth at lower levels of service intensity	48%	38%	3%	11%
44	Home- and Community-Based Treatment and Support Services (Nonresidential) - Outpatient individual therapy	55%	35%	1%	8%
45	Home- and Community-Based Treatment and Support Services (Nonresidential) - Outpatient group therapy	29%	45%	8%	18%
46	Home- and Community-Based Treatment and Support Services (Nonresidential) - Outpatient family therapy	37%	45%	4%	14%
47	Home- and Community-Based Treatment and Support Services (Nonresidential) - Medication treatment/management	47%	42%	1%	10%
48	Home- and Community-Based Treatment and Support Services (Nonresidential) - Crisis response services, non-mobile (24 hours, 7 days)	48%	36%	6%	10%
49	Home- and Community-Based Treatment and Support Services (Nonresidential) - Mobile crisis and stabilization services (24 hours, 7 days)	42%	39%	9%	9%
50	Home- and Community-Based Treatment and Support Services (Nonresidential) - Intensive in-home services	35%	45%	5%	14%
51	Home- and Community-Based Treatment and Support Services (Nonresidential) - School-based behavioral health services	44%	44%	2%	9%
52	Home- and Community-Based Treatment and Support Services (Nonresidential) - Day treatment	29%	40%	12%	19%
53	Home- and Community-Based Treatment and Support Services (Nonresidential) - Substance use treatment	42%	46%	2%	10%
54	Home- and Community-Based Treatment and Support Services (Nonresidential) - Therapeutic behavioral aide services	20%	37%	10%	33%
55	Home- and Community-Based Treatment and Support Services (Nonresidential) - Behavior management skills training	27%	46%	8%	20%
56	Home- and Community-Based Treatment and Support Services (Nonresidential) - Tele-behavioral health services	11%	35%	20%	34%
57	Home- and Community-Based Treatment and Support Services (Nonresidential) - Youth peer support	22%	46%	15%	17%
58	Home- and Community-Based Treatment and Support Services (Nonresidential) - Family peer support	38%	45%	5%	13%
59	Home- and Community-Based Treatment and Support Services (Nonresidential) - Youth and family education	33%	48%	4%	15%
60	Home- and Community-Based Treatment and Support Services (Nonresidential) - Respite services	32%	52%	5%	11%
61	Home- and Community-Based Treatment and Support Services (Nonresidential) - Therapeutic mentoring	14%	33%	16%	37%
62	Home- and Community-Based Treatment and Support Services (Nonresidential) - Mental health consultation	39%	42%	4%	15%
63	Home- and Community-Based Treatment and Support Services (Nonresidential) - Supported education and employment	26%	50%	7%	17%

64	Home- and Community-Based Treatment and Support Services (Nonresidential) - Supported independent living	22%	49%	8%	21%

Item		substantially/ extensively implemented	somewhat/ moderately implemented	not at all implemented	don't know
65	Home- and Community-Based Treatment and Support Services (Nonresidential) – Transportation	14%	61%	12%	13%
66	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Therapeutic foster care	29%	32%	6%	33%
67	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Therapeutic group home care	22%	26%	16%	37%
68	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Crisis stabilization beds	22%	31%	20%	28%
69	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Medical detoxification	13%	21%	17%	49%
70	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Substance use residential treatment	20%	32%	16%	32%
71	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Residential treatment	35%	32%	11%	22%
72	Out-of-Home Treatment Services for Short-Term Treatment Goals that are Linked to Home- and Community-Based Services and Supports - Inpatient hospitalization	34%	39%	9%	18%
73	Infrastructure Components - Point of accountability structure for system of care management and oversight	33%	33%	5%	29%
74	Infrastructure Components - Financing for system of care infrastructure and services	17%	29%	11%	43%
75	Infrastructure Components - Structure and/or process to manage care and costs for high-need populations (e.g., care management entities)	18%	28%	9%	45%
76	Infrastructure Components - Structure and/or process for interagency partnerships and agreements	35%	35%	4%	26%
77	Infrastructure Components - Structure and/or process for partnerships with family organization and family leaders	29%	35%	7%	29%
78	Infrastructure Components - Structure and/or process for partnerships with youth organization and youth leaders	24%	35%	12%	28%
79	Infrastructure Components - Defined access/entry points to care	42%	34%	4%	20%
80	Infrastructure Components - Extensive provider network to provide comprehensive array of services and supports	33%	41%	8%	18%
81	Infrastructure Components - Structure and/or process for training, TA, and workforce development	22%	38%	9%	31%
82	Infrastructure Components - Structure and/or process for measuring and monitoring quality, outcomes, and costs (including IT system) and for using data for continuous quality improvement	19%	33%	9%	40%
83	Infrastructure Components - Structure and/or process for strategic communications/social marketing	15%	32%	13%	39%
84	Infrastructure Components - Structure and/or process for strategic planning and identifying and resolving barriers	26%	36%	8%	30%
85	Child-Serving Systems Commitment - Mental health system	60%	28%	2%	10%

86	Child-Serving Systems Commitment - Child welfare system	46%	35%	4%	14%
Item		**substantially/ extensively implemented**	**somewhat/ moderately implemented**	**not at all implemented**	**don't know**
87	Child-Serving Systems Commitment - Juvenile justice system	40%	36%	7%	18%
88	Child-Serving Systems Commitment - Education system	38%	39%	6%	16%
89	Child-Serving Systems Commitment - Health system	27%	39%	7%	26%
90	Child-Serving Systems Commitment - Substance use treatment system	34%	34%	6%	27%
91	Child-Serving Systems Commitment - Courts/judiciary system	28%	39%	7%	26%
92	Child-Serving Systems Commitment - Medicaid system	25%	35%	7%	33%
93	Policy and Decision Makers Commitment - High-level policy and decision makers at the local community or regional level	39%	34%	5%	21%
94	Providers Commitment - Provider agency administrators and mid-level managers	54%	30%	2%	14%
95	Providers Commitment- Direct service providers (clinicians and others)	55%	30%	1%	14%
96	Family and Youth Leaders Commitment- Family leaders	40%	22%	2%	36%
97	Family and Youth Leaders Commitment - Youth leaders	34%	22%	5%	39%
98	Managed Care Organizations Commitment - Behavioral health managed care organizations	33%	30%	5%	32%
99	Managed Care Organizations Commitment- Managed care organizations managing both physical health and behavioral health	29%	30%	5%	35%
100	Overall Assessment - To what extent do you believe that the system of care approach is being implemented in your community or region?	36%	51%	3%	10%

Appendix B: Short Answer Responses

Short answer responses (identifiers removed)

- I would like to see increased supports for preschool families and youngsters
- It's important to have the front line team represented at the discussion table when work flows are being created to allow for a smoother transition process.
- I believe in the philosophy of System Of Care but concerned that on a state level allocation of funds are lacking to accurate accomplish desired goals!
- 1 year ago I would have answered extensively implemented in most of these areas. However the implementation of CFTSS and the new HCBS has set us back significantly in availability of intensive and creative services. The potential is huge with these services however, the lack of staff and providers has left our well formed system of care in a crisis and families and youth are receiving the brunt of the impact.
- Agencies are not able to sustain HCBS services due to the reimbursement rate. The qualifications for providers and supervisors are not being filled due to sustainability. Families are not adequately being served due to lack of services and long wait lists. Care managers feel ineffective due to not being able to refer families to services.
- [Answered the questions based on my county instead of the region as] I think it's important to know that there is a real lack of services in the county and although the services exist in the region, distance is a real barrier for many people.
- Answers given about service availability have to do with capacity/wait list issues at provider organizations due to staffing changes necessitated by children's system Medicaid transition, and slow C-YES process.
- As an educator in our region, I am very pleased with the interest on the part of all those providing behavioral health services and support in collaborating with educational agencies and family support groups in an effort to improve the care and potential for success of youth in our region.
- XXX County has a Dual Commissioner (MH & DSS) who is open and committed to SOC. MH/LGU is committed to SOC and is able to dedicate staff (Community Systems Coordinator) to the cause, but need direction. Attended SOC Summit in 9/2018. Have laid foundation of SOC with DSS Leadership - but now need to demonstrate (via participation in Systemic Mapping Workshop) that the commitment of NYS (with OMH as the lead agency) in the SOC initiative is not just me talking for the past 14 months - but it is actually happening. XXX is perfectly poised: large enough to have resources, small enough to manage.
- Currently applying for SAMHSA grant
- Currently there are no parents/caregivers or youth on the SOC committee. Although there are many community providers on the committee, most are not following the SOC approach.
- For SOC to be successful peers need to be supported by the state & funding streams to do the job. SOC was a great way to promote and support not just the peer network but the importance of cross systems working together. If we fail our peer advocates... we fail the youth and families in these systems and the SOC model.
- For some of the questions that asked about availability or array of services I selected that they have not been implemented or only somewhat as there simply are not many services available. It is not that people don't want to provide them they simply don't exist. Also one key player left out of the survey was OPWDD services. You asked about OMH services, Child Welfare, Juvenile Justice and even education but left out OPWDD; that is part of the problem that system does not seem to want to engage with or provide services in a system of care.
- XXX County has a strong community of provider agencies working to meet the needs of the most high risk

children, families and adults in the community. All members seem truly vested in meeting the needs and there are many good services but the need far exceeds the availability of services and many, many children, families and adults are without the services they desperately need. Funding stream requirements can lead to some redundancy of services (i.e.: case management) and the money spent on the redundant service could be better applied elsewhere. Mental health services are by far the most needed local service.

- Groups like Collaborative Solutions Network are making great efforts on many of these goals. They need more buy-in from individuals at high decision-making levels to encourage actions needed from the top on down. Need less silos of care and more collaboration in general.
- I am new to this position (within the past three months), therefore I am still learning the SOC program.
- I am new to this position and am in the learning phase.
- I am referencing my comments on the XXX System of Care
- I apologize but I do not know anything about the System of Care Program.
- I apologize for my lack of knowledge on these subjects as I have just come into my position here about a month ago.
- I attended a SOC training/informational meeting a couple of months ago and weeks ago began preparing to implement new pro-gram embracing the SOC philosophy. I have much to learn and will have a stronger since of confidence completing future surveys.
- I became aware of SOC more formally through this survey. I answered the questions as best I could based on my knowledge of how my school and my students/families are impacted by System of Care as it relates to supports, services and access to health and mental health. My school partners with numerous community agencies such as Health Home entities that are part of SOC. The system is hard to navigate for parents. The services offered are too few for the many children impacted by related health and mental health disorders.
- Schools have become "centers" for child wellness. The Health Home folks and the private agencies are over worked and cannot keep pace with referrals. I have found these agencies to be tremendously helpful, support-ive and integral. However they are over-whelmed with number of referrals. Conceptually the SOC is a solid framework , however the implementation and resources needed to reach a vast number of students impacted by their health and mental health is monumental. Continue with the good work of SOC.
- I believe a hands on approach to introducing System of Care would be beneficial to our county.
- I believe individually people in our community are very interested in the welfare of themselves and others. However, I believe some of the new changes (especially with the health home care management system) has made it difficult to provide quality hands-on services to the children and family served due to the amount of paperwork and layers attached to obtaining and keeping services. There is also not enough funding or people hired to provide some of the services that have been allotted to serve the children in our community. One example is the Psychosocial Rehabilitation Service, which does not pay enough to obtain qualified service providers, and still has a waiting list to obtain services. The Youth Peer Support Services I do not even believe have been implemented in our county, so still referring to a mentorship program through XXX that has a LONG waiting list. Hesitant to make some referrals in fear of setting a family up for a service that won't be provided. I believe many of the HCBS services still do not have enough providers in our county. We lack appropriate higher level of educational services within the county, and although the county utilizes day treatments in the region, it seems as though there are fewer options available.
- I believe that XXX, BS Children's Services Coordinator For XX Counseling Center is an excellent point person for the SOC initiative. Currently XX is spear heading our initiative.
- I believe that we started with a good foundation for our local SOC but things slowly died down and new stakeholders (such as hospitals and other local agencies) were not brought to the table so we have the same 8/9 agencies as always.

- I believe there are pockets of people that really understand SOC and try hard to fight the battle with more than just their words. I do not believe that you can truly understand the SOC values and daily practice of them without having actually been in the trenches with families, fighting with schools to address unmet needs or clinics that discharge a youth because they did not engage with them in 3 visits. I feel it has become a token phrase for those not having to be held accountable for their actions. Anyone can say they believe them and use them daily in their work, but as soon as someone or a system challenges the implementation and beliefs around them, people back down. Every day is a fight with systems and individuals in power that use the words, but don't truly know the meaning. Actions truly do speak louder than words. My program which is very small has been doing high fidelity wraparound and practicing SOC values since 2002. SOC has not been active in my county for many years and I know there are no other programs doing wraparound. It can be very isolating work. I am not sure the people in power in XXX County even know what we do and the great work we do using Wraparound and the CFT model and that it is successful. How are systems monitored and held accountable when they say they have implemented and practice the values and beliefs?? How will it be sustained moving forward as it stopped years after the implementation of my program?
- I believe we are still functioning in silo's and not as integrated. LHD's are not invited to the table, as they should be. I had to ask to be invited to the Regional Planning Consortium to gain a better understanding of the Health Homes. However, I am the only LHD representative at the table.
- I do believe that everyone is working hard to provide services to the children and families in need throughout our counties and community's. The breakdown is in the understanding of roles and responsibility's and how the various agency's can work together to support each other and play their part. It seems each agency operates in a silo rather than with systemic operations to meet the needs of the child/family. The need is to actually develop and function as a network of service and support to each other and the children/Family's.
- I feel like I wasn't much help on the survey as we do not provide any services for children or youth. Our population is strictly adults 18 years of age and older.
- I feel that many responses to questions would have been more favorable to a system of care prior to the recent Medicaid redesign and subsequent changes in service delivery for youth.
- I have been in the children's mental health field for many, many years and I have found that the system is so busy trying to find a solution that they change direction too many times. Never giving a plan a time to work. If we had the money that has been spent on different programs and processes we'd have more money to put into programs specifically for peer-run solutions
- I have just become the Train the trainer for SOC in XXX. I would love to have XXX buy into this and be able to implement this. I am middle management so it's not my call and I am unsure how the deciders in the county will be invested in this or not.
- I have not received direct information about SOC and am not a reliable source to comment on the areas addressed in this survey to give feedback. I would be interested in getting more information about each area addressed in the survey to better answer the questions.
- I have worked in the system for many years and always committed to SOC philosophy and goals however, I have been part of so many work groups and so many conferences/processes to reduce the silo's or barriers between state agencies, that in my opinion have a tremendous influence on local structures because of funding streams and programmatic regulations that can be in conflict between the various human service systems that it is disheartening. I see little change at that level and the responsibility continually being put back on the local agencies that administer programs but in reality have little input into the funding mechanisms or processes or priority decision making as far as programming etc.
- I know very little about how this is being implemented in any of the counties we serve.
- I strongly believe efforts are made to collaborate with systems of care and community providers to ensure the efficiency of the quality of care provided to children and families.

- I think it is hard to report out in the survey what actual barriers may be. All Care Management staff have been trained on the values of Systems of Care "person centered, family focused" etc. but may not know it is related to System of Care. More education on how this is all related an referred to can help. My staff are not familiar with "wrap around services". All are well versed on the importance of collaboration and all service providers working together to meet child's needs but we hit many road blocks as not all the people you encounter in the child welfare system have the same priorities.
- I think the intention is our county among SOC leadership is very positive and forward thinking. The challenge remains helping agencies and workers, already over committed and often underpaid, to take time to fully understand. Being a family peer support, I find it hard for families to stay positively engaged as there are fewer and fewer services/programs to help their families.
- I was called last week and asked to be apart of the regional planning group. I am committed to learning more and making connections in the this county to support our students and families.
- I wasn't sure if some questions applied to the county's oversight /implementation or my agency.
- I work for the XXX School District. In our school district we are implementing our own system of care through partnerships with local providers including XXX (care management providing agency) and XXX (direct services agency). We also offer some programs and services within our schools including food pantries and mental health satellite offices. I'm interested in learning more about the statewide call for SOC and how our school district can be a part of this initiative to help students and families!
- I would like to receive more information about becoming more involved in XXX County's System of Care initiative.
- I would like to see a more formal SOC implemented.
- If I asked my co-workers about System of Care, I doubt many (if any) would know what I was talking about. I only know about SOC due to my past experiences with mental health agencies and organizations. I don't believe SOC principals are too engrained with any of OCFS (as a whole) as the trainings of new staff only marginally addresses the principals.
- In my position, I work approx. 8 hrs a month, and my exposure beyond the functions of my committee are limited.
- In our county there is a significant lack of work force to implement these changes. I have observed more people around the table but fewer interventions being delivered due to the complexity of the process and the lack of people to provide the services.
- In this area, many providers appear unwilling to work together.
- It appears that Medicaid redesign has watered down available services and spread available resources out more thinly in rural areas. This leaves families who need resources and supports with less. Cultural consideration should be paid to rural upstate are-as. These geographical areas need a unique approach as it poses unique barriers for families and providers seeking to reach these populations.
- It remains difficult for some children and families to access services which would help them....either they do not have the right insurance, or the program is Medicaid only, or the program is full. Also, the system is sometimes so confusing to figure out...as if it is designed to be too confusing or restrictive for use. If professionals have a difficult time navigating, imagine what families in crisis feel like.
- It's great. However after going through the large transformation in Children's Mental Health, we have some re-building to do.
- Like other counties with a large non-Medicaid population we seem to be developing a two tier SOC, one for children with Medicaid and one for children with commercial insurance. The services available to children with Medicaid are more diverse, better reimbursed and are able to be accessed earlier in the course of treatment. The SOC for children with commercial insurance, who do not meet HCBS LOC, is substantially lacking in comparison.

- Main barrier is insufficient providers in our area.
- Much of our area's issues in implementing SOC is resources, access to care, and funding - it is not the lack of desire to implement.
- My request to complete the survey is the first I have heard of this.
- Not enough staff to support the system!!!!!
- NRCIL in XXX County does a lot of work with System of Care. They are a great organization that are very active in getting the word out and any changes of system of care to all health and human services agencies in XXX County.
- Obviously, if I've been identified as someone to participate in this survey and know almost nothing to very little about the SOC, there is much work to be done and very little commitment to it or promotion of it. I would wonder if this suggests the county needs some extensive reconstruction of its systems and leadership. I hear, at times, that XXX County is rich with resources and care, however I might suggest the communication, collaboration, accountability, genuine care, outcome driven approaches, and inclusive approach among and between systems is lacking. Perhaps an appointment of a lead agency to create a SOC oversight plan is in need and could be part of the solution. Perhaps an independent agency, outside of county systems, could be the best fit for this undertaking.
- Our County has all the key components that could lead to successful integration of the SOC philosophy and workflow, however over the years, the agencies have become silo'd and the system feels fractured, with little coordination or communication.
- Our SPOA Coordinator is in the beginning stages of getting our community partners together to starting coordinating SOC efforts. She will also be attending the SOC Facilitators training in April to be able to bring this back to XXX County.
- Our system of care in XXX County continues to be very fragmented and siloed. There does not appear to be a lead agency or on-going communication between public and community providers. There is a lack of ownership and follow through from key stakeholders.
- Our system of Care is incorporating adults that have very different needs including Long Term Care needs. This has become con-fusing.
- XXX County is not part of the high fidelity wraparound pilot project but we do try to implement the principles so I was unsure how to answer the question about implementing high fidelity wraparound. CFTSS services are theoretically available in XXX County but provider agencies are having significant difficulty hiring staff due to the low reimbursement rates and even more difficulty finding staff who are willing to travel to XXX County. In reality, these services are available on a very limited basis. XXX County is in the process of re-establishing its efforts on a planned approach to implementing systems of care principles. We have a committee with a rapidly growing membership.
- SOC is lacking is small rural communities. There are major gaps, or lack of services or no services at all.
- Some of the questions were not clear related to what perspective were answering them from. The questions related linkages be-tween HCBS and services (ie foster care, inpatient care) was unclear since HCBS is not directly linked to these services, and some of these service settings are excluded. In general, it would be helpful if SOC was incorporated into existing infrastructure, such as health home to increase efficiencies. This would improve client outcomes by maximizing existing resources.
- Some resources are available thru out of county resources and are extensively utilized even though those services are not available in this county.
- Sorry but in truth I am not fully versed with a lot of the terminology I will be attending my first conference in XXX this week 2/27

- SPOA, NYS OMH and children's agencies independent of civil service all work in concert to bring about the best outcome for SED children and their families.
- Stopped doing System of Care formal approach several years ago when operated by XXX. Too many hoops for little to no ROI. De-signed local system outside of SOC.
- Thank you!
- The "system" does not have enough community and family support. Children at risk are released from residential settings without a solid plan of action or coordination with the school districts in order to provide the support needed for continued success. Our families do not have the mental health or substance abuse support in order to best support their children. Our mental health organizations are overwhelmed and wait lists extensive. There aren't any strict guidelines with the Office of Family and Children Services or Probation to hold children or families accountable. Children are released from care when they have not fully participated in their programs; when their time is up, they are released regardless. The school districts are not given advanced noticed of the return of students with significant needs and often do not have the programming necessary for these students. This sets those children up for failure. Not only do many districts not have their own specialized programming for these students but when students are released from care in January and dropped at the door step of the school district, many local BOCES programs are at capacity and so are those located within the XXX Region. If the programs are not at capacity, they cannot meet the needs of these students. This has led to some students being referred BACK out to residential settings through the district - which in my professional opinion is inappropriate and irresponsible of those who were in charge of that student's care.
- The county providers as a whole care more about what something is going to cost rather than what it will do for the people of the community. It is very difficult to get services for certain age groups and very difficult to assist families at their most basic needs in order to begin to help them with other area of stressors.
- The extreme rural nature and tiny population of XXX County limit the services and resources available to us. Within those tight constraints, the agencies involved in the provision of services work extremely well together, are in excellent communication and coordination, and are staffed by fully committed individuals. We do a remarkably good job, but represent a model that could not be easily replicated in larger counties. We need more flexibility to use our resources creatively than the State generally sees fit to grant.
- The ideals are fully appreciated and supported by community leaders, however the fiscal landscape is a barrier to actually providing the services to the many families that request and need them. Agencies that are fiscally stressed are not able to compete for staff for the important work that needs to be done. We are able to focus on how we treat the families in a person centered and partnership relationship, but many agencies fall short in delivering the amount of services that are needed.
- The need for a cohesive sustainability plan is essential for agencies in order to maintain high quality care within our System of Care. Advocacy for commercial insurances to cover all services to include crisis stabilization is highly needed. We need participants within our community to lobby and educate the data and outcomes of the success of our System of Care programs. We need to be solution focused with identifying barriers. Maintaining transparency and giving feedback to the state is essential in growth and quality.
- The XXX manages a BluePrints for Healthy Youth Development community with 23 EBPs which we adhere to with monastic fidelity. We have created an internal system of care (lower case s and c) because we find other providers lack literacy in evidence. We would enjoy collaborating with SOC and increasing EBP literacy across the entire system
- The problem we are all dealing with is having enough staff to provide the services that are needed. Our county works collaboratively and to the best of our ability but there are serious gaps.
- The SOC in this county is restricted by the general lack of qualified service providers, lack of public and private transportation, and the socio-economic level of the population. The needs greatly outweigh the available finances, services, and providers. The few services that are in place are generally overwhelmed with little hope

of things getting better. Mental health clinicians burn out and leave due to the level of stress from high case-loads. This county needs all the help, both educational and financial, that it can get.

- The survey was too long
- The system desperately needs input from families and workers on the front lines. No one has asked us how this should work. Many families feel disenfranchised and further stigmatized and the Medicaid transformation is the antithesis of a person-centered system. I have several families who have applied for family of one Medicaid and have been waiting months for decisions and dealing with constant demands for more documentation, intrusive home visits, and questions about personal information. We as Care Managers, (many of us well-educated and carrying a large student loan debt) struggle to understand this system, how can we expect lay people to understand its complexities? I saw a notice that the governor has put together a "cost saving panel Medicaid panel." The panel does not have one Medicaid recipient or front line worker on the panel. It is reported that this panel cannot make recommendations that will allow for cuts to Medicaid, but the transformation has already caused major cuts to services to the most needy individuals. The transformation has moved power away from local counties to the state. Ex.: Those applying for a family of one Medicaid have to submit an application to the entity or Maximus. Maximus workers are located in New York City. they then contract a provider (nurse/assessor) to meet with the family. One of my family's met with an assessor who had never worked in our county. The assessor performed a CANS assessment at the first meeting with the family. I take a full 30 days to complete this after having built some rap-port and gathered history for the individual and family I am assessing. The assessor makes several home or community visits gathering hundreds of documents and then the information is sent back to a worker in New York City. A local Maximus representative then meets with the family again (the family missing more work, school, etc.) and additional information is usually requested. One family I worked with for which I submitted an application on 4/7/19 did not gain approval until 10/19 when the child was placed in a community residence. In that time they were required to provide a year's worth of financial and personal information. This same family and I attended a scheduled meeting with the local Maximus representative and when we arrived we were told that there was not an appointment. Since I had a copy of an email sent to me by CYES , I was able to prove that there was an appointment, but what if I was not there? The family missed work that day, they had all of their documentation ready. Two other families I've worked with have expressed deep frustration and anger about the process and I have strongly encouraged them to lodge complaints. They have filed those complaints. One family includes a licensed social worker who is completely overwhelmed with this process and has often felt like giving up because it is so stressful for her and the youth in her home. I could go on an on about all of the difficulties and challenges, including the burden that is being placed on care managers. System transformation starts at the grass roots level and is driven to success when there is buy in from those it serves. I am finding it difficult to find a way to buy in and so are the families I serve.
- The way the survey was written, we were not sure if you were asking about our agency vs. resources in the community in some sections.
- There are a real lack of services for families in crisis and particularly if they have private insurance. Many are spending days in ER rooms with no options for families. The LRE movements are a problem the closing of county ER clinic all impacts families. We also need a local partial hospital program. These families need us to be more available and a flexible system.
- There are some beginning planning activities and discussions taking place.
- There is a general lack of services, transportation, and finances in this county. There is a lack of communication between service providers where one may have information about a service while others do not. It is also very difficult getting families to accept wrap-around services. Families have told me they feel it is an invasion of privacy. They don't want people coming to their homes and interfering with their lives.
- There is a lack of timely community services and supports available to children with and without Medicaid. This is increasing their level of need and placing children in inpatient settings and residential settings that could potentially be successful in their homes and communities with supportive services. Not enough access

to CFTS services (for children with Medicaid) and a long C-yes process is creating a problem for children and their families leading to spending increased time in hospitals and Residential programs. There is also, a group of children that C-YES has determined doesn't meet their level of care and aren't eligible for Medicaid or CFTS services but the child and family has determined needing a higher level of support.

- There is such a disconnect with this questionnaire that I stopped answering the questions. I have been involved in the Systems of Care work for multiple years and the issue I find is that SOC promotes effective Cross Systems work but we don't see effective cross systems work at the state level. At the county level I believe that we work very effectively and do great cross systems work. At the state level its a complete mess, Services such as COTI and Mobile Crisis struggle with guidance and ability to bill Medicaid threatening the future of these programs. CFTSS providers can't hire staff due to rates and regulations and many services are unavailable to the vast majority of people that qualify for the services. Changes to PINS laws, Family First legislation coming down through OCFS, and OMH RTF's now requiring the kids agree to attend an RTF make it extremely difficult to place kids in residential care while the necessary community based supports to maintain these youth with the community either don't exist, aren't funded well enough, aren't ready to provide the service, or can't maintain staff to consistently provide services. Kids that were traditionally being placed in residential levels of care are being pushed back into communities and schools without the necessary supports available and ready to provide services.
- Department of Ed never seems to be involved in state level cross systems planning, at some point they are going to find themselves with a crisis on their hands as these kids that traditionally met residential levels of care don't get placed and the schools are forced to try and maintain and educate them. Current school structures aren't designed to deal with these levels of behaviors and there aren't enough alternative and behavioral type school settings available to support what the entire system is doing. OPWDD basically doesn't place any youth and push this issue off on other systems. It is extremely difficult through this system to get any crisis sup-ports or intensive behavioral supports within the home. SPOA's have had to fight tooth and nail to be involved in the Medicaid re-design and still have some ability to track what services families are receiving and if these services are being effective. When statewide systems can't seem to work together and be on the same page or follow the principles identified within SOC it becomes difficult to be involved in these types of state lead initiatives.
- There is unequal participation and commitment to SOC. Some of this is related to expectations regarding immediate improvements and disappointment in slow change or progress.
- We appreciate the State's adoption and leadership on SOC and Wraparound to help us advance our County's commitment to both.
- We are committed caring professionals supporting children and families in XXX County and doing the best we can with the services we have.
- We are a tribal health services located between XXX and XXX Counties and depending on where child and family live we access or refer to higher levels of care in each county.
- We are in need of another care manager at an intensive level. The clinic that works with children and families of high needs has at least 20 children that could be served at this level. XXX cut one of the positions leaving only one position.
- We are in the beginning stages of implementing SOC - about 8 months. We are excited about how it's bringing a wide array of providers, community members, peers, etc. together and are looking forward to the future. Just a little note: HCBS and HFW services are not reimbursed at a rate that is commensurate with the level of services required to have fidelity to the service.
- We had a federal SOC grant from XX-XX and made significant progress on all aspects covered in the survey. Since we have had a complete turnover of County leaders and have lost the momentum and SOC focus. We have an excellent integrated system but are no longer family-driven and youth focused; and are operating with limited wraparound interventions. Help!

- We had a system of care that was working well. It is unfortunate that it seems to have gone backwards in the last couple of years. It could be because of a change of directors and coordinators with a different perspective. It could also be, I feel, the Medicaid redesign became a business for agencies to capture clients for payment. This has resulted in much turnover in staff and to large of case-loads for people to work with. I have been working in this field and am one of the grassroots players of systems of care. It is not the same as it has been designed or intended to be.
- We have a dedicated, interdependent group of folks that are at the core of the XXX Network. Over the last ten years we have en-gaged in a variety of planning processes and have evolved through several leadership models. We are proud to say that we have tackled some system barriers and challenges with ingenuity, hard work and tenacity WITHOUT any significant funding and a lack of top leadership involvement. WE continue to support the XXX website and encourage cross system planning that upholds the SOC values whenever we can. We are excited that we have a solution focused planning meeting of the top leaders in both human services and education coming up in April!
- We have a great group of people on our staff that provide quality services to the youth and families that we serve. It is very disheartening that the financial state of the SOC is causing regions and agencies across the state to not be able to support these wonderful services.
- I hope that we can come up with a plan to continue to provide these services to the youth in our care.
- We have a very informed, trained, and educated peer community- very eager to implement SOC with individuals and family. We have a rural community- that have some agencies holding on to the old models of CCSI and other models from 20-25 years ago- and believe in their mind- that they are providing good care and options to families. This is very sad- We have a wonderful MH provider agency in the community- eager to implement SOC with the FPA, YPA, and Peer Specialists- but other entities are not fully buying into the SOC model and high fidelity wrap around model. We had our peers trained by OMH to implement and support the high fidelity wrap around work flow, as peers. We are eager to embrace SOC in our community- there are not many standing with us ready to engage in services and supports with families and individuals. How can you help counties that have limited buy in- even after training has been offered? Our children and families deserve this level of care and a chance to be successful while making informed decisions. Doing work the way we have always done it, is not success. Thank you for asking.
- We have just begun development and implementation of the System of Care services.
- We honestly do not have time to do these trainings. Staff are so overworked due to the poor rates and no shows with families. This idea of system of care worked in our former world of SPOA and the B2H/OMH waivers. It does not work with care management and the service array as it is currently set up. No training is going to help with a severely flawed and wasteful system that we are currently trying to function within. I do not fault the county for these short comings or the agencies trying to succeed, I fault CMS, DOH and the MRT group that developed our current state. Again SOC training will not help.
- We lack many resources in our community that would be cost-effective and beneficial, such as, in-home physical and speech therapists, intensive case managers, etc.
- We need diversification of service providers. Too many providers hold a monopoly. The closest Child Pysch unit is XXX which is at least 30-40 min away on a good travel day. Not enough resources for the teenage population is available.
- We need funding and service providers.
- Well, as you can gauge from my responses, I'm surprised that I was identified to take this survey. I am the Director of OP Clinic services and school-located satellites for OMH and OASAS counseling services provided by this agency. We do not provide Children's Health Homes- we are not HCBS- in our county, the SPOA and CCSI Tier 2 manage children's community based services, waivered programs, parent partners, etc and are well attended by representatives from every children's service locally. Have they embraced SOC verbiage?

Approaches? If yes, my staff attending these meetings has not brought back an understanding of this in a meaningful way. We provide clinic and school based counseling, and refer out for everything else. How well that is coordinated, using the model you describe (and that I googled, frankly), I cannot address. It may be being done, it may even be great- but how it impacts with us is limited to what we do to get services that are needed and available in our rural community, according to whatever steps we are asked to take.

- XXX County has an extensive history of, and experience with, SOC implementation that predates the NYS SOC initiative.
- When XXX County held the grant, it gave the community an opportunity to truly ensure "no decision about me without me."
- Whether or not a child has Medicaid would impact many of my answers
- While I am familiar with the System of Care and know that it has been implemented in our community, I had to answer I don't know to most of the questions as I am not sure what the level of implementation is.
- Yes. I do not see how SOC will flourish currently because of the lack of synergy, and the chaos in the County. I do see hope and progress concerning collaborations though, and feel that Counties such as XXX need outside inputs to alter the existing approach-es.

Appendix C: Sample Selection

Below several methods are used to determine the sites that may be most helpful to contact for qualitative interviews.

1. **High scores on subscales of SOC survey relevant to the domains of interest.** These scores could help identify counties with effective strategies in the domains of interest in place.
2. **Recent SOC grant recipients who are no longer grant-funded.** These sites could help identify strategies that were put into place during the funding period to build SOCs that were sustained post-grant.
3. **Input from the project team.** The team provided additional input based on their familiarity with the SOCs throughout the state, resulting in several adjustments to the sample list.

High scoring sites on SOC survey on subscales relevant to the domains of interest[14]

Interviewing counties with high scores may help identify the counties with effective strategies in place to succeed in the identified domains. Counties indicated had an avg score of 3.00+/4 on the corresponding subscales.

Domain 1: Cross-systems efforts to strengthen SOC

CLMHD description: N/A

Coordinated approach subscale of the SOC Principles section: This subscale addresses whether care coordination, cross system coordination, and cross system care plans are in place.

- Coordinated Approach - Basic care coordination is provided for children and families at lower levels of service intensity
- Coordinated Approach - Care is coordinated across multiple child-serving agencies and systems
- Coordinated Approach - Intensive/targeted care coordination with a dedicated care coordinator is provided to high-need youth and families
- Coordinated Approach - One overall plan of care is created across child-serving agencies and systems (there may be more detailed plans for individual systems as part of the overall plan)

Putnam (3.44), Nassau (3.35), Suffolk (3.25), Erie (3.22), Chenango (3.21), Greene (3.20), Chautauqua (3.18), Albany (3.14), Cayuga (3.07)

Domain 2: Blending/braiding funding to support SOC

CLMHD description: How and if counties are blending &/or braiding funding to support system of care (e.g., county tax levy, state aid, preventive services, grants, Family First Preservation Act, MRT, OMH Reinvestment).

- N/A, No item/scale on blended/braided funding

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14 See Appendix for county by county averages

Domain 3: Funding, supporting & sustaining SOC components

CLMHD description: How and if counties are funding, supporting & sustaining system of care components (e.g., wraparound facilitation, care coordination, evidence-based practices, family/peer support, crisis services, infrastructure, flexible service dollars, school-based efforts. (e.g., funding wrap facilitators, non CFTSS peer support, training soc/wrap & respite).

Evidence informed approach subscale of the SOC Principles section: This subscale addresses whether evidence informed practices are operating and fidelity is measured.

- Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Best practice guidelines, clinical protocols, and manuals are provided to practitioners
- Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Evidence-informed practices are implemented within the array of services and supports to improve outcomes
- Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Fidelity to evidence-informed practices and outcomes is measured
- Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches - Providers are trained in specific evidence-informed practices and/or evidence-informed practice components

Cayuga (3.88), Chautauqua (3.02), Albany (3.00)

Individualized, Wraparound Approach to Service Planning and Delivery subscale of the SOC Principles section: This subscale addresses whether a county is using a wraparound approach.

- Individualized, Wraparound Approach to Service Planning and Delivery - Flexible funds are available to meet child and family needs not financed by other sources
- Individualized, Wraparound Approach to Service Planning and Delivery - Individualized assessments of child and family strengths and needs are used to plan services and supports
- Individualized, Wraparound Approach to Service Planning and Delivery - Individualized child and family teams are used (including family, youth, providers, etc.) to develop and implement a customized service plan
- Individualized, Wraparound Approach to Service Planning and Delivery - Individualized service plans are developed and implemented for each child and family that address multiple life domains
- Individualized, Wraparound Approach to Service Planning and Delivery - Services include informal and natural supports in addition to treatment

Putnam (3.54), Cayuga (3.26), Dutchess (3.25), Chautauqua (3.23), Chenango (3.14), Genesee (3.12), Suffolk (3.08), Erie (3.05), Nassau (3.04), Otsego (3.01)

Infrastructure subscale: This subscale addresses whether infrastructure is in place to support the SOC components.

- Infrastructure Components - Defined access/entry points to care
- Infrastructure Components - Extensive provider network to provide comprehensive array of services and supports
- Infrastructure Components - Financing for system of care infrastructure and services
- Infrastructure Components - Point of accountability structure for system of care management and oversight
- Infrastructure Components - Structure and/or process for interagency partnerships and agreements
- Infrastructure Components - Structure and/or process for measuring and monitoring quality, outcomes, and costs (including IT system) and for using data for continuous quality improvement
- Infrastructure Components - Structure and/or process for partnerships with family organization and family

leaders

- Infrastructure Components - Structure and/or process for partnerships with youth organization and youth leaders
- Infrastructure Components - Structure and/or process for strategic communications/social marketing
- Infrastructure Components - Structure and/or process for strategic planning and identifying and resolving barriers
- Infrastructure Components - Structure and/or process for training, TA, and workforce development
- Infrastructure Components - Structure and/or process to manage care and costs for high-need populations (e.g., care management entities)

Cayuga (3.11), Putnam (3.04)

Family-Driven Approach subscale of the SOC Principles section: This subscale addresses whether a family-driven approach is being implemented.

- Family-Driven Approach - Families have a choice of services and supports
- Family-Driven Approach - Families have a primary decision making role in service planning and delivery
- Family-Driven Approach - Families have access to peer support
- Family-Driven Approach - Family strengths are incorporated in service planning and delivery

Putnam (3.68), Wyoming (3.60), Chautauqua (3.43), Nassau (3.43), Suffolk (3.40), Chenango (3.31), Otsego (3.29), Niagara (3.22), Orange (3.20), Dutchess (3.11), Essex (3.07), Rensselaer (3.07), Erie (3.02), Greene (3.00)

Youth-Guided Approach subscale of the SOC Principles section: This subscale addresses whether a youth-guided approach is being implemented.

- Youth-Guided Approach - A youth organization exists and supports youth involvement at the system and service delivery levels
- Youth-Guided Approach - Youth are active partners in service planning and delivery
- Youth-Guided Approach - Youth have a choice of services and supports
- Youth-Guided Approach - Youth have access to peer support
- Youth-Guided Approach - Youth strengths and interests are incorporated in service planning and delivery

Wyoming (3.40), Putnam (3.34), Nassau (3.27)

Domain 4: Collecting cross-systems data to facilitate cross-systems work

How and if counties are collecting cross-systems data to drive county cross-systems planning, (e.g., how are sites measuring impact of system reform, change and impact on resource allocation, collecting data for planning, decision making, and Quality improvement).

Data and Accountability subscale of the SOC Principles section: This subscale addresses whether electronic health records exist and if data is collected and used to support quality improvement.

- Data and Accountability - Data are collected regularly on the quality and outcomes of services and supports and are used for continuous quality improvement
- Data and Accountability - Electronic health records exist

Cayuga (3.55), Greene (3.50), Chautauqua (3.25), Chemung (3.17), Wyoming (3.10), Genesee (3.10), Suffolk (3.09), Clinton (3.08), Albany (3.07), Erie (3.00)

Summary

Counties that indicated an avg score of 3.00+/4 on the corresponding subscales.

Cross-systems work	Evidence Informed	Individualized, Wraparound	Infrastructure	Data and Accountability	Youth-Guided	Family-Driven
Putnam	Cayuga	Putnam	Cayuga	Cayuga	Wyoming	Putnam
Nassau	Chautauqua	Cayuga	Putnam	Greene	Putnam	Wyoming
Suffolk	Albany	Dutchess		Chautauqua	Nassau	Chautauqua
Erie		Chautauqua		Chemung		Nassau
Chenango		Chenango		Wyoming		Suffolk
Greene		Genesee		Genesee		Chenango
Chautauqua		Suffolk		Suffolk		Otsego
Albany		Erie		Clinton		Niagara
Cayuga		Nassau		Albany		Orange
		Otsego		Erie		Dutchess
						Essex
						Rensselaer
						Erie
						Greene

County	Total Appearances
Chautauqua	5
Putnam	5
Cayuga	4
Nassau	4
Suffolk	4
Albany	3
Chenango	3
Erie	3
Greene	3
Wyoming	3
Dutchess	2
Genesee	2
Otsego	2
Chemung	1
Clinton	1
Niagara	1
Rensselaer	1

Recent SOC grant recipients who are no longer grant funded

May help identify elements of SOC and SOC strategies that were put in place with grant funding, but that have been sustainable.

Site/county	Year(s) funded[15]	Currently funded?
Cayuga	2016	No
Chautauqua	2008, 2015, 2019	Yes
Herkimer	2019	Yes
Monroe	2012	No
Nassau	2008	No
NYC	2020	Yes
NYS	2016, 2020	Yes
Onondaga	2009, 2015, 2019	Yes
Orange	2008	No
Otsego	2017/2018	Yes
Rockland	2016	No

Summary: Potential counties for interview sample: goal is 10-20 group interviews

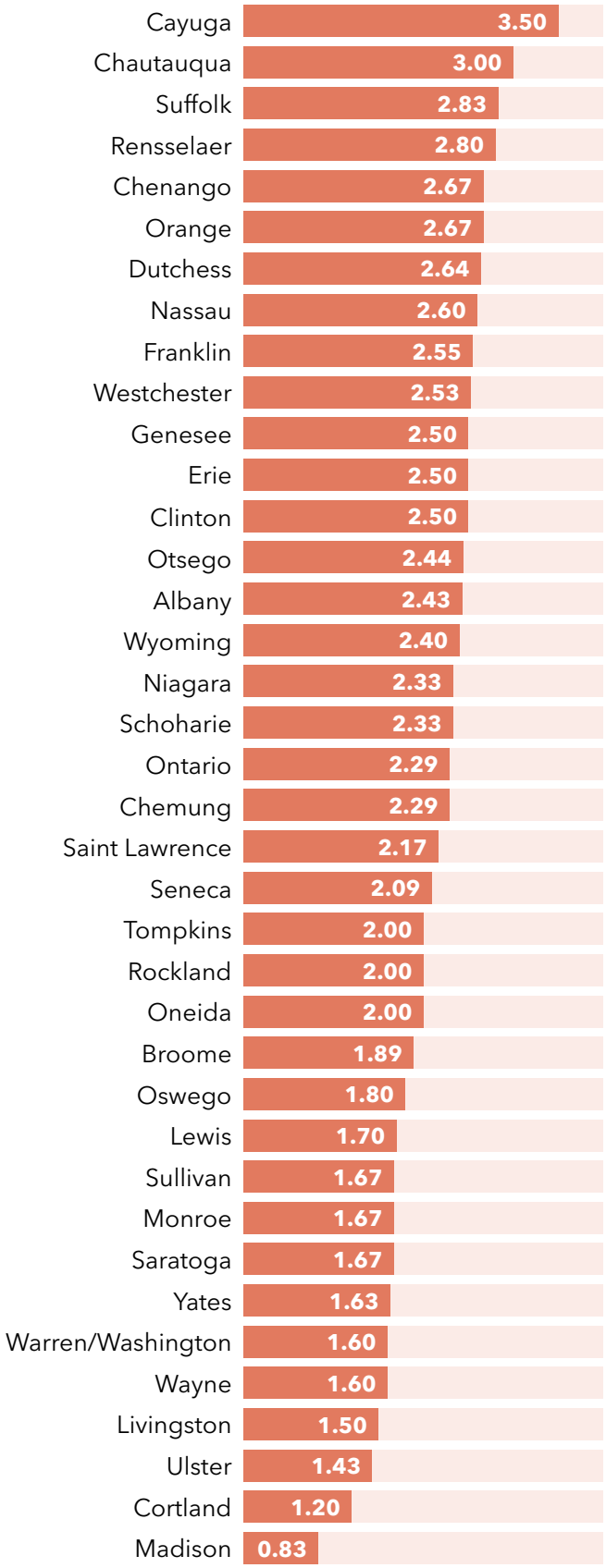
Based on committee discussion, it was recommended that only one Long Island county (i.e., Nassau or Suffolk) be included, and that Westchester County be added to the interview sample list.

- Albany
- Cayuga
- Chautauqua
- Chenango
- Dutchess
- Erie
- Genesee
- Greene
- Monroe
- Nassau
- Orange
- Otsego
- Putnam
- Rockland
- Westchester
- Wyoming

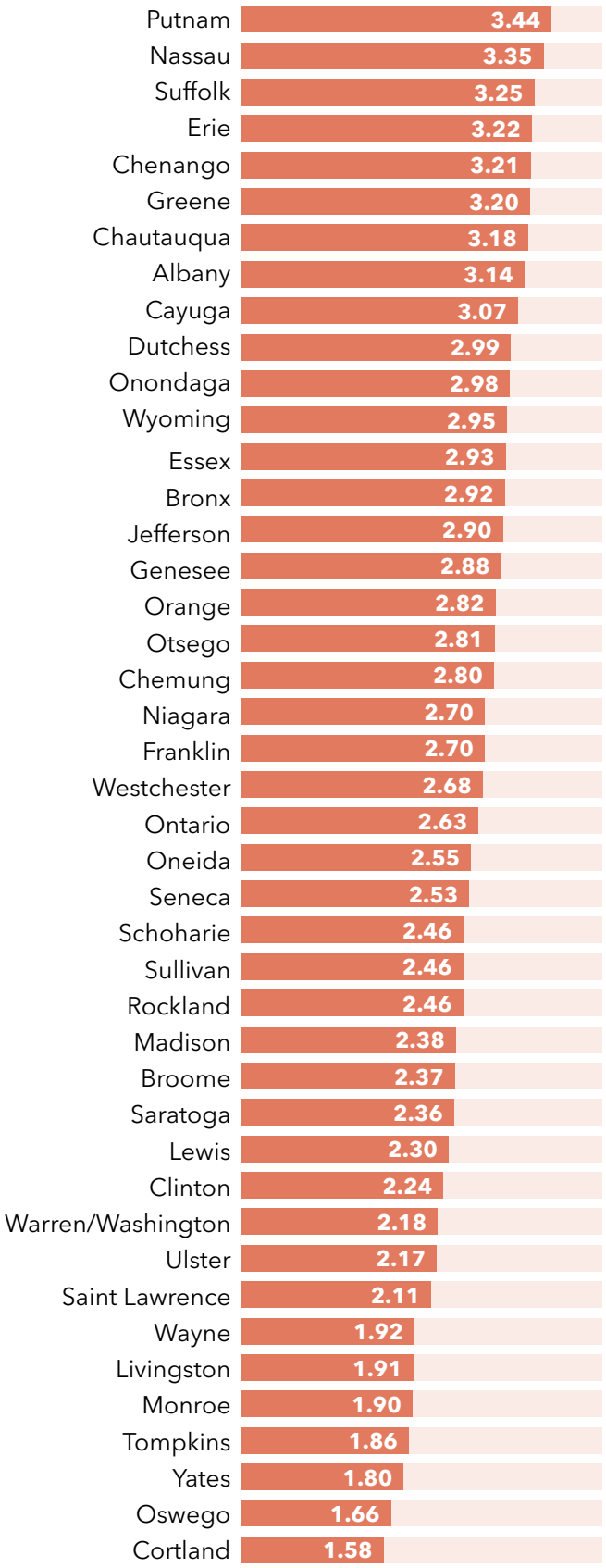
15 Earliest funding year included was 2008. 2013 grantee data is missing due to a broken link on the SAMHSA website.

Subscale Scores by County used for sample selection

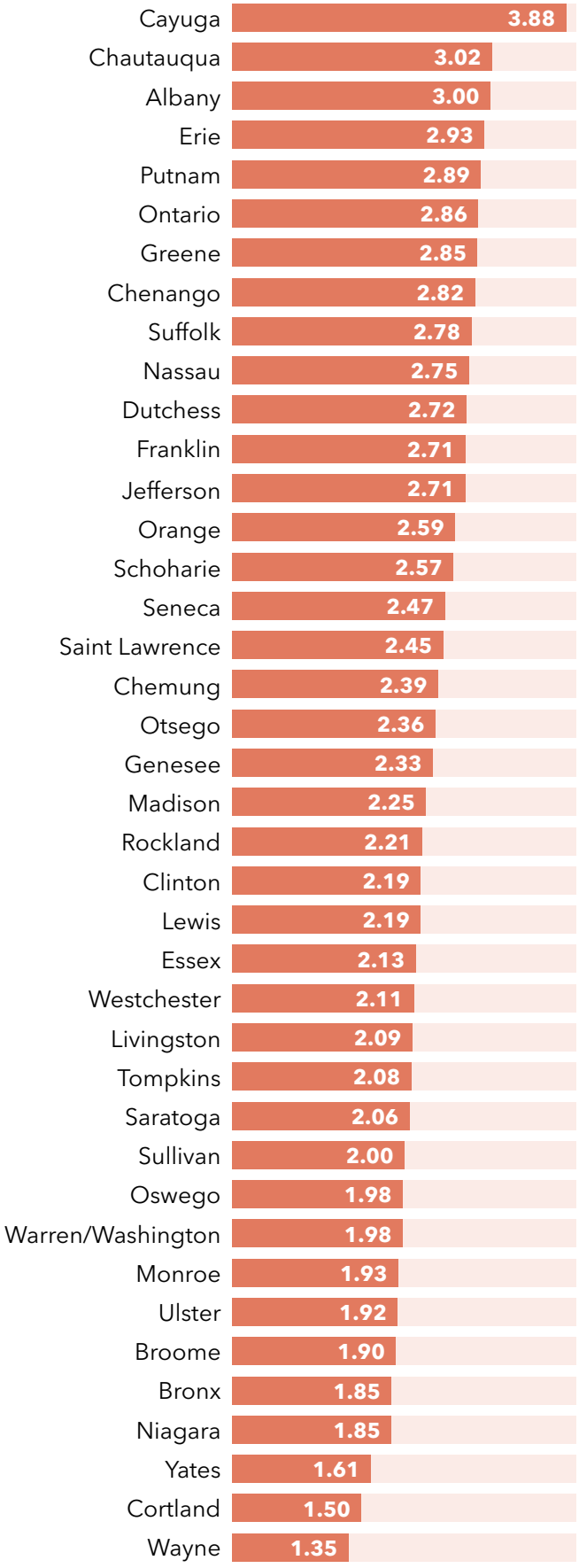
SOC implementation



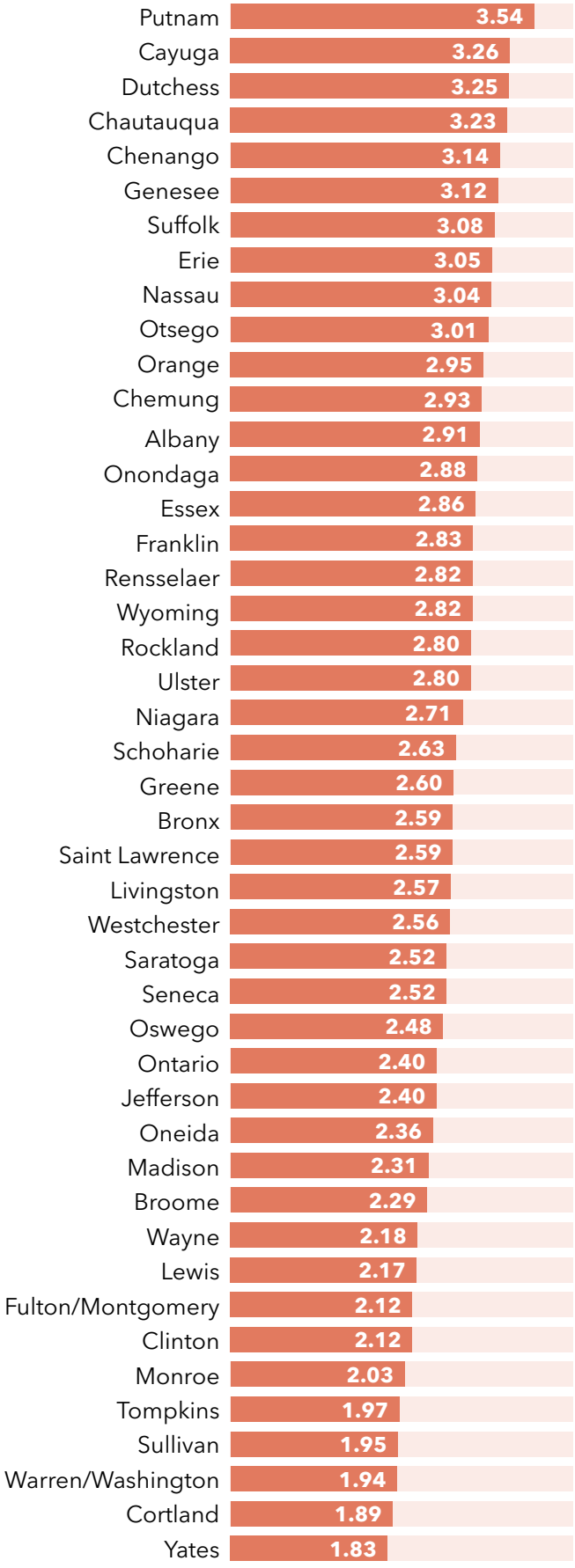
Coordinated approach



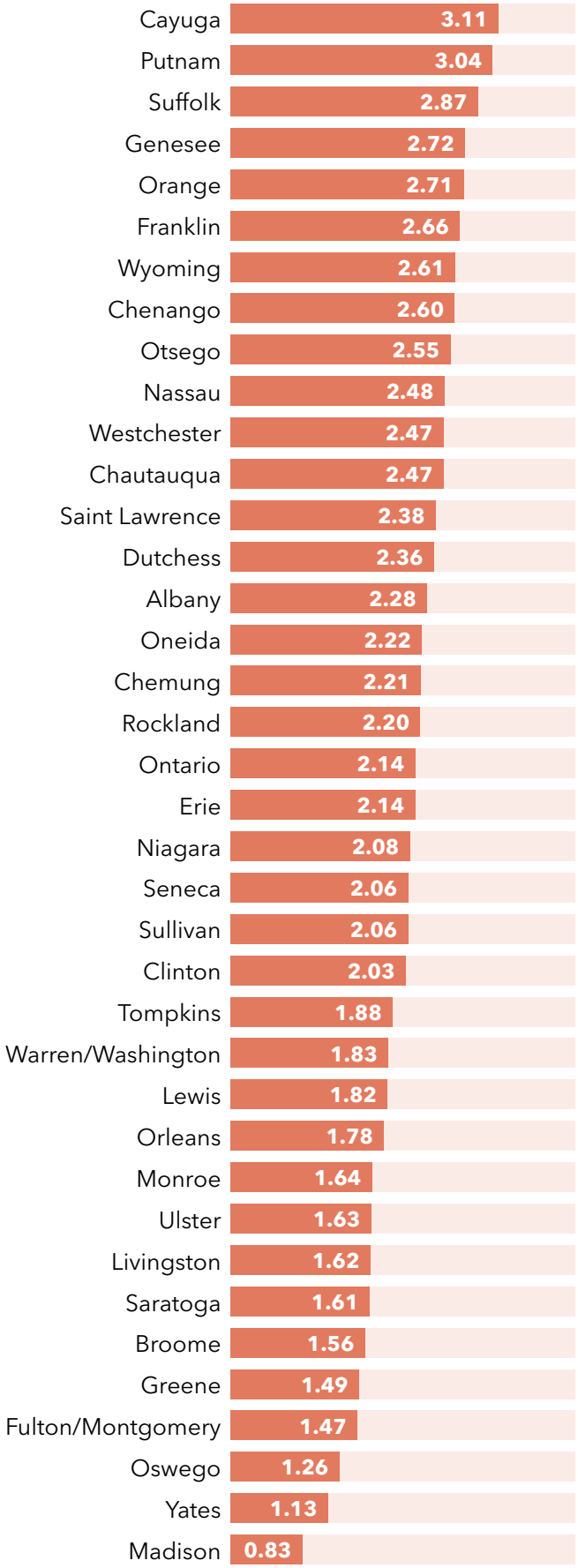
Evidence informed



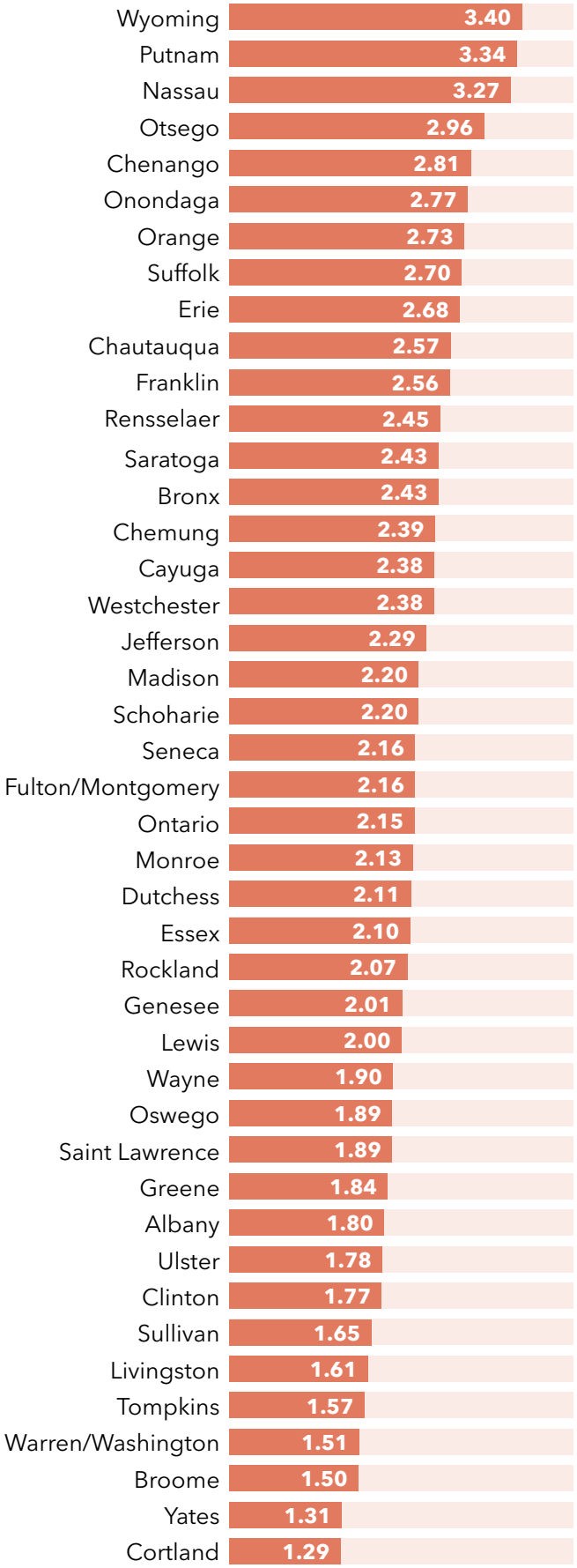
Individualized, wraparound approach



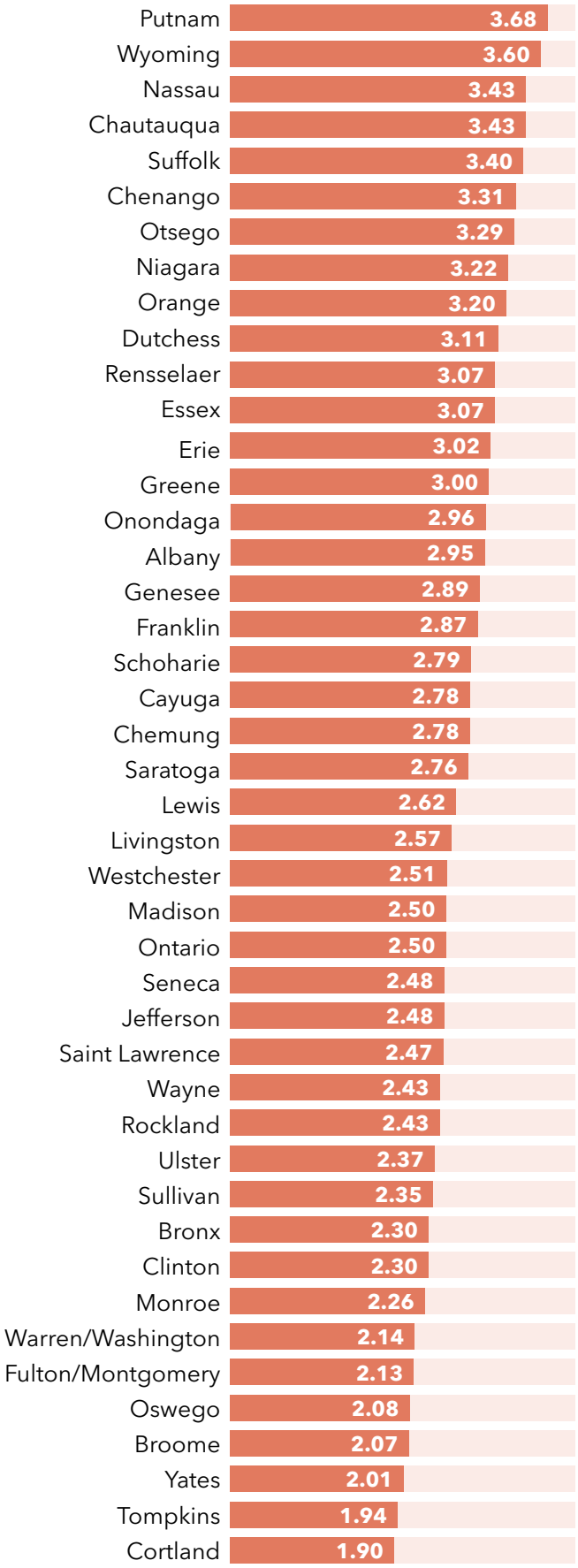
Infrastructure



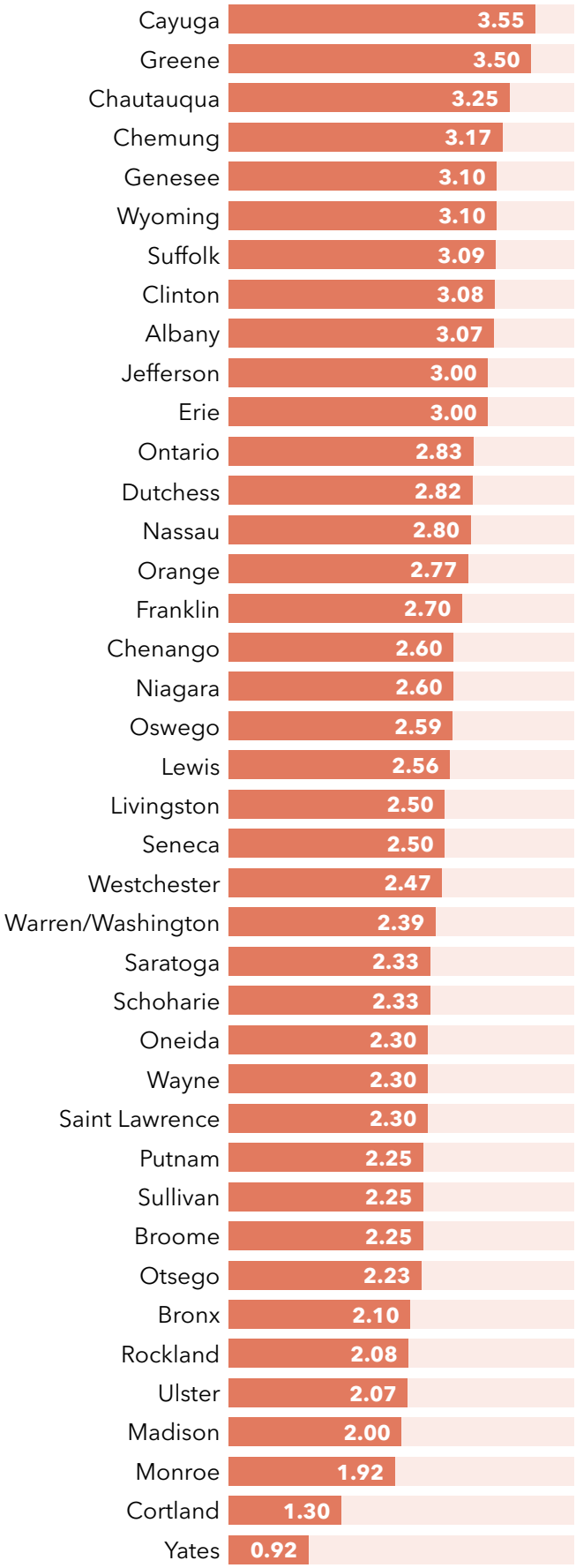
Youth-guided approach



Family-driven approach



Data and accountability



Appendix D: CLMHD Interview Protocol

Cross-system work

1. Do you have a regular **collaborative meeting** with multiple reps from child-serving systems to discuss **individual youth**? [prompt: These meetings may be called "SPOA meetings" or "tier 1" meetings]

If No

   a. Have you ever had one? If yes, what contributed to this practice ending?
   b. Is there interest in (re)establishing one?
      i. If yes, what are the barriers?
      ii. If no, why do you think that is?

If Yes

   c. Who attends? [ASK IF THEY HAVE AN ATTENDANCE RECORD SO YOU DON'T HAVE TO GO THROUGH ALL THESE AGENCIES/SYSTEMS.] Check each of the following:

Mental Health	☐	community providers	☐
SPOA	☐	crisis providers	☐
DSS	☐	Family Peer Advocate	☐
Child Welfare	☐	Youth Peer Advocate	☐
Intellectual /Developmental Disabilities	☐	Youth	☐
Juvenile Justice	☐	Caregivers	☐
Sub Abuse	☐	state agencies	☐
public health	☐	Managed Care Organization	☐
school district/BOCES reps	☐	Health Home/CMA	☐
medical/healthcare	☐	Any other representatives we who also come that we didn't ask about?	☐

   d. How is it going? (Prompts: How is it functioning? Is it achieving what it intends to achieve? What could be improved?)
   e. What is the purpose of these meetings? (e.g., to identify services).
   f. What level of staff attend the meetings (e.g., direct care, middle managers, directors, executives)?
   g. Which populations do you focus on, i.e., Medicaid vs. private, early childhood + TAY, youth newly referred to services, youth who need additional services, complex cases, etc.?
   h. What role do MCOs and HH play in your planning process and in these meetings?
   i. Are the youth being discussed and their families/caregivers at this table?
   j. How does this meeting or process connect to wraparound service planning and care coordination?
   k. Who is responsible for scheduling these meetings? (probe for whether HH or SPOAs responsible)

2. Do you have a regular collaborative meeting with multiple reps from child- serving systems to discuss broader child-serving initiatives and oversee system of care policies?

If No

a. Have you ever had one? If yes, what contributed to the loss of this practice?
b. Is there interest in (re)establishing one? If yes, what are the barriers? If no, why do you think that is?

If Yes

a. Who attends? Check each of the following

MH	☐	medical/healthcare	☐
CW	☐	community providers	☐
DD	☐	CSEs	☐
DSS	☐	family and youth organizations	☐
JJ and/or other law enforcement	☐	MCO	☐
Sub Abuse	☐	HH	☐
public health	☐	Regional interagency Technical Assistance Teams (RiTAT)	☐
school district/BOCES reps	☐	Any other representatives we may have missed?	☐

b. How is it going? (Prompts: How is it functioning? Is it achieving what it intends to achieve? What could be improved?)
c. What cross-systems initiatives, policies, procedures have been implemented in your county as a result of these meetings?
d. Do you have the support from state agencies you need to carry out this work?
e. What role do MCOs and HH play in your planning process and in these meetings?
f. Who is the responsible party for facilitating of these meetings (i.e., LGU, CSB Board, etc.)

3. Do you have a collective, common mission/vision statement for all child- serving systems?

If No

a. Have you ever had such a statement? If yes, what contributed to the loss of this statement?
b. Is there interest in (re)establishing a statement? If yes, what are the barriers? If no, why do you think that is?

If Yes

a. Who contributed to the development of this statement?
b. Did family and youth contribute to the development?
c. How does it inform the work you do?

Cross-systems data

Now we're going to talk about using data to inform practice, policy and other decisions. While all children's systems may maintain their own data and information systems, we're wondering about the extent to which each system shares data with one another.

4. Does your county share data across systems to better understand how to serve youth county?

If Yes

a. Which systems' data sources do you have access to (e.g., psykes), and for which purposes do you use these data sources?

5. Do you have someone in your county who is responsible for pulling data or conducting analyses and sharing it with cross-systems groups such as in cross-systems meetings?

   If Yes

   a. Is this person / are they paid for this work, if so what portion of their salary (e.g., .50 FTE)
   b. What tools do they use? (e.g., computer, pen/paper, excel, access, another stats program)

6. What indicators do you use to know whether changes you make in how you serve children are actually benefiting children?

7. What initiatives, policies, procedures, program changes have been implemented because of data analysis and findings?

8. How do these indicators align with Medicaid requirements of MCOs and HHs?

Funding and sustainability

9. What additional resources could you use – financial and otherwise – to better support your system of care?

   If they haven't submitted the funding chart—ask if they need help with it.

10. If they have submitted the funding chart—ask, Are you concerned that you may not be able to continue to offer any of the services listed above in the future? If so, which ones? Why?

General System of Care

11. Many people have said identifying how to actually put the lofty values/principles of SOC into practice is difficult, so we want to know from people who are doing the work ways that they think it should be done – what are some ways that you have operationalized the values and what are some other ways you can operationalize them?

12. How do you get systems to actively care and work together to serve children and youth involved or at risk for involvement with multiple systems?

    a. Have you developed cross-system MOUs, MOAs, policies, operating procedures?
    b. Have you developed any cross-system training?

Instructions on completing the service/funding table

The following table identifies services/programs your county may offer (in the far-left column) and the funding sources you may use to support these services/programs (in the top row).

Complete the table by doing the following:

1. Place an "X" in each box to indicate each funding source you use to fund each service/program. For example, if you use Medicaid to fund care coordination, place an X in that box.
2. If you have multiple services or programs within a specific service/program category, write the name of that service/program in the box that corresponds with its funding source.
3. In the "Another funding source" column, please specify what that funding source is.

4. In the "Other service/ program" row, please specify what that service/program is.
5. If you do not fund a service/program, select the "Don't fund/offer" option.

Below is an example of a completed table, followed by blank table for you to complete.

If you have any questions, please contact Tom LaPorte at tlaporte@albany.edu.

SAMPLE CHART

	County tax levy	State aid	Discretionary Grants	Block Grants (e.g., MH block grant)	Family First Prevention Services Act	Medicaid	OMH Reinvestment	Another funding source	Child welfare funding (e.g., 4b)	Juvenile Justice funding	Substance Use	Don't fund/ offer
Health Home Care Management using High Fidelity Wraparound[16]		x	x			x						
Intensive care coordination using wraparound but not the NYS High Fidelity Wraparound Model												x
Health Home Care Management not using HFW		x				x						
Other Care coordination						x						
Evidence-based practices		Trauma-Focused CBT				Multi-dimensional Family Therapy						
Family peer support		x				x						
Youth peer support												x
Mobile crisis		x										
Flexible service dollars								Private donation				x
School-based behavioral health efforts			PBIS initiative					School funds				
Primary Prevention Services				x								
Trainings												x
Respite				x								
Housing support					x							
Intensive in-home services						x						
Supported employment		x					x					x
Therapeutic foster care									x			
Other service/ program		x										
Infrastructure[17]					x							

16 "Wraparound" is a team-based process to develop and implement individualized service and support plans for children with serious emotional and behavioral needs and their families. Wraparound implementation for a specific youth or family is typically coordinated by a trained wraparound facilitator or care coordinator, who convenes and works with a team of individuals relevant to the youth and family, including natural supports. Teams meet regularly (e.g., at least every 30–45 days), and transition out of formal wraparound occurs when priority needs have been met or adequate progress has been made toward these needs. The wraparound process also includes the following characteristics: Efforts are based in the community; family and youth perspectives are sought and prioritized; services and supports are individualized to meet specific needs of the children and families; the process is culturally competent and strengths based; wraparound teams have flexible funding; team members include people drawn from family members' natural support network; and the team monitors progress on measurable indicators of success and uses this information to change the plan as necessary (Sather & Bruns, 2016).

17 SOC infrastructure includes structures and processes for such functions as system management, data management and quality improvement, interagency partnerships, partnerships with youth and family organizations and leaders, financing, workforce development, and others (Pires, 2010; Stroul & Le, 2017).

COMPLETE THIS CHART

	County tax levy	State aid	Discretionary Grants	Block Grants (e.g., MH block grant)	Family First Prevention Services Act	Medicaid	OMH Reinvestment	Another funding source	Child welfare funding (e.g., 4b)	Juvenile Justice funding	Substance Use	Don't fund/ offer
Health Home Care Management using High Fidelity Wraparound												
Intensive care coordination using wraparound but not the NYS High Fidelity Wraparound Model												
Health Home Care Management not using HFW												
Other Care coordination												
Evidence-based practices												
Family peer support												
Youth peer support												
Mobile crisis												
Flexible service dollars												
School-based behavioral health efforts												
Primary Prevention Services												
Trainings												
Respite												
Housing support												
Intensive in-home services												
Supported employment												
Therapeutic foster care												
Other service/ program												
Infrastructure												

Appendix E: Interview Participants

County interview participants

County	Participant	Role
Chautauqua	Rachel Ludwig	Project Director of Chautauqua Tapestry Resilience Initiative
Chautauqua	Carmelo Hernandez	Director of Community Mental Hygiene Services, Chautauqua County Department of Mental Hygiene.
Chautauqua	Kathy Swanson	Fiscal Supervisor, Chautauqua County Dept. of Mental Hygiene
Chenango	Liz Warneck	Community Support Services Program Coordinator
Dutchess	Kate Castell	ECCSI (Enhanced Coordinated Children's Services) Coordinator, Astor Services for Children & Families
Dutchess	Tom Morris	Deputy Director, Dutchess County Office of Probation & Community Corrections
Dutchess	Deborah DiSanza	Coordinator of Children's Services and Children's SPOA Coordinator, DBCH
Dutchess	Todd Karlin	Chief Program Officer, Astor Services for Children & Families
Dutchess	Jean-Marie Niebuhr	Deputy Commissioner, Director of Community Services, DBCH
Erie	Marie Sly	Coordinator, Children and Youth Service Integration, Dept. of Mental Health
Erie	Mark O'Brien	Commissioner of Mental Heath
Erie	Catie Gavin	First Deputy Commissioner of Family Wellness, Dept. of Social Services
Erie	Kelli Blakeley	Deputy Commissioner, Dept. of Probation
Erie	Lynn Kaczmarowski	Coordinator of Disability Services, Dept. of Mental Health
Genesee	Mike Fleming	SPOA Coordinator, Genesee County Mental Health Services
Genesee	Candi Biegas	Children's SPOA Case Facilitator, Genesee County Mental Health Services
Monroe	Melissa Hayward	Senior Manager, Children's Behavioral Health Services, Office of Mental Health
Monroe	Jessica Wattington	Planning & Project Manager, Training Coordinator, Children's Behavioral Health Services, Office of Mental Health
Nassau	Kathryn Artesani	Children's SPOA Coordinator, Nassau County Office of Mental Health
Orange	Darcie Miller	Commissioner of Social Services & Mental Health
Orange	Jackie Metakes	Director, Mental Health Assessment Team
Orange	Angela Turk	Director, Children's Services
Orange	Anne-Marie Freitas	Family Support Coordinator, Access: Supports for Living
Orange	Katarina Hoass	Chief Clinical Officer, Access: Supports for Living
Orange	Maddie Miller	Deputy Director, Orange County Probation

County	Participant	Role
Orange	Anne Caldwell	Senior Supervisor, DSS
Otsego	Sally Tedesco	SPOA Coordinator, Otsego County Dept. of Mental Health
Otsego	Marion Mossman	Project Director, Otsego County System of Care
Otsego	Jeanette Pavlus	Director of Community Services, Otsego Dept. of Mental Health
Otsego	Miguel Martinez	Program Manager, Otsego County Addiction Recovery Services
Putnam	Michael Piazza	Commissioner, Putnam County Department of Social Services
Putnam	Dawn Mullins	CCSI, SPOA & Children's Mental Health Services Coordinator, Putnam County
Rockland	Mariel Piña	Children's LGU Representative & C-SPOA Coordinator, Rockland County Department of Mental Health
Rockland	Susan Hoerter	Commissioner, Rockland County Dept. of Mental Health
Westchester	Michael Orth	Commissioner, Westchester County Dept. of Community Mental Health
Westchester	Victoria Shaw	Program Coordinator, Westchester County Dept. of Community Mental Health
Westchester	Kerry Whelan-Megley	Executive Director of Family Ties of Westchester, Inc.
Westchester	DaMia Harris-Madden	Executive Director, Westchester County Youth Bureau
Westchester	Mary Kate Cabaleiro	Program Administrator, Westchester County Youth Bureau
Westchester	Andrew Ecker	Coordinator, Guidance & Child Study Center at Putnam Northern Westchester BOCES
Westchester	John Befus	First Deputy Commissioner of the Westchester County Dept. of Social Services
Wyoming	Karen Feustal	Assistant Director of Child & Family Services, C-SPOA Coordinator, Wyoming County
Wyoming	Kelly Dryja	Director of Community Services, Mental Health Department, Wyoming County

System of Care Implementation in New York State

Prepared for the NYS Conference of Local Mental Hygiene Directors, Inc.

December 31, 2021

About the Center for Human Services Research

The Center for Human Services Research (CHSR) is a research department at the University at Albany. CHSR has nearly 30 years of experience conducting evaluation research, designing information systems, and informing program and policy development for a broad range of agencies serving vulnerable populations. For more information about CHSR, please visit www.albany.edu/chsr

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