TEAM UP | SCALING & SUSTAINABILITY CENTER™

Exploring Opportunities to Advance Behavioral Health Services in New York City

Practice-Level Needs Assessment

BOSTON MEDICAL CENTER

August 2024 – August 2025

Funding for the NYC TEAM UP Roadmap has been provided by The Carmel Hill Fund.

Introduction

- This assessed a set of primary care practices in New York City for their interest and readiness to do TEAM UP. In the process, we endeavored to learn about the environment to provide integrated behavioral health to children in NYC at the "micro" or practice level. This project complements the macro level landscape analysis completed by Manatt Health as part of the overall Exploring Opportunities to Advance Behavioral Health Services in New York City project funded by The Carmel Hill Fund.
- In this report, we:
  - Review our methodology for selecting and assessing practices
  - Report on the practices selected
  - Depict the results of the leadership assessment across practices (overall results; not practice specific)
  - Describe the patterns and themes in the care pathway for pediatric behavioral health integration in New York City
  - Provide recommendations that contribute to how to target an entry strategy for TEAM UP in NYC
- While this report has limited practice-specific information, summary reports have also been developed for each practice outlining the key learning from the assessment.

Assessment Goals and Approach

- Goal 1: To understand the practice's implementation of integrated behavioral health services for children and youth, their revenue sources and value-based care journey, as well as its culture around change. This goal is about readiness for change required to implement TEAM UP or components of the model.
  - Approach: A one-hour interview of practice leadership using questions based on several validated questionnaires from the National Association of Community Health Centers, the Population Health Management Capabilities Assessment Tool, Level of Integration Measure, and the Mental Health Practice Readiness Inventory.
- Goal 2: To understand the clinical pathway for screening and addressing the BH needs of children at the practice and associated needs and barriers. This will contribute to understanding the gaps and areas of greatest need as well as how TEAM UP's potential services might be tailored or offered in component parts to meet specific needs.
  - Approach: A 1 to 1.5-hour survey of a pediatric care team structured around TEAM UP's Integrated BH Pathway, using case studies for the three key age groups: 0-5 years old, school-aged, and adolescent.
- Goal 3: To gather background data on the practice and the community that it serves that can be used to understand the context for the other components of the assessment.
  - Approach: A brief written questionnaire to be completed by the practice manager or population health manager.

**For the three Health and Hospital sites, we did one leadership interview of the pediatric leadership in the H+H Central Office*

Overview of the Integrated Behavioral Health Pathway

Accessing Primary Care	Screening	Identification	Engagement	Care Planning and Coordination	Care Delivery
How do infants, toddler, school-aged kids, adolescents access care in your practice?	What screening do infants, toddlers, school-aged, adolescent patients receive?	What decisions or actions are taken by the PCP following the screening tool's results?	What BH care/service options are discussed with patients when a BH issue is identified?	How do you plan for the care need, share information and coordinate internally and with schools and outside agencies?	How is BH care delivered to infants, toddler, school-aged kids, and adolescents?






Practice Selection

This report is based on case studies of eight practices, curated based on their general expression of interest in behavioral health integration and team based pediatric care. It is important to remember that this is not a random selection of pediatric practices in NYC.

Selection Criteria:

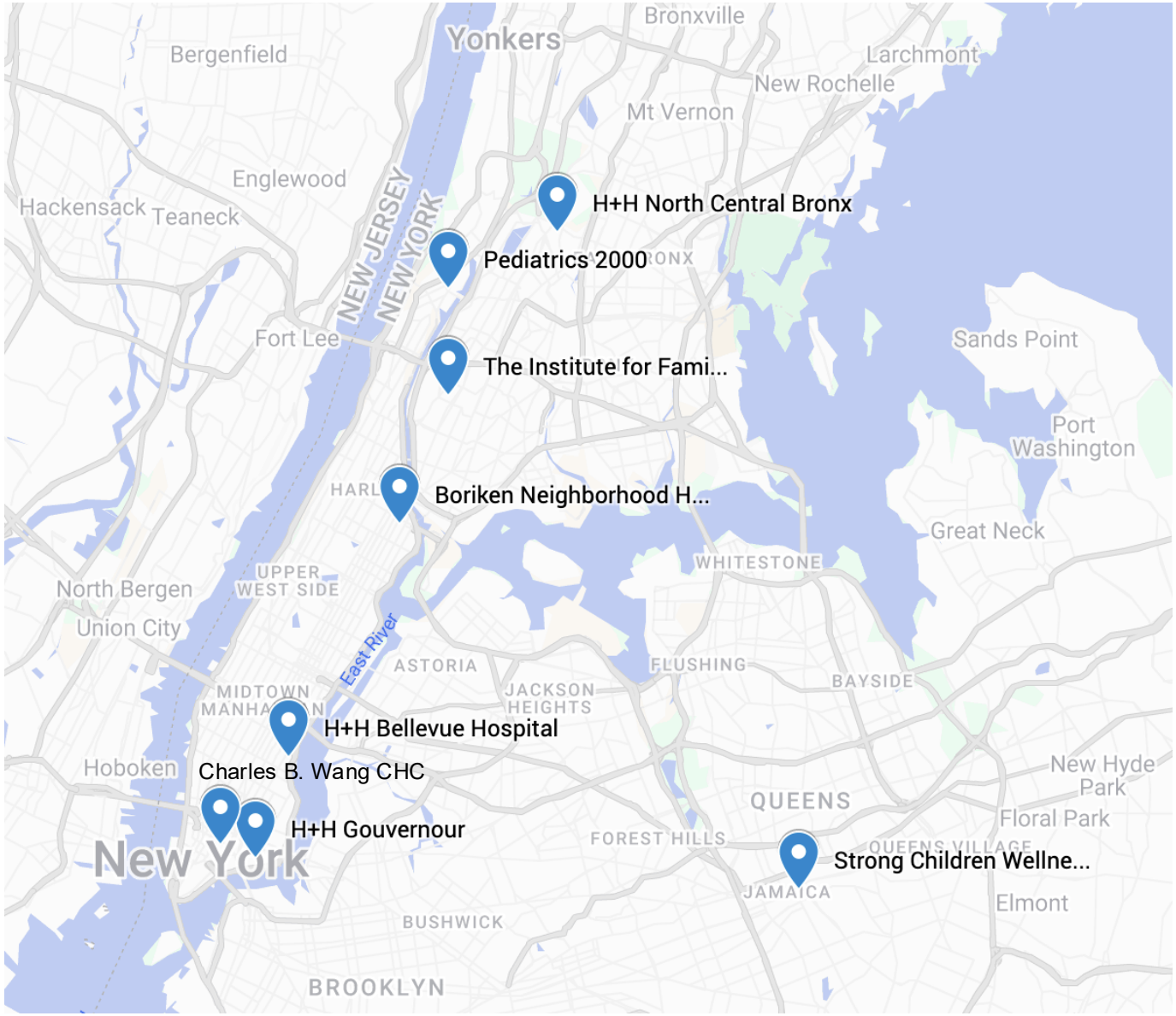
- What the practices have in common:
  - More than 2000 children in the practice's patient panel, in pediatrics or family medicine*
  - Willing to participate and motivated to further expand on integrated BH and population health capabilities
  - A majority of their pediatric panel is on Medicaid and CHIP

What varies among practices:

- Type of practice, including FQHCs, private practices, and H+H practices (one of which is based in an academic medical center)
- Population served, ranging from various Latino populations, to largely Asian to a significant Black population
- Geographic location – across 3 of the 5 boroughs of NYC

**The one exception to this 2000 pediatric panel cut-off is Strong Child Wellness which is new and rapidly growing toward this number and we felt had such a unique model that it should be considered.*

Practice Assessment Participants Across New York City



Demographics of Participating Practices

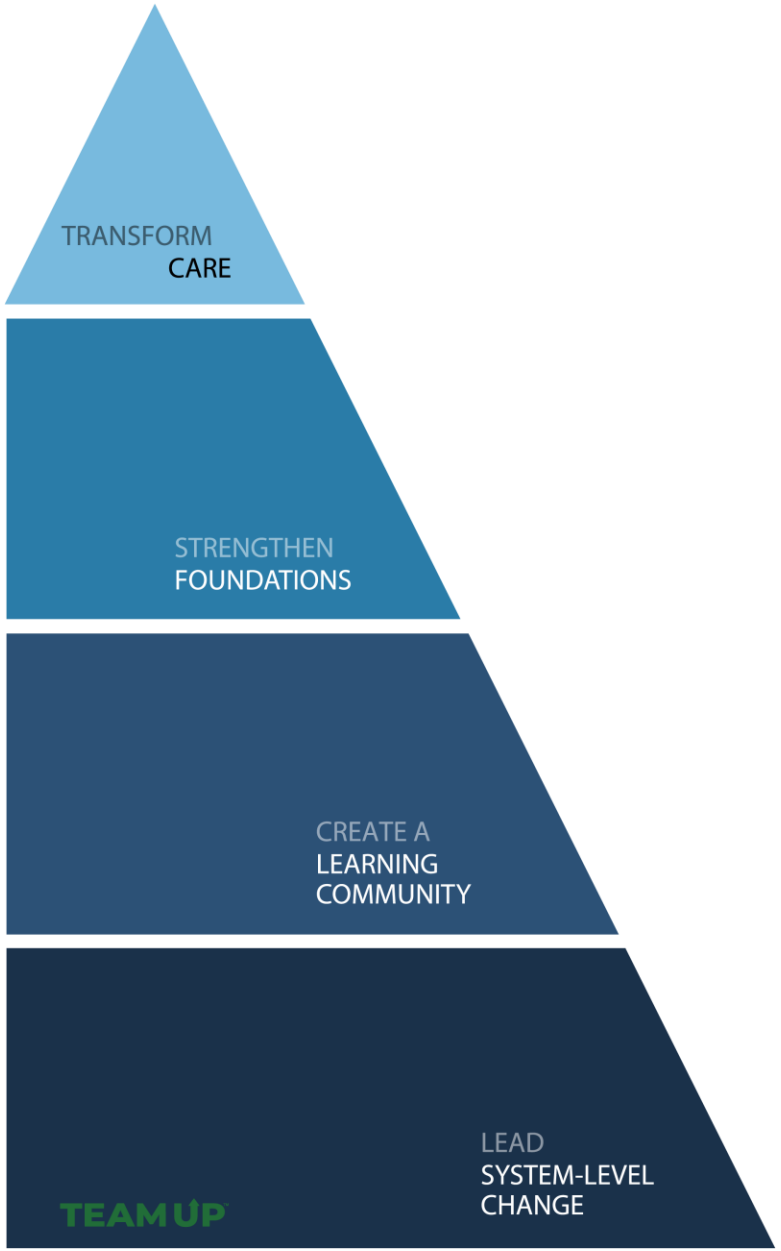
Practice Name	Type of Practice	Pediatric Patients	% of Total Patients	Key Population Served	Public vs. Private Payers
H+H Bellevue	Health and Hospitals	9,988	29%	68% Hispanic/Latino 14% Black/African American	76% Medicaid 4% Commercial
H+H North Central Bronx	Health and Hospitals	10,753	25%	53% Hispanic/Latino 26% Black/ African American	75% Medicaid 6% Commercial
H+H Gouverneur	Health and Hospitals	5,997	26%	66% Hispanic/Latino 13% Black/ African American	68% Medicaid 7% Commercial
Charles B. Wang Community Health Center	FQHC	21,814	34%	6% Hispanic/Latino 81.8 % Asian	63% Medicaid 12% Commercial
Strong Children Wellness	Private Practice	1,355	82.1%	30% Hispanic/Latino 36% Black/ African American	78% Medicaid 19% Commercial
Boriken Neighborhood Health Center * (From UDS)	FQHC	4,702	37.8%	72.4% Hispanic/Latino	71% Medicaid
Institute of Family Health	FQHC	24,234	23.7%	45% Hispanic/Latino 37% Black/African American	72% Medicaid 17% Commercial
Pediatrics 2000	Private Practice	11,434	100%	59% Hispanic/Latino	90-95% Medicaid 4% Commercial

Recruitment Gaps

Recruiting practices proved to be more difficult than anticipated. In our view, this was partly because TEAM UP was an unknown program to pediatric practices in NYC and partly because it was an extraordinarily stressful time for practices and FQHCs dependent largely on federal Medicaid and CHIP funding and serving large immigrant populations.

We would highlight three major gaps where we were unable to secure participating practices:

- A practice in Brooklyn (the largest borough)
- A practice serving a majority of patients who identify as Black
- An academic practice
  - One H+H practice was based at NYC/Bellevue, but its funding was through H+H not the academic medical center



Leadership Assessment Findings

The following slides describe findings for the themes discussed during the practice leadership interviews

Section 1: Organizational Capabilities and Readiness

Strategic Focus

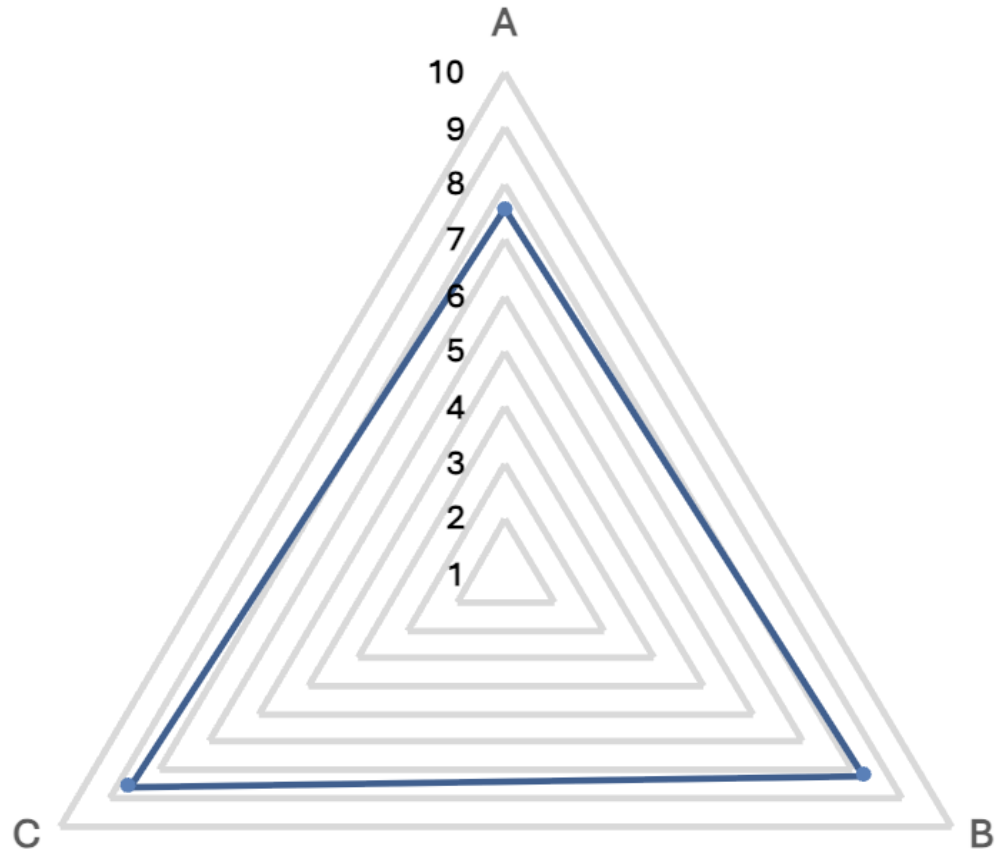
Questions Asked of Leadership

A. Leadership and staff share an organizational vision and plan to transform in alignment with mission and financial sustainability.

B. The leadership is knowledgeable about payment reform efforts and their implications for the practice's mission and services.

C. Organization has leadership buy-in and commitment for identifying and addressing patients' behavioral health needs.

Mapping of Responses



1 – Low/least developed 10 – High/most developed

Patterns and Themes on Strategic Focus

- Behavioral health integration was ranked high as a key strategic focus. While they had more caveats in other areas of strategy, this was an area where they all felt focused and in alignment.
- In general, leadership teams reported alignment on overall strategy though many noted that current environment added uncertainty to their strategic focus.
- Practices were more varied in their assessment of where they are on value-based care (VBC). Some were relatively insulated from the VBC world, while other practices discussed plans to join an ACO and had cobbled together reimbursement through a variety of VBC related programs such as care management, HealthySteps, and Collaborative Care.

"Behavioral health is incredibly central to our work"

Change Management

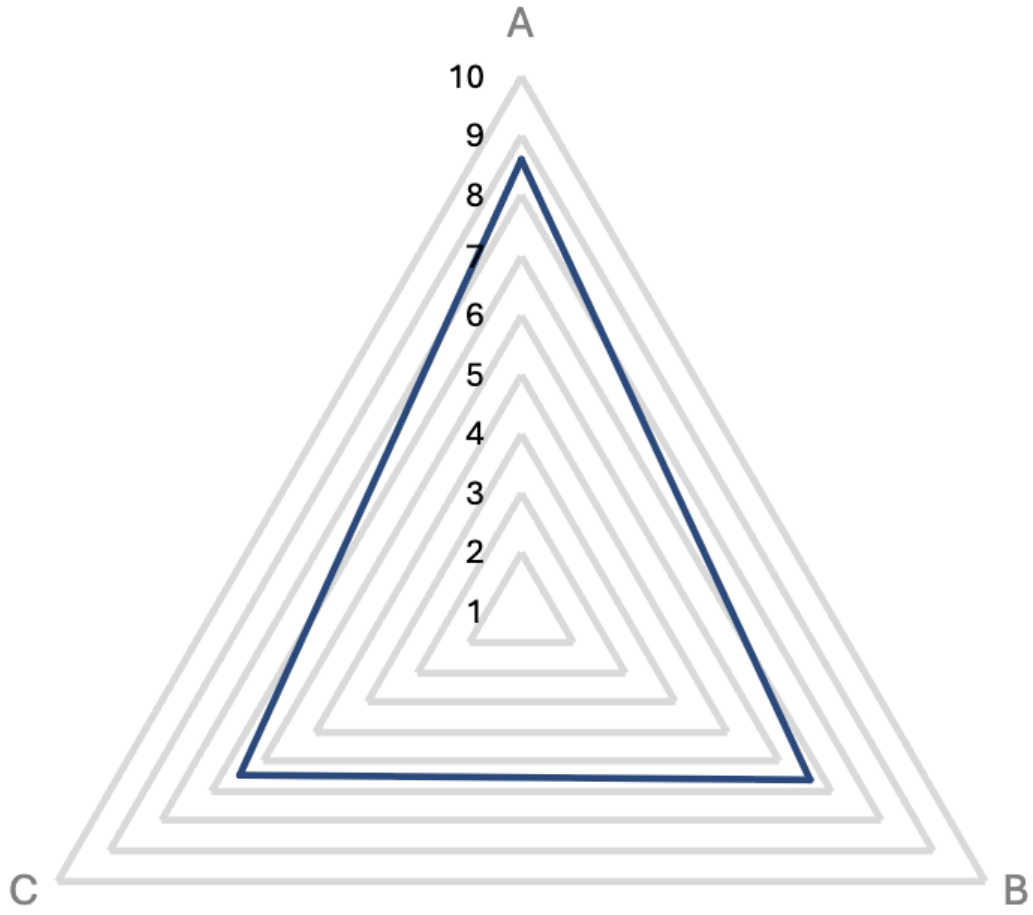
Questions Asked of Leadership

A. People in this organization operate as a real team.

B. Leadership at this organization creates an environment where things can be accomplished.

C. The organization appropriately and adaptively communicates and manages change to sustain current and future transformation efforts.

Mapping of Responses



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Patterns and Themes on Change Management

- Leadership in all organizations felt that they operated as a team and created an environment for change.
- However, nearly all acknowledged that they didn't have systems or resources, such as project managers or change management methodologies, to apply to change.
- One of the barriers cited by several practices were staff and providers who have been there a long time.

"We try to create an environment where we as founders are really accessible to the staff and welcome ideas for new modalities and programs. A lot of times the ideas are stifled by funding, but the environment is open and inclusive for ideas. Staff have brought new ideas which they have been able to implement."

"[There are] a lot of silos but one of the strengths of the leadership team is the strong relationship with the site leadership and strong connection with other departments in central office and there is trust from the leaders above them."

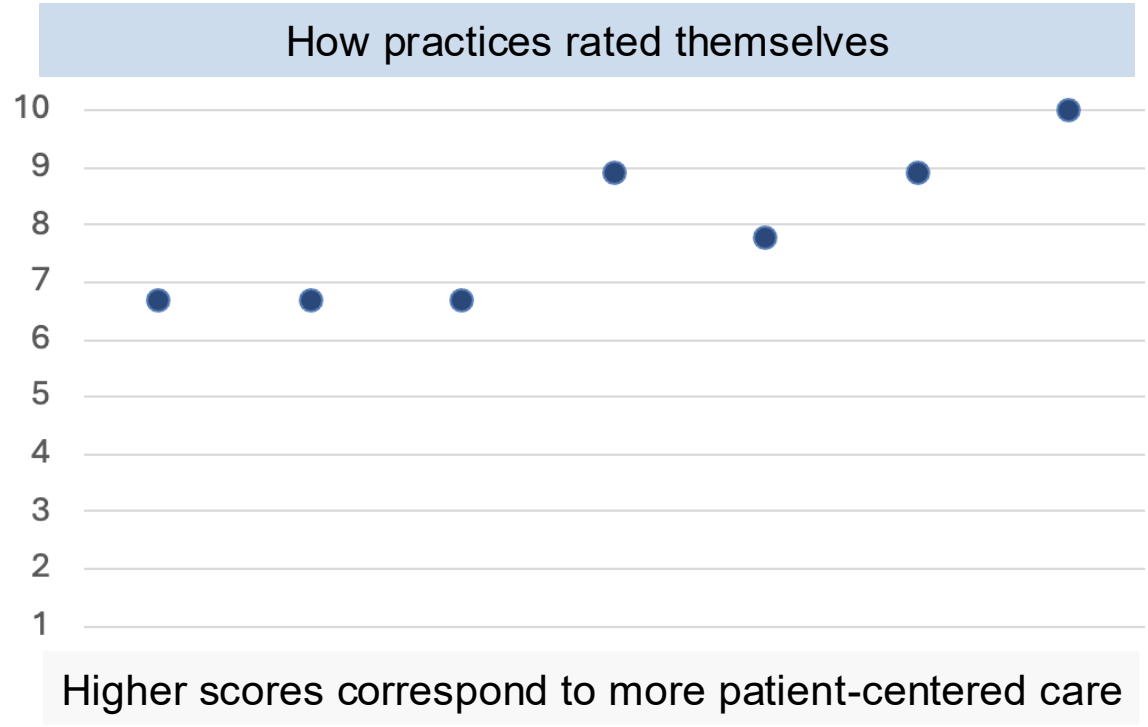
Patient Centered Care

Patterns and Themes

- Overall, the practices we talked to ranked themselves quite high on patient centered care.
- They particularly cited hiring staff from the population served and speaking the language of the patient (figuratively and actually).
- While many indicated they had a culture of cultural humility and co-creating care plans, only a couple had actual training in these areas.

“This is what our health center is known for. However, we don't have many formal programs or training ... so it’s more apprenticeship. We need to make sure that we don’t lose this as we get bigger.”

The practice provides patient-centered care



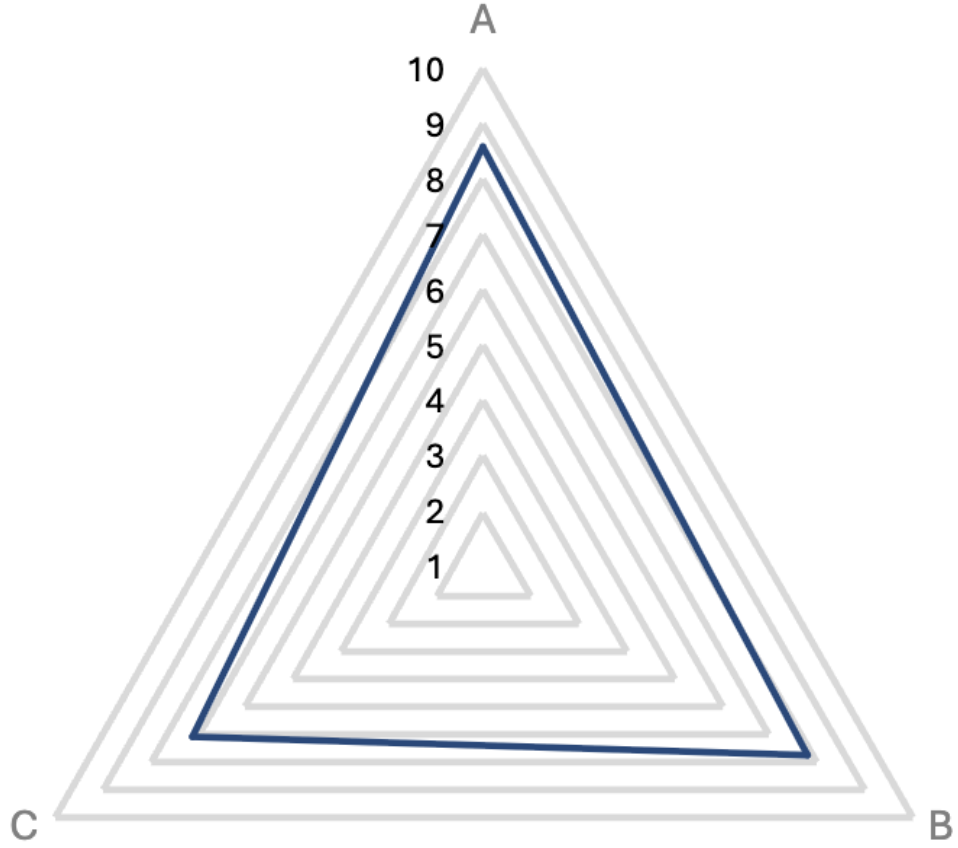
Section 2: Population Health and Clinical Model

Model of Care

Questions Asked of Leadership

A. Care team members provide services at the top of their training.
B. All visits focus on preventive care in addition to acute problems and are driven by guidelines and registries.
C. Behavioral Health Services are integrated with primary care services.

Mapping of Responses



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Patterns and Themes on Change Management

- Leadership in all organizations felt that they operated as a team and created an environment for change.
- However, nearly all acknowledged that they didn't have systems or resources, such as project managers or change management methodologies, to apply to change.
- One of the barriers cited by several practices were staff and providers who have been there a long time.

"Our goal is to make the handoff easy and smooth and low stigma, which counts for a lot in our environment."

“I get that and they are paying for my expertise but think that part of patient centered care is sometimes doing what the patient needs like sending a fax…”

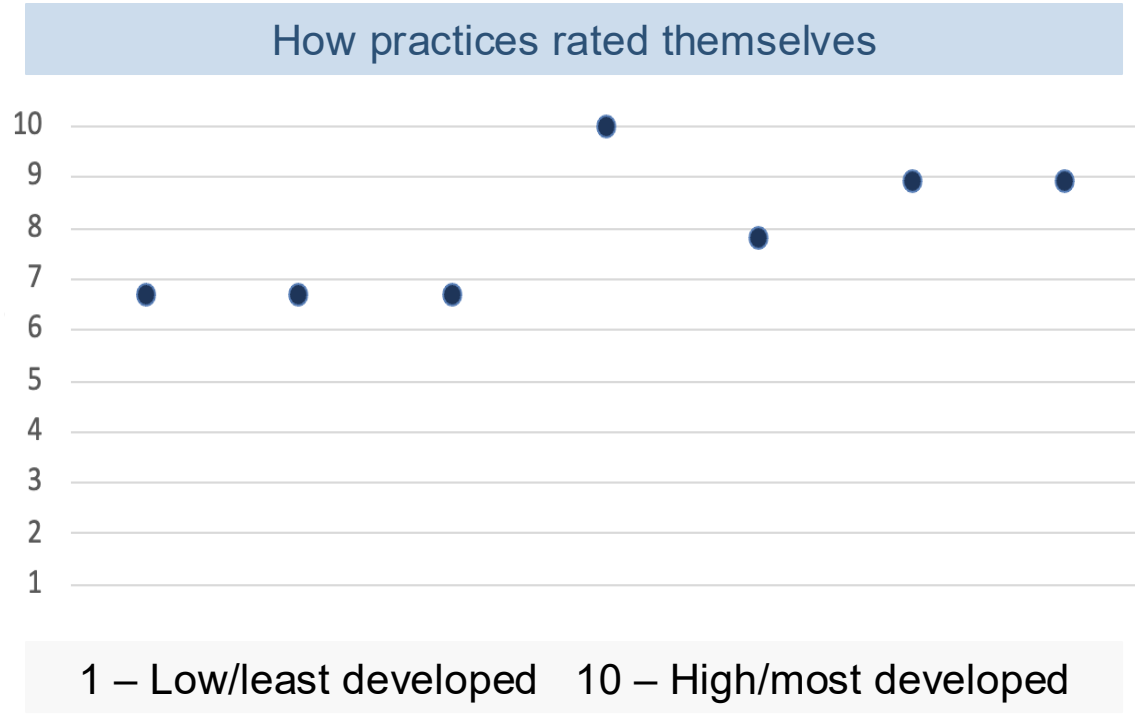
Section 3: Data and Quality

Practice Quality Improvement

Patterns and Themes

- Quality improvement was clearly embedded in all the practices though they had different organizational approaches
- At H+H, a centralized data and quality function supports the individual practices, though implementation in the field is variable.
- The Institute for Family Health has a sophisticated quality improvement capability, with an interdisciplinary team, a separate QI function for behavioral health, and an annual symposium to share QI results across the Institute.
- At the private practices, while QI was clearly a focus it was more embedded in the clinical teams and driven by ACO and/or licensure requirements.
- Many practices had the benefits of the data capabilities of Epic.

The practice has knowledge and experience with quality improvement



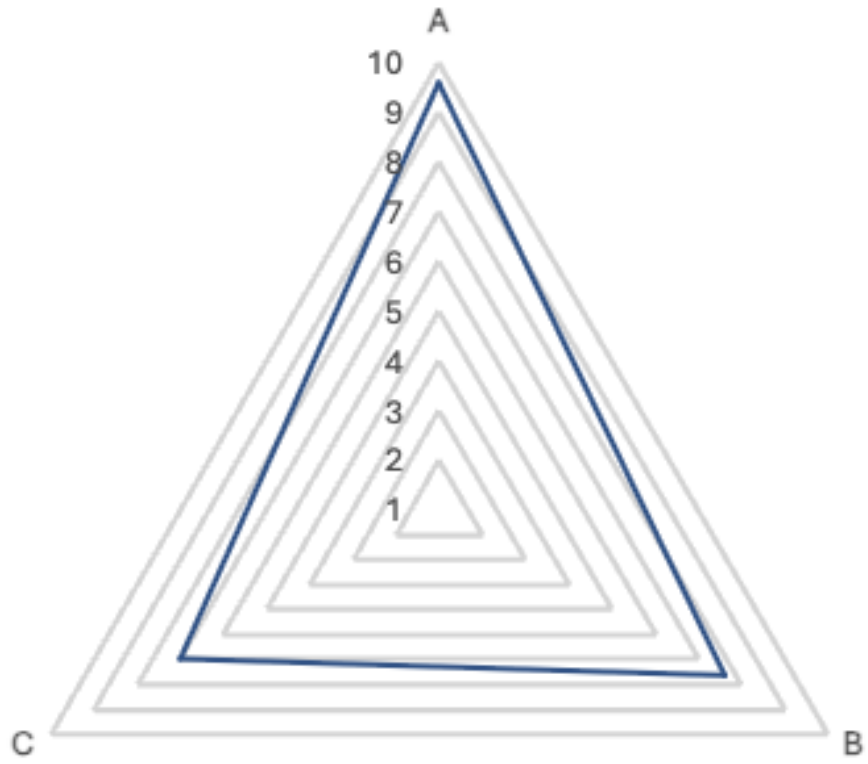
"It is encouraged and required but there is a need for quality work on the quality of the projects [in the field]."

Detection, Tracking and Referral of BH Services

Questions Asked of Leadership

A. The clinic systematically detects and serves the behavioral health needs of patients.
B. The clinic systematically tracks the progress of behavioral health treatment.
C. Pediatric behavioral health services are readily available (either within the system or well-developed community relationships).

Mapping of Responses



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Patterns and Themes on Detection, Tracking and Referral of BH Services

- Practices ranked themselves high on their ability to screen and detect behavioral health needs and this was borne out by the screening information provided as well as the clinical interviews.
- They did not rate themselves as high, however, when it came to the ongoing follow up of behavioral needs. Causes for this included the inadequate number of internal resources, the lack of strong referral relationships in the community, and the absence of any electronic connection with the organizations to which they are referring.
- The lowest rating in this section was for the availability of adequate referral resources. We heard this consistently, from the difficulty of hiring social workers to the lack of availability of resources in the community, particularly for ASD assessment and treatment. The one exception is the Institute for Family Health which has developed and refers to its own Article 31 mental health centers.

"If [patient's symptoms are] active will go to ER, if it's something urgent [self-harm] then do have the ability to get a good appointment like for next week. For other BH concerns some appointments take a year and stay in a limbo."

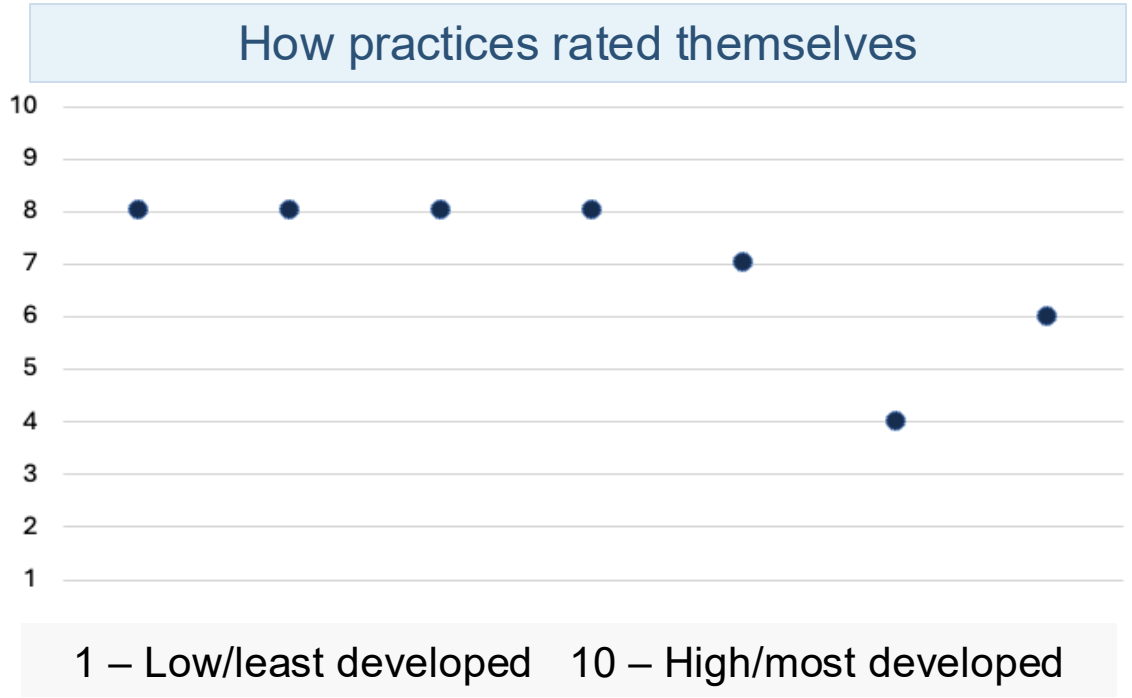
Practice Data Capacity

Patterns and Themes

- Organizations met their needs for data and analytics in very different ways, from a centralized department at H+H to having dedicated analytics staff, to making data and supporting tools accessible to users.

“We have really fantastic access to data. Everyone even at the individual provider level has the ability to run records about themselves and their own metrics...”

The organization has the necessary skills, roles and staff to understand organization's existing data, explore new data sources, and present insights from data.



Section 4: Behavioral Health Integration

Role of Behavioral Health Specialists on Pediatric Care Team

Questions Asked of Leadership

A. The clinic has a sufficient number of behavioral health specialists (BHSs) on site. BHS includes psychologists and licensed and unlicensed SW.

B. The BHSs are integrated into the workflow of the clinic.

C. The BHSs share access to the electronic medical record (EMR)/patient chart with the primary care providers (PCPs).

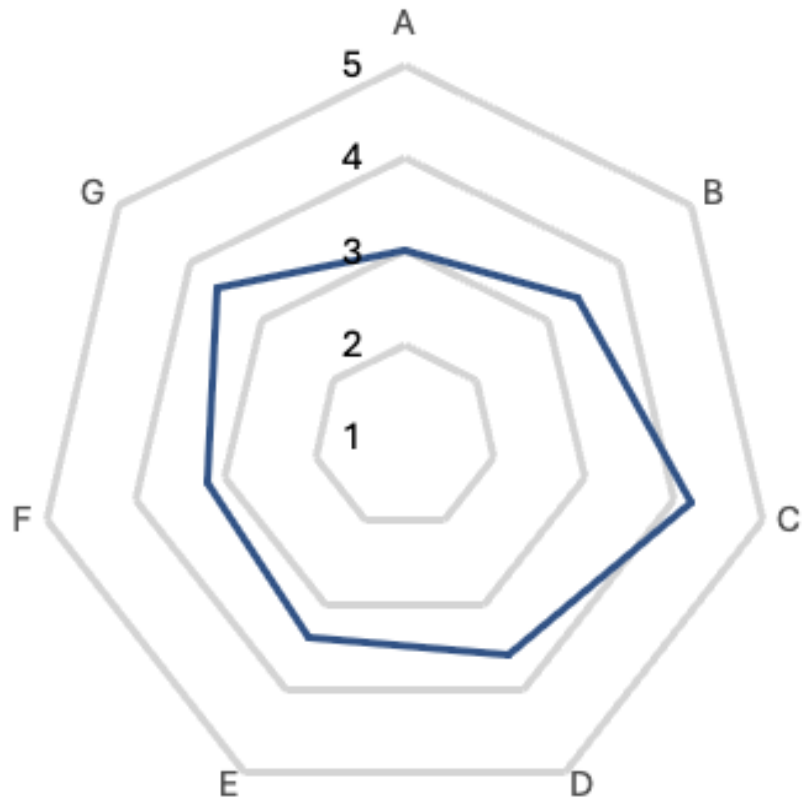
D. PCPs and BHSs do “warm hand-offs” according to patient needs.

E. PCPs and BHSs regularly consult about patient care in our clinic.

F. The BHSs take part in clinic meetings.

G. The BHSs are readily available to see patients and consult with PCPs in the clinic.

Mapping of Responses



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Patterns and Themes on Detection, Tracking and Referral of BH Services

- There was a wide range here from those who had BH specialists fully integrated for all ages of children to practices that had integrated staff associated with specific programs and age groups (HealthySteps and Collaborative Care) and practices that had very few or no BH specialists on the team.
- Several of the practices highlighted vacant positions or the need for more staffing of BHS roles, including the Health and Hospitals. Others, such as Strong Children Wellness and the Institute for Family Health see themselves as adequately staffed in this area.
- All practices that had BH Specialists had them integrated in the electronic health record. Although the Institute called out that they were an early adopter of this practice when they implemented Epic, it has quickly become standard practice.
- While PCPs and BHS consult on patients and do warm-handoffs at a relatively high rate, participation by BHS's in clinical meetings was lower.

RE: Warm Hand-offs:

"Yes, but it doesn't always work. Because there is one person and 5 needs and so don't get a warm hand-off, but they are part of the culture."

Community Health Worker (CHW) Integration

Questions Asked of Leadership

A. The clinic has sufficient number of CHWs or peers on site.

B. The CHWs or peers are integrated into the workflow of the clinic.

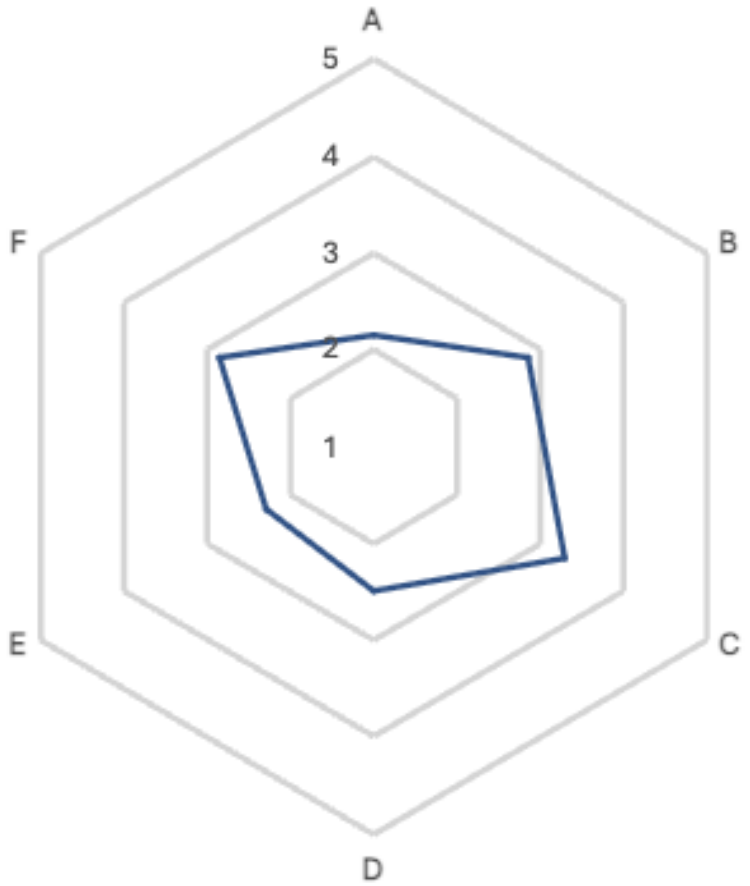
C. The CHWs and peers share access to the electronic medical record (EMR)/patient chart with the primary care providers (PCPs).

D. PCPs and CHWs do “warm hand-offs" according to patient needs.

E. The CHWs and peers take part in clinic meetings.

F. The CHWs and peers are readily available to see patients and consult with PCPs in the clinic.

Mapping of Responses



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Patterns and Themes on Community Health Worker Integration

- We broadened this question to include all non-clinical staff on the care team, such as care coordinators. Still, some of the practices had no one playing this role on the team and those that did generally felt that the number was insufficient.
- Similar to the BHS, CHWs and care coordinators were integrated into the electronic health record and available to consult with the PCP and often for warm-handoffs but generally did not attend clinical meetings.

“I would say 1 [on scale of 1-5] because we have CHW for early childhood to get them to EI but little to no support on BH.”

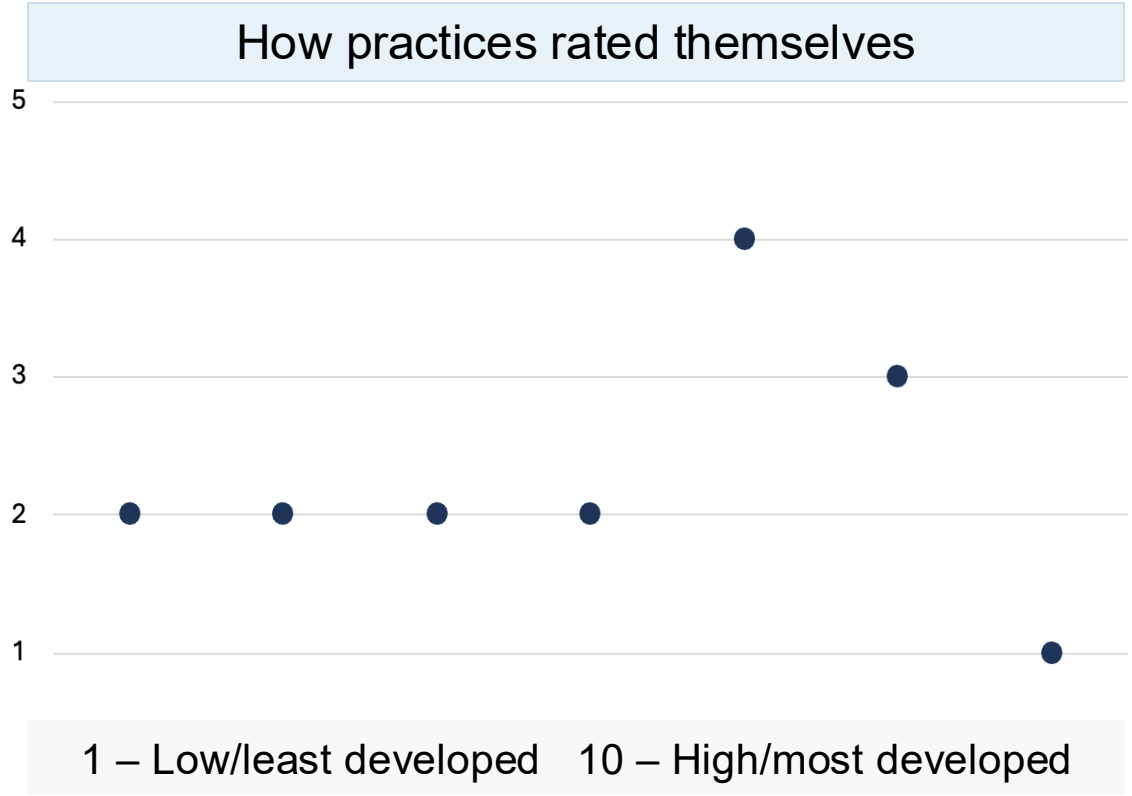
Integrated Care Training

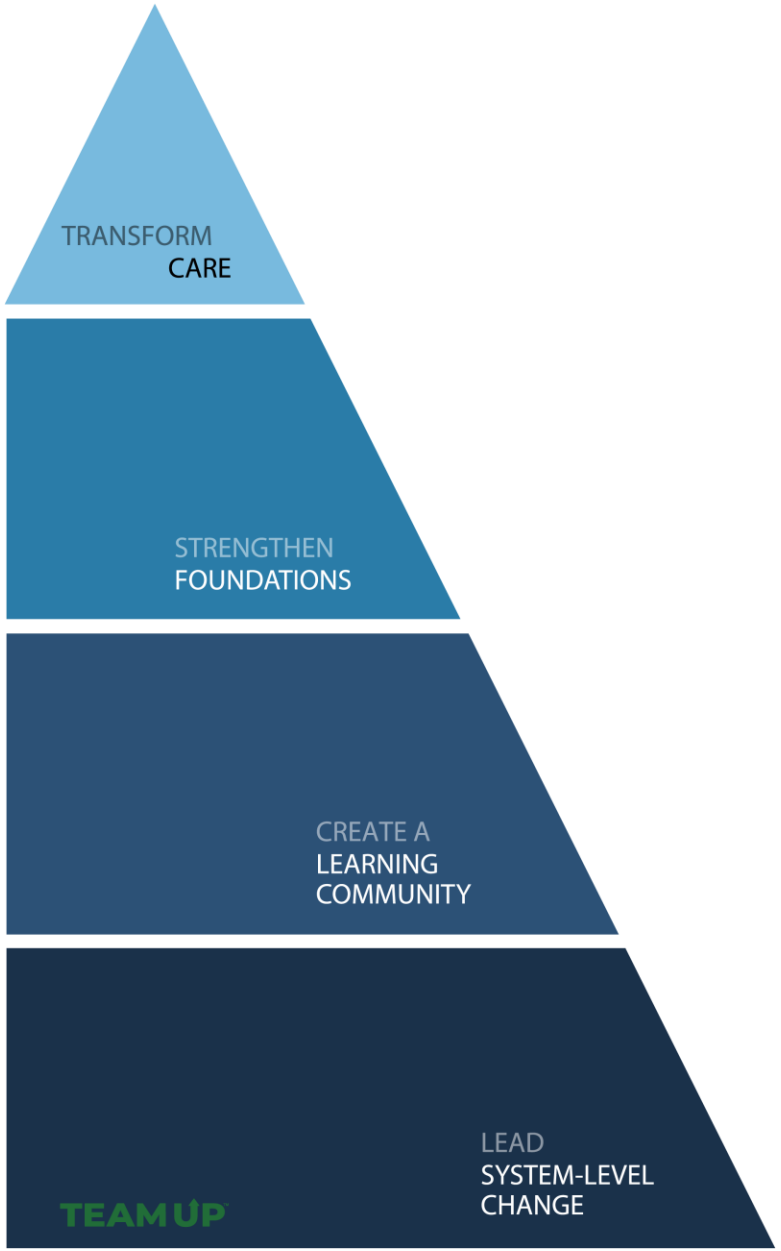
Patterns and Themes

In general, none of the practices had formal training program to support behavioral health integration.

“We have been trying to be intentional in finding additional training and mentorship as appropriate, but it has fallen on the leadership to do it. It's an area that we are trying to improve on…”

All clinic staff receives integrated care training





Clinical Pathway Findings

The following slides describe findings modeled after the steps in the TEAM UP integrated behavioral health model.

Overview of the BH Clinical Pathway

Accessing Primary Care	Screening	Identification	Engagement	Care Planning and Coordination	Care Delivery
How do infants, toddler, school-aged kids, adolescents access care in your practice?	What screening do infants, toddlers, school-aged, adolescent patients receive?	What decisions or actions are taken by the PCP following the screening tool's results?	What BH care/service options are discussed with patients when a BH issue is identified?	How do you plan for the care need, share information and coordinate internally and with schools and outside agencies?	How is BH care delivered to infants, toddler, school-aged kids, and adolescents?






Accessing Primary Care

Questions

- Are there screeners for HRSNs?
- Are there screeners for caregivers such as maternal depression or substance use?
- How is the screening administered? When is the instrument(s) administered and by whom? How is administered to patients who prefer a language other than English?
- Do you screen thru a portal such as MyChart or any other "self-serve" tools?
- How are the screeners collected and entered into the child's EMR?

Themes

- The majority of children and families are from the community; referral sources include local hospitals, schools, community programs such as HeadStart and word of mouth from parents.
- For those with prenatal care programs, they tend to get those children as patients.
- All practices have outreach programs particularly around immunizations but other population health management capability for children varies among sites.

Screening

Questions

- How do infants, toddler, school-aged kids, and adolescents access care in your practice?
- Where are the access points for primary care?
  - Explore the role of school-based health centers for school-aged and adolescents.
  - Do you measure continuity and empanelment?
- Do you do outreach to schedule well child, immunization, and follow up visits?

Themes

- All practices seem to follow age-appropriate guidelines for screening including developmental, BH, maternal depression and HRSN screens; many places did use SWYC as part of their tools
- The majority have it incorporated in their EHR (especially those with Epic) but some still screen on paper and scan it into the health records
- Some practices use iPads integrated with EHR for screenings and others are still screening in paper.
- At all practices we heard how important is to listen to parents and patients to really understand what's going on. Screenings are only a part of the work.

Identification

Questions

- Once a screener is completed, what assessment is done by the care provider to identify BH concerns in infants, toddlers, school-aged children, and adolescents ?
- Share what happens in the actual visit when a screen is positive and when it raises concerns? What does the PCP do?
- Are there follow up screeners if the screen is concerning?

Themes

- For children under 3, HealthySteps is well established in the city, and a social worker supports the care coordination needed
- For school-age and adolescents, practices seem to have limited onsite resources, and warm hand offs are not common. Many of them offer Collaborative Care for adolescents which helps support the team.
- For those practices with onsite developmental pediatrics or a psychiatrist, children have more timely access, and the team can close the loops with these providers. Once a referral is placed in the community, monitoring becomes challenging and relies on parents and guardians.
- Some pediatricians feel comfortable prescribing for common conditions, ADHD or mild depression for example, especially once the regimen is established.

Engagement

Questions

- What options are discussed with infants, toddlers, school-aged children, and adolescents who have a BH concern identified?
- Explore which team member(s) are available onsite to the PCP (collocated or not) and what network is easily accessible thru referrals.
- Warm-handoff or not? How is it supported by Electronic Health Record or work queues?
- Explore if they have a formal program (Healthy Steps, etc..).
- Explore family/caregiver engagement/education.
- What gaps and barriers do you encounter in engaging children and families?

Themes

- For school-age and adolescents, practices seem to have limited onsite resources, and when they do, warm hand offs are not common.
- Practices rely highly on parents' engagement with outside organizations and particularly with the school system.
- There are not established training programs for pediatrics staff in BHI beyond what people do individually, EHR trainings, and sometimes program or grant based workflow trainings.
- Some practices use "Project TEACH" for consultations and trainings such as CBT, etc.
- Other programs we heard include MOM program and Common Point (schools).

Care Planning and Coordination

Questions

- How do you plan for the care need, share information and coordinate internally and with schools and outside agencies?

Themes

- Many sites can offer short term therapy within primary care but beyond that need to refer to their mental health department (where they have it and it has capacity) or refer out.
- We saw challenges in coordinating with community organizations, in varying degrees, across all practices.
- Even for sites with social workers and CHWs, closing the loops outside of the practice is not possible, so depends on parents and caregivers to follow up.
- Care teams rely on schools IEP process to do assessment because they lack other timely resources to refer to in the community.

Care Delivery

Questions

- How is BH care delivered to infants, toddler, school-aged kids, and adolescents?
- What is referred out and to whom?
- Are there sites that you refer to routinely?
- For routine referral sites, do you have formal relationships with particular referral sites?
- How is the PCP connected to external BH providers? Prescribers?
- What's your relationship with prescribers in your network?
- How do you coordinate with the schools? Who is responsible?
- Do you work with community organizations for BH access or other support? Who is responsible?
- What are the biggest barriers and challenges that you face in getting services for children?

Themes

- Most organizations have established relationships in the community, but referrals seem to happen more organically and are dependent on the staff relationships with others; H+H practices and the Institute for Family Health can rely more on their own system and less on community relationships, and care is more integrated as a result.
- Pediatricians in the practices did not indicate they have relationships or communications with prescribers in the community.
- Relationships with schools was noticeable at the FQHC but less in other contexts.

Recommendations/Thoughts for TEAM UP Implementation

- While there is overall focus on BH in pediatric primary care, the programs that exist tend to be siloed in particular age groups: HealthySteps for early childhood; Collaborative Care for adolescents. This is partly because age-restricted funding exists for these programs. Given this, it will be important for TEAM UP to figure out how to work with these programs, despite having different focus and orientation, and perhaps leverage the funding.
- Most of the practices that we spoke with rely on services in the community and outside of their organization to serve the BH needs of their patients, particularly when the needs are severe or complex. There are two issues here: first, these services are limited, and second, the patient's progress is essentially lost to follow up except for the caregivers' liaison efforts. To the extent that the TEAM UP model can address these gaps with the introduction of the integrated care team (BH clinicians and CHWs), and provider training to keep more in house, it will make a significant difference for those practices.
- Clearly there are staffing shortage for BH clinicians reinforced by wage scales at FQHCs and community practices. This may be a barrier for TEAM UP but to the extent that a CHW can allow the BH clinicians to focus more on clinical work and less on coordinating services, it will alleviate some of this problem.
- Practices spoke, sometimes cynically, about the BH staffing and programs that "they used to have" under a grant or DSRIP. Both HealthySteps and Collaborative Care are less transient because they have funding mechanisms that support sustainability. It will be important for TEAM UP to let participating pilot practices know that sustainability is a priority.
- Practices universally did not have formal training programs for integrated BH. This could be a key value that TEAM UP could provide, perhaps more broadly than in full TEAM UP pilot sites.
- The interface with schools is an area that is ripe for quality improvement. Creating tools or training in this area could be of high value to primary care and the children they serve.

Acknowledgements

Our sincere thank you to all the participating practices for their time and insights.

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