TEAM UP | SCALING & SUSTAINABILITY CENTER™

Exploring Opportunities to Expand Behavioral Health Services in New York City

NYC TEAM UP Roadmap

BOSTON MEDICAL CENTER

August 2024 – August 2025

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Overview

With funding support from The Carmel Hill Fund, the TEAM UP Scaling and Sustainability Center completed a yearlong needs assessment to create the "NYC TEAM UP Roadmap". The Roadmap outlines system- and practice-level themes regarding the pediatric behavioral health (BH) landscape in New York City (NYC) and identified opportunities for positive impact. In March of 2023, the Mayor of NYC and the Commissioner of Department of Health and Mental Hygiene issued a Mental Health Plan for the City of New York with one of the priorities being the mental health of children, youth and families. In response to this crisis, the TEAM UP Center set out to assess the current investments in BH, gaps in care and potential opportunities for future investments, including how the TEAM UP Model™ could be responsive to the needs of children and youth in NYC. In this report, we will highlight some of the main takeaways from our assessment.

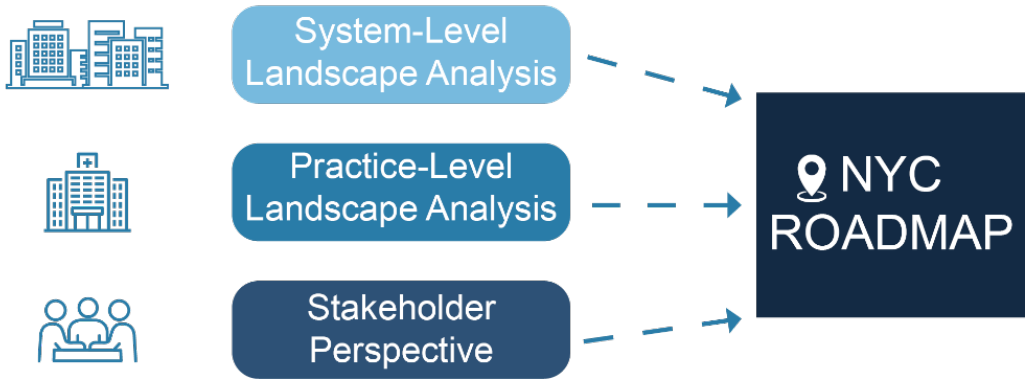

Figure 1: Outline of the NYC Roadmap Approach

To assess the BH landscape in NYC, we took a three-pronged approach, depicted in Figure 1 above. The System-Level Landscape Analysis provided an overview of the administrative structure, policy landscape, and the clinical systems that play a role in providing BH services for children. The Practice-Level Needs Assessment examined the delivery of BH services at the clinic level and experiences of families as they navigated the BH system. Findings are presented as case studies of a diverse group of practices across the city. Stakeholder Perspectives, which were obtained through interviews with key informants from government agencies and health care delivery entities provided views from a diverse set of agencies and organizations that contribute to the pediatric BH landscape. They helped to identify gaps in services and opportunities for further work. All three workstreams occurred simultaneously and informed each other. A summary of each workstream is provided in this Roadmap with a link to each detailed report.

System-Level Landscape Analysis

The System-Level Landscape Analysis, which was conducted by Manatt Health, provided the TEAM UP Center with an overview of the key features of New York's healthcare landscape. The main themes of the System-Level Landscape Analysis are described in Figure 2 below.

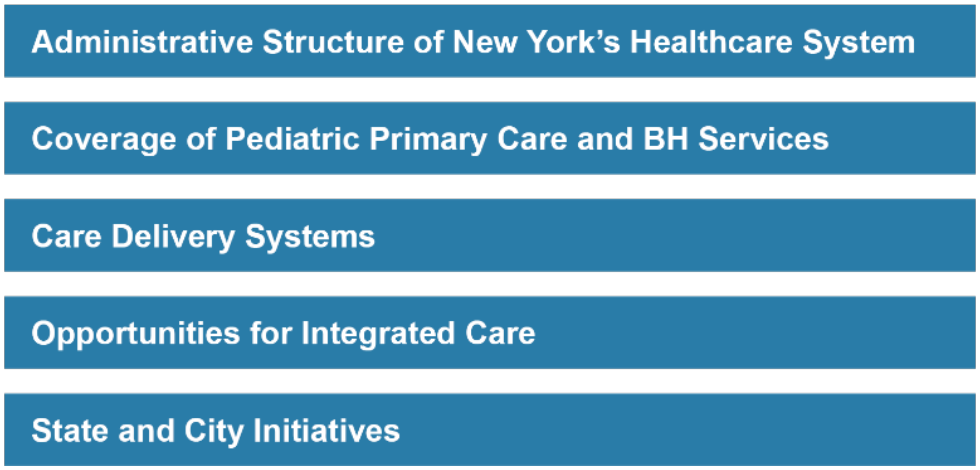

Figure 2: Main Themes of the System-Level Landscape Analysis

At the State level, four agencies have responsibility for overseeing the administration of healthcare services. These agencies are the New York State (NYS) Department of Health (DOH), NYS Office of Mental Health (OMH), NYS Office of Addiction Services and Supports (OASAS) and the NYS Department of Financial Services (DFS). The state – as opposed to city - agencies serve as the primary policymakers for healthcare coverage and services and therefore are the drivers of transformation efforts. At the city level, the NYC Department of Health and Mental Hygiene (DOHMH) houses two bureaus, the Bureau of Mental Hygiene and the Bureau of Children, Youth and Families, which provide pediatric BH related services. City agencies provide data-driven public health information and sponsor several BH programs in collaboration with local organizations.

Healthcare coverage is extensive in NYC. According to the 2023 Children's Health Care Report Card published by Georgetown University Center for Children and Families, only 2.8% of NYS's children were uninsured. The primary sources of coverage for children are Medicaid and Child Health Plus (CHP). CHP is a public payer that provides free or low-cost health insurance to children who do not qualify for Medicaid regardless of immigration status.

Most children covered by Medicaid are enrolled in one of nine Medicaid Managed Care (MMC) Plans. Two of the main MMC plans are MetroPlus, which is publicly owned by NYC Health+Hospitals, and Healthfirst, which is a provider-sponsored non-profit plan.

These programs cover a robust set of behavioral health services. However, it remains unclear how the 2025 One Big Beautiful Bill Act (OBBBA) will affect healthcare delivery and impact access to care.

Primary care in NYC is delivered through four main systems: hospital-based clinics; Federally Qualified Health Centers (FQHCs); School-Based Health Centers (SBHCs); and private practices, which are sometimes affiliated with larger independent practice associations (IPA). A major provider of care is the NYC Health and Hospitals (H+H) system which serves over 1 million patients annually. H+H has the capacity to provide intensive behavioral health care through their Comprehensive Psychiatric Emergency Program (CPEP) and outpatient clinics, as well as their numerous primary care sites across all 5 boroughs of NYC. Large FQHCs, which are multisite and serve thousands of patients annually, include the Institute for Family Health, Sunset Park Health Council and Urban Health Plan among others. Several FQHCs implemented HealthySteps and the Collaborative Care Model (CoCM) to provide BH services to their pediatric patients. A large IPA with a significant reach across smaller independent practices is SOMOS Community Care which focuses on providing culturally responsive healthcare for over a million patients. Of note, both small and large private practices provide a sizeable portion of primary care to children in NYC. The number of sites across the city allows families to access care in close proximity to their neighborhood. BH services in private practices are variable and often totally absent.

Although the coverage of behavioral health services by Medicaid and CHP is robust, children experience difficulties accessing behavioral health services due to a variety of factors, including workforce shortages. The limited number of providers who speak languages other than English or will accept public insurance affects access. The state initiative through the New York Equity Reform (NYHER) 1115 Waiver Amendment has established a Career Pathways Program (CPT) to train new healthcare workers, including behavioral health providers and community health workers (CHWs), with the goal of addressing this shortage. Further details about the CPT program are found in the Stakeholder Perspectives report. Other programs – e.g. HealthySteps and Project TEACH both funded by OMH - are the result of investments from state agencies to advance integrated behavioral health services in primary care. Further details of HealthySteps and Project TEACH are outlined later in the Practice-Level Needs Assessment report and the Stakeholder Perspectives report.

Detailed system-level considerations are outlined in the full report.

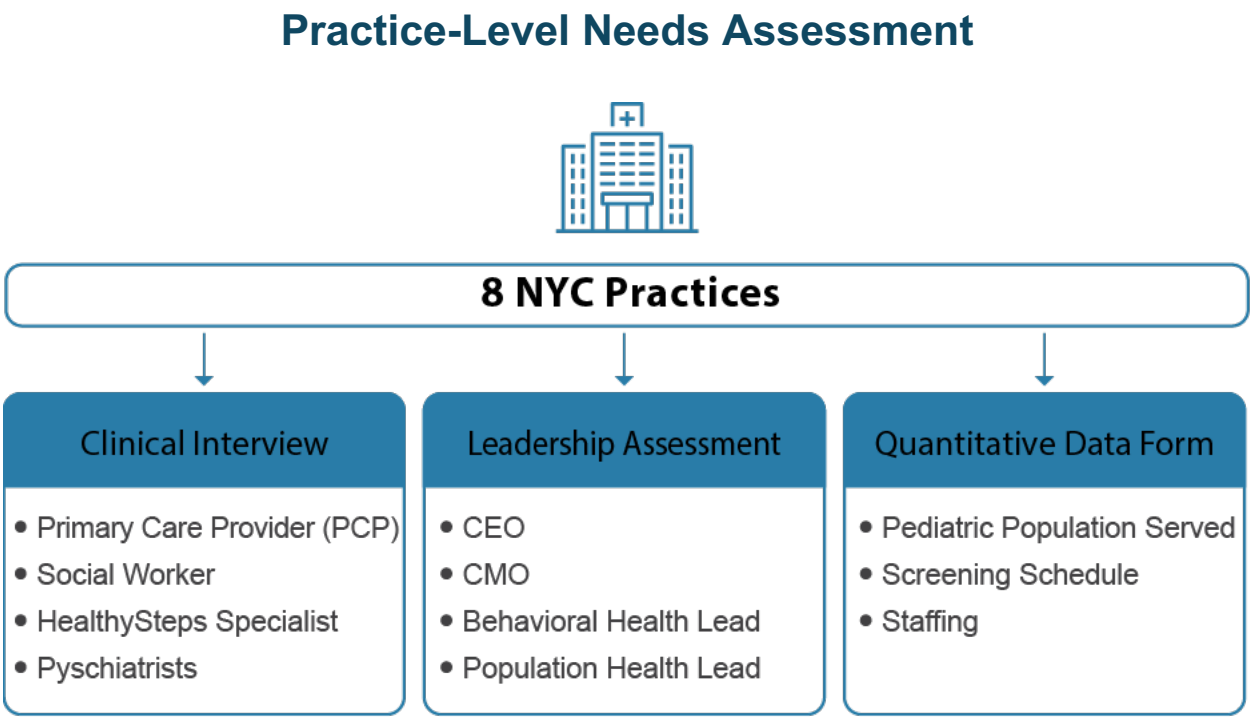

Figure 3: Outline of the Practice-Level Needs Assessment Approach

The Practice-Level Needs Assessment was led by two independent consultants, Susan Kaufman and Dr. Julita Mir, who have combined expertise in primary care transformation, value-based payment methodologies, and integrated BH initiatives. As depicted in Figure 3 above, the Practice-Level Needs Assessment had three components: 1) a discussion with clinical teams to understand the delivery of patient care and provision of BH services: 2) a meeting with the practice leadership to understand their strategy for and commitment to meeting the behavioral health needs of their pediatric population: 3) data collected through completion of a standardized form to describe the pediatric population served (number, racial/ethnic mix), the use of BH/developmental screening tools, and practice staffing. Using this data, a profile was created for each practice, which summarized BH services offered, the importance of BH services in the long-term strategic priorities of the practice, and the existing gaps in care. Participating practices included three H+H practices, three independent FQHCs, and two private practices. The clinical interview employed TEAM UP's behavioral health pathway described in Figure 4 to guide the conversation with providers and identify the strengths and gaps of their current work.

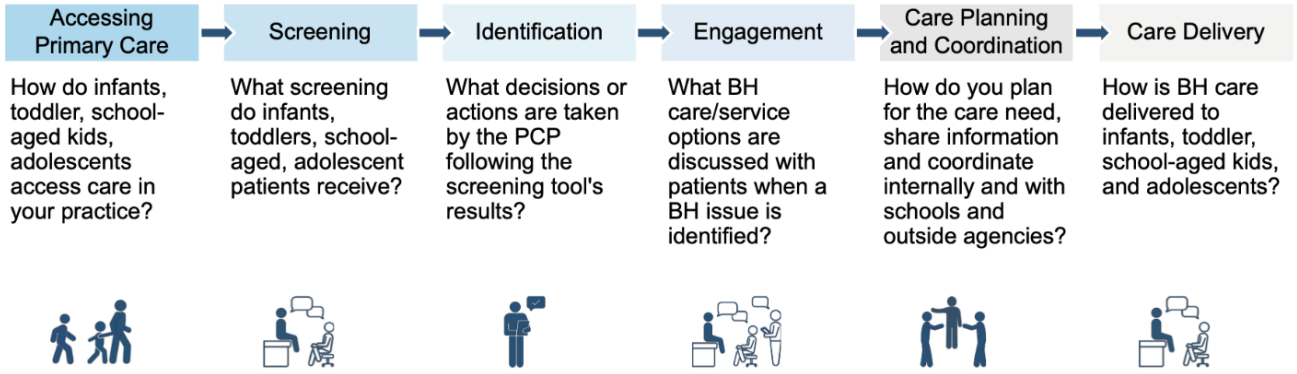

Figure 4: Adapted TEAM UP Integrated BH Clinical Pathway

Some BH services in pediatric primary care are delivered through formal age-specific programs – e.g., HealthySteps (early childhood) and the Collaborative Care Model ((CoCM), adolescents who meet diagnostic criteria for specific diagnoses like depression, anxiety, or ADHD). Although these programs support the practices to develop the capacity to address the needs of these populations in a sustainable manner (funding from OMH for Healthy Steps; insurance reimbursement for CoCM), services are siloed and often disrupted once the child does fit eligibility criteria (i.e. aged out or no longer meeting diagnostic criteria). For children who are not served by these programs, practices rely on referrals to community-based organizations (CBOs) particularly for the school age population and for children who require intensive services. Navigating the referral process, long waitlists, and a lack of linguistically competent providers are common barriers which limit or delay access to services.

The clinical interviews elucidated common practice challenges and needs. Practices note a lack of formal BH training programs for their staff. Many primary care providers describe using the services offered by Project TEACH to access training on first line psychotropic medication prescribing and psychiatric consultation regarding BH referrals. Although Project TEACH is considered a very valuable resource, providers note a desire to expand their capacity to provide direct BH care within their practice and to improve support to parents navigating referrals to external programs. Improved coordination with schools is also an identified need – to facilitate communication, obtain necessary documentation, and access services for patients with developmental concerns. These areas of need are modestly met by social workers on the care team who devote a portion of their time providing care coordination support to help patients access care. Although this support is crucial, social workers note feeling strained by the volume of need and the demand for direct therapeutic services.

The leadership assessments reveal that all eight practices share a common strategic goal to expand behavioral health services delivered in primary care. They identify a lack

of resources or systems alignment – specifically, insufficient reimbursement for behavioral health services and difficulty finding BH providers - as barriers to achieve this goal.

The quantitative data form reveals that many primary care practices are very large and serve children of diverse backgrounds. Some of the participating practices serve over 20,000 children annually across several sites. From this data form we also found common pediatric screeners include the SWYC, Peds and M-CHAT in early childhood and the PHQ-2, PHQ-9, GAD-7 and CRAFT for adolescents. While there is more consistent screening in early childhood and adolescence, school age children rarely have formal screenings offered at annual well-child visits although two practices did use the PSC-17 in this population.

As the final question, practices were asked to share if they had a magic wand, what they would want to see more of in their practice. Without hesitation, nearly all practices asked for more BH support on site and more staff to facilitate connection to external services. One initiative that could potentially facilitate closed-loop referrals is the Social Care Network (SCN) and UniteUs platform, both of which are supported by the NYHER 1115 waiver. The ability to track referrals and their outcomes would be a useful tool for primary care practices although the current intent of the SCN is to respond to health-related social needs (HRSN) only.

Additional practice level findings are detailed in the full report linked here.

Stakeholder Perspectives

Throughout the yearlong assessment process, TEAM UP Center staff made connections to agencies and organizations that could contribute to our understanding of the NYC BH landscape. Stakeholder interviews were open-ended and focused on current investments in BH care, potential areas for additional work, and TEAM UP's potential fit with identified needs. We conducted 14 interviews that spanned a range of organizations (Figure 5). A detailed list of participants can be found in the Stakeholder Perspective report.

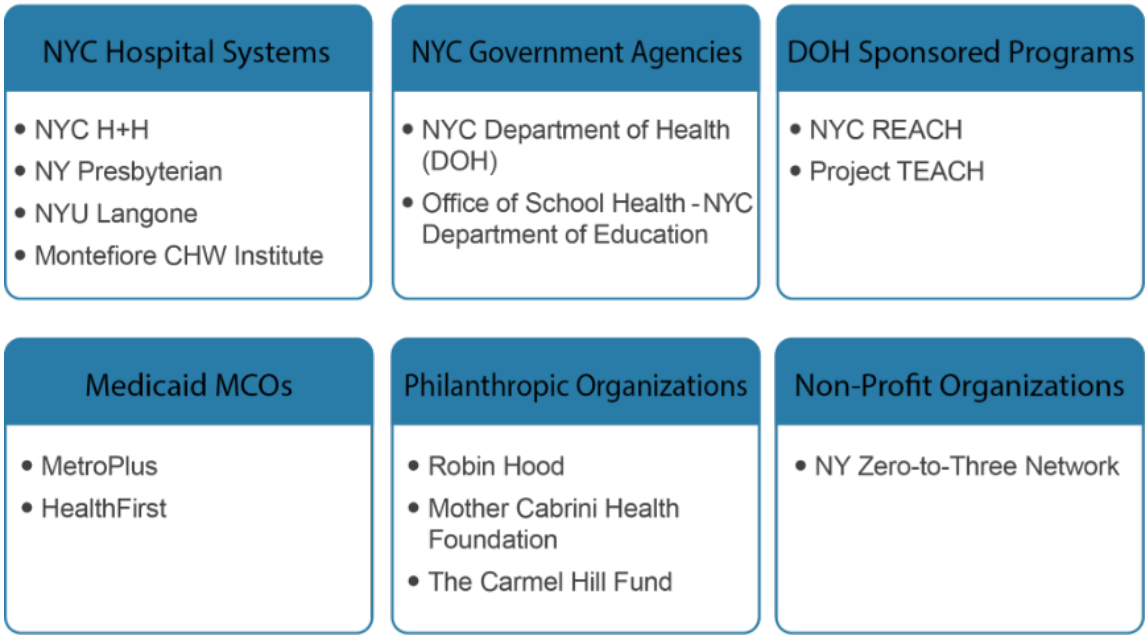

Figure 5: Outline of Participating Stakeholders

The interviews helped elucidate the entire BH service delivery system throughout the city. They confirmed the widespread adoption and implementation of HealthySteps and CoCM and their role in providing access to BH services in primary care. Beyond these established primary care-based programs, SBHCs are seen as important BH access points for school age children and adolescents. Although the capacity of SBHCs is varied, there are plans underway to expand BH services offered in schools. The NYC Early Childhood Mental Health Clinics, a network of 5 sites, provide BH services for children under five and their families. Most importantly, an array of CBOs serves as a major provider of BH services across the city. Despite their large number, their capacity to meet the needs of the diverse NYC population is insufficient to meet demand.

Regarding workforce training, Project TEACH is identified as an important resource for primary care providers. The Training and Technical Assistance Center (TTAC), which is part of the Early Childhood Mental Health Network, is another resource that provides

clinicians and early childhood educators with the skills they need to support healthy social emotional development of young children. This program, along with HealthySteps, underscores the substantial investments in early childhood.

As mentioned previously, the Career Pathways Program was approved in January 2024 in response to the need to expand the BH workforce. The CPT program provides financial assistance for tuition and training for several professional roles, including licensed mental health counselors, masters-prepared social workers and CHWs, all of whom are important members of an integrated BH care team. This program has been implemented only recently; as a result, its full impact has yet to be determined. It is hoped that this investment will become an important pathway to augment the BH workforce.

Specific to the CHW role, stakeholders explained that while CHW services are currently reimbursed by Medicaid for members who are under 21 years old, the revenues from the limited reimbursement rates do not adequately cover CHW salaries. The challenge of covering CHW salaries makes it difficult to sustain positions. The Montefiore CHW Institute is a tremendous resource that currently provides training for CHWs to meet the requirements for Medicaid billing and to address HRSNs. The Institute is interested in expanding their reach outside of the Bronx and augmenting their curriculum to prepare CHWs to work in pediatric primary care integrated settings.

Overall, across clinical programs, BH care access points, and investments to support the BH workforce, stakeholder interviews deepened our understanding of the current BH landscape and the opportunities for growth. These interviews also helped build relationships between the TEAM UP Center staff and NYC-based leaders, laying the groundwork for further partnership and collaboration.

Further details are outlined in the Stakeholder Perspective report.

Strategic Implications for the TEAM UP Center

The NYC TEAM UP Roadmap findings support the potential of the TEAM UP model to augment current investments to expand the BH services provided in primary care and address the unmet gap experienced by children, youth, and families. The TEAM UP model is a comprehensive, full spectrum model that provides integrated behavioral health services to all children in pediatric primary care. Some of the model's core components are (Figure 6):

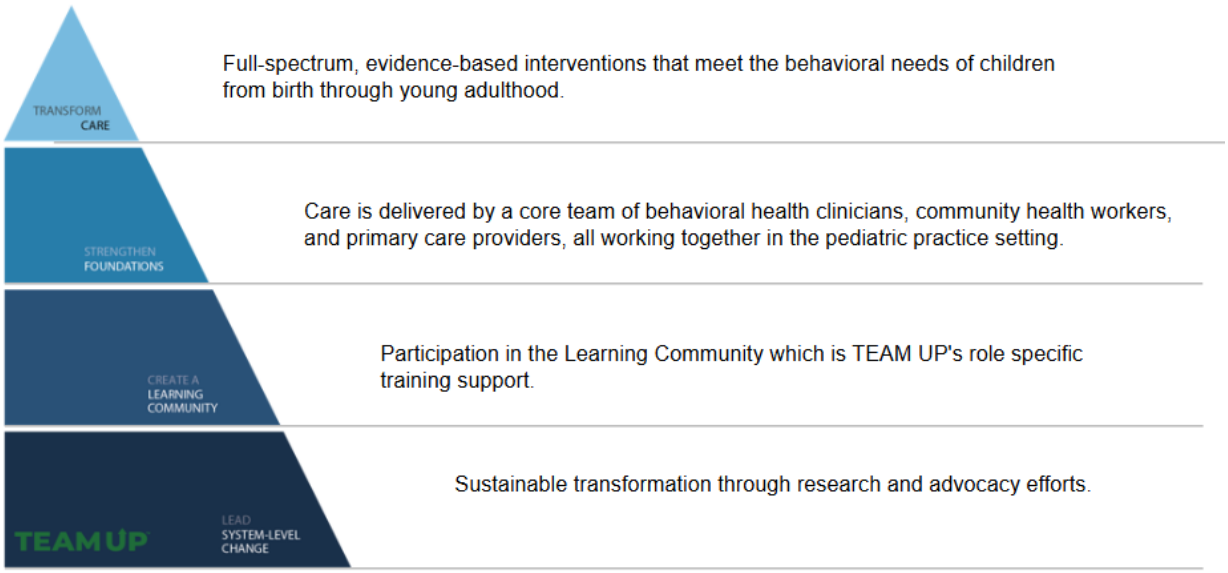

Figure 6: Core Components of the TEAM UP Model

Each of the model components could potentially meet several of the identified needs in the BH landscape. First, The model's focus on children from birth through young adulthood allows for a consistent singular model that serves all the patients in a pediatric primary care practice. Currently, models like HealthySteps and Collaborative Care serve a subset of children. Building on their strengths, they can work collaboratively with the TEAM UP model to meet the needs of all patients.

Furthermore, the creation of integrated care teams can bring together primary care providers, BH clinicians and CHWs to offer families prompt access to BH services without long waitlists and complicated referral processes. The presence of BH clinicians in primary care, an important component of the model, can provide timely therapeutic support to patients who have an emerging or diagnosed BH need. In addition, the integrated CHW can provide culturally and linguistically competent psychoeducation, advocacy and navigation support to external services for patients that are better served by an external agency.

Also, the model emphasizes clinical training through a Learning Community that supports all members of the integrated care team to work at the top of their skill level, allowing practices to address emerging BH needs promptly and efficiently. The Learning Community could integrate current training programs like Project TEACH and the Montefiore CHW Institute to support the needs of primary care practices. Also, workforce development efforts like the CPT program can potentially augment the number of available BH providers and CHWs.

Finally, as part of model implementation, the TEAM UP Center conducts evaluation activities to understand the model's impact on access and reach. These findings support research to advance the knowledge of integrated behavioral healthcare and inform advocacy for policy change.

Overall, the TEAM UP model provides an excellent opportunity for timely BH access to all children regardless of their age or BH need with the flexibility to unify the current investments present in the NYC landscape.

Recommendations for Advancing the BH Landscape

NYC has strong investments in place to support pediatric behavioral health across the city. Informed by the findings outlined in this Roadmap, we recommend a pilot project to implement the full TEAM UP model to advance the capacity of integrated behavioral health service delivery. We believe that implementation of the model could have a positive impact through the following approaches (Figure 7):

Figure 7. The TEAM UP Center's Recommendations to Advance the BH Landscape

Adress unmet gaps in access to care:

- Implementation of universal screening in primary care as part of the TEAM UP model can allow for early identification of BH needs. This change would be especially impactful for the school age population who are not consistently screened for BH concerns.

Sync up with clinical innovation already underway

- The TEAM UP model can interweave the current investments in early childhood (HealthySteps) and adolescence (Collaborative Care Model) into one full spectrum approach.

Bring together partners to build the BH workforce

- Advocate for the Careers Pathways Training Program to partner with primary care practices and organizations that serve pediatric populations to infuse newly trained behavioral health clinicians and community health workers into their staff.

Also, promote the CPT program to students from diverse backgrounds to meet the linguistic and multicultural needs of the NYC population.

- Collaborate with the Montefiore CHW Institute to supplement the Learning Community's role specific training and provide NYC context specific knowledge to integrated CHWs.
- Facilitate coordination between Project TEACH and pediatric practices to strengthen assessment, diagnosis, and treatment skills within the primary care provider workforce.

Leverage state investments in billing and revenue

- The model can leverage the current CHW Medicaid benefit to support sustainability of CHW roles in primary care. We would advocate for further expansion of the CHW benefit to include reimbursement for non-patient facing services like communicating with schools and CBOs to coordinate services.

Demonstrate impact

- Implementing the TEAM UP model in tandem with data collection efforts allows us to evaluate the positive impact the model can have to build consensus across stakeholders. These findings can support advocacy for policy and reimbursement structures that ensure sustainability of the model long-term.

Appendix 1. Glossary of Acronyms

Acronym	Definition
CHP	Child Health Plus
CHW	Community Health Worker
CoCM	Collaborative Care Model
CPEP	Comprehensive Psychiatric Emergency Program
CPT	Career Pathways Training Program
CRAFFT	Car, Relax, Alone, Forget, Friends Trouble for Substance Use Disorder
DFS	Department of Financial Services
DOH	Department of Health
DOHMH	Department of Health and Mental Hygiene
FQHCs	Federally Qualified Health Centers
GAD-7	Generalized Anxiety Disorder (7-item)
H+H	NYC Health+Hospitals
HRSN	Health related social needs
IPA	Independent Practice Association
M-CHAT	Modified Checklist for Autism in Toddlers
MMC	Medicaid Managed Care
NYHER	New York Health Equity Reform
OASAS	Office of Addiction Services and Supports
OBBBA	One Big Beautiful Bill Act
OMH	Office of Mental Health
PEDS	Parents' Evaluation of Developmental Status
PHQ-2	Patient Health Questionnaire (2-item)
PHQ-9	Patient Health Questionnaire (9-item)
PSC-17	Pediatric Symptoms Checklist (17-item)
SBHCs	School-Based Health Centers
SCN	Social Care Network
SWYC	Survey of Well-being of Young Children
TTAC	Training and Technical Assistance Center

Appendix 2. System-Level Landscape Analysis

manatt

To:	TEAM UP Scaling and Sustainability Center
From:	Manatt Health
Date:	July 15, 2025
Subject:	New York City Systems-Level Landscape Analysis: Strategic Implications for TEAM UP

Introduction

This memo outlines strategic considerations for advancing and sustaining the TEAM UP model in New York City, including market-entry decisions, partnership development, and policy engagement strategies. Drawing on Manatt's existing knowledge and expertise in New York, as well as new research conducted for TEAM UP, it describes key features of New York's healthcare landscape, including the structure for administering the State's healthcare programs, coverage and delivery of primary care and behavioral health care for children, and relevant policy initiatives and financing strategies. We conclude the memo with discussions of the implications and recommendations for TEAM UP as it weighs an expansion into New York City.

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Administrative Structure of New York's Healthcare System

New York's healthcare system is governed by a complex and fragmented administrative structure. Four State agencies — the Department of Health (DOH), the Office of Mental Health (OMH), the Office of Addiction Services and Supports (OASAS), and the Department of Financial Services (DFS) — share responsibility for overseeing components of health care delivery across the State. While each agency operates with distinct agendas, staff resources and expertise, and stakeholder communities, they are tasked with co-regulating key healthcare programs. This can result in misaligned priorities, inefficient processes, and even competition for limited State resources. The agencies are funded through the State budget process, with the State fiscal year running from April 1 to March 31.

At the city level, the New York City Department of Health and Mental Hygiene (DOHMH) serves as the primary health authority, with both primary care and behavioral health-focused programs. DOHMH is one of the largest public health agencies in the world, responsible for implementing public health programs tailored to New York City's unique demographics and challenges. DOHMM is funded through the City budget process; the city's fiscal year for the city runs from June 1 to May 31.

Broadly speaking, the State agencies are responsible for developing and managing statewide programs and initiatives, regulating payers and providers, licensing and certifying healthcare professionals, overseeing statewide health data collection and surveillance, and providing oversight and support to local health departments; New York City DOHM runs citywide public health programs and campaigns, can adopt more stringent health regulations than the State's, provides free or low-cost clinical services for city residents (e.g., STI testing, immunizations), and manages local health inspections.

Despite overlapping areas of focus between State and city agencies, there is often limited alignment in policy execution, data sharing, and programmatic integration. This siloed approach has led to redundant reporting requirements and administrative burdens for providers who must work with both the State and the city. For TEAM UP to enter the New York City market, it will need to navigate both city and State-level regulations, initiatives and policy goals.

Coverage of Children's Primary Care and Behavioral Health Care

New York City currently boasts near-universal health coverage for children, with only 2.6% of children remaining uninsured. The primary sources of coverage are Medicaid and Child Health Plus ("CHP," the State's Children's Health Insurance Program), which together serve approximately 56% of the city's pediatric population.

- Medicaid Managed Care (MMC): Most Medicaid-eligible children are enrolled in one of nine MMC plans operating in New York City. These plans cover children up to age 20, with eligibility extending to families earning up to 154% of the federal poverty level (FPL). There are no premiums or copayments for this population.
- Child Health Plus (CHP): CHP covers children up to age 19 in families earning between 154% and 600% of the FPL. Premiums are income-based and, currently, children can enroll regardless of immigration status.

Three plans—Healthfirst, Fidelis Care, and MetroPlus—account for approximately 75% of Medicaid and CHP enrollment in New York City. Two of these three plans are provider-sponsored non-profit plans: MetroPlus is owned by New York City Health + Hospitals (NYC H+H) and Healthfirst is owned by 18 downstate hospitals, including several H+H hospitals.

Both Medicaid and CHP cover a robust suite of behavioral health services, such as Children's Home and Community-Based Services (HCBS), Children and Family Treatment and Support Services (CFTSS), Health Home Care Coordination, High-Fidelity Wraparound, and Youth Assertive Community Treatment (ACT).

The high rate of coverage and relatively broad scope of covered benefits in New York State, including in New York City, likely will be disrupted by policies advanced in the 2025 One Big Beautiful Bill Act (OBBBA), including its new restrictions on eligibility for immigrants and work requirements for certain adults. OBBBA slashes federal funding for public coverage programs and makes it more difficult for individuals to access coverage, including substantial changes in how Medicaid and New York's Essential Plan (EP) are funded and operated, which will place enormous strain on New York's healthcare system. New York has estimated that OBBBA will cost the State $13.5 billion annually as a result of lost federal funding and new State costs. Given the magnitude of the cuts to federal funding, New York has noted that it will be impossible for the State to absorb the impacts and that significant changes to eligibility, financing and benefits will be required.

Delivery System Serving Children

Settings and Practices Delivering Primary Care and Behavioral Health Care

Hospital-based practices provide a significant portion of pediatric primary care to Medicaid and CHP-enrolled kids in New York City. FQHCs, school-based health centers, and private practices also play a key role.

- **Hospital-Based Clinics:** The primary providers of pediatric care for Medicaid and CHP enrollees, these clinics are often located within or affiliated with major hospital systems.
- **Federally Qualified Health Centers (FQHCs):** While there are many in the city (496 total), not all FQHCs offer robust pediatric services.
- **School-Based Health Centers (SBHCs):** Totaling 146 across the city, SBHCs typically operate in partnership with hospitals. The carve-in of SBHC services into MMC continues to be delayed at the State level (currently slated to occur no sooner than April 1, 2026); these services continue to be reimbursed through the Medicaid fee-for-service system.
- **Private Practices:** These serve a smaller share of the Medicaid and CHP pediatric population and are more prevalent in areas with limited hospital or FQHC capacity.

Key Players in New York City Delivery System Serving Children

Hospital-Based Clinics		FQHCs	
Providers	**Location**	**Providers**	**Location**
NYC H + H	All boroughs	**SOMOS Community Care**	Bronx
BronxCare	Bronx	**Institute for Family Health**	Bronx, Manhattan, Brooklyn
Maimonides	Brooklyn	**Sunset Park Health Council**	Manhattan, Brooklyn
Montefiore	Bronx	**Bronx Community Health Network**	Bronx, Queens
Mount Sinai	Manhattan		
Northwell	Brooklyn, Manhattan, Queens	**Urban Health Plan**	Bronx, Queens
NYU Langone	Manhattan, Brooklyn		

Spotlight: New York City Health + Hospital

NYC H+H, the city's municipal hospital system, plays a core role in the delivery of care to children across New York City and we recommend TEAM UP consider it as a central component of its approach to piloting and deploying its model in New York City. See below for more on NYC H+H.

NYC Health + Hospital is the largest municipal health care delivery system in the U.S., serving more than 1 million patients annually across all 5 boroughs of the City.

Acute Care Hospitals

10 locations across the Bronx, Brooklyn, Manhattan and Queens

All locations have pediatric emergency departments and 6 have psychiatric emergency departments

Gotham Health Centers

6 large centers and many smaller practices, located in high-need areas

Primary care services offered at each location based on assessed neighborhood need

Primary Care

For adult and pediatric patients, offered at hospital and community-based locations across all boroughs

Behavioral Health Care

Providing inpatient and outpatient services, e.g., Comprehensive Psychiatric Emergency Program (CPEP), Outpatient Clinics, Intensive Outpatient Programs, Services for Youth, ACT, and Partial Hospitalization

Known Access and Quality Issues

Despite New York's robust coverage of behavioral health care through Medicaid and CHP, access to care remains a significant challenge. Like many parts of the country, the capacity of New York

City's child and adolescent behavioral health delivery system is limited. Over half (56%) of New York City children report difficulty accessing mental health care when they need it. Leading causes of these access challenges include:

- **Workforce shortages**, particularly among providers of color, non-English-speaking clinicians, and those trained in evidence-based practices;
- **Providers not accepting public coverage**, such as Medicaid and CHP, or other forms of insurance; and
- **Misaligned service availability with areas of greatest need**, particularly in low-income neighborhoods, exacerbating disparities in patient experience and outcomes.

Integration of Physical and Behavioral Health

In part driven by the reasons highlighted above, New York City's behavioral health care delivery system includes significant siloes: it is common for families to need to visit entirely separate providers to address their children's physical and mental health needs. Coordination between parts of the healthcare system (as well as related social service providers) can be limited, leading to a fragmented care experience.

In 2014, New York State began implementation of its Delivery System Redesign Incentive Payment (DSRIP) Program, an initiative established under a now-expired Medicaid 1115 waiver that drove billions of dollars to largely hospital-based "Performing Provider Systems" (PPS) to implement specific projects in support of the overarching goal of reducing hospital readmissions. One such project was primary care/behavioral health "co-location." All 25 PPS opted into the co-location project, which focused on the adult population and involved spatially-adjacent clinical care delivery, warm handoffs, and care teams to advance physical and behavioral health integration. However, the lack of sustainable funding following the DSRIP demonstration period has resulted in very few entities being able to maintain these efforts, much less expand them to younger patient populations.

Beyond the DSRIP co-location project, New York State has not endorsed a specific integrated behavioral health model. HealthySteps has made inroads with New York State policymakers, though, successfully advocating for increased funding and reimbursement for integrated care for young children. For example, the State's Fiscal Year 2024 budget included a $12 million in additional funding for the HealthySteps program, with the aim of adding up to 50 HealthySteps clinics Statewide. Similar State-level investments have not been made in integrated care for school-aged and older children who are not served by the HealthySteps model.

New York State has implemented regulatory reforms that seek to increase coverage of integrated care, though. For example, the State instituted Medicaid billing for preventive behavioral health services (effective April 2023), reimbursement for additional provider types (e.g., community health workers) effective January 2024, and increased provider licensure thresholds to facilitate integrated care delivery (effective October 2024). Both the financing strategy section of this memo and the Working Session 1 deck include additional information on these initiatives and how they may relate to TEAM UP's model.

Technical Assistance Resources for Providers Offering Integrated Care

Despite the lack of sustained investment in integrated care, there are some resources available in New York City and across the State to support practices and providers taking steps toward

more integrated primary and behavioral health care. Some of the most relevant potential resources include:

- **Project TEACH NY:** An OMH-funded program that provides child health providers with consultations and referrals to tele-psychiatry services and offers resources such as guidelines for incorporating screening and treatment of behavioral health into pediatric primary care settings.
- **Training and Technical Assistance Center (TTAC):** Through a partnership between New York University's McSilver Institute and the New York Center for Child Development, TTAC offers in-person and web-based trainings and a range of resource materials for professionals who work with children age zero through five. The resources are designed for mental health professionals serving children and their families in the New York City DOHMH-funded Early Childhood Therapeutic Centers, as well as professionals working in New York City outpatient mental health clinics; Early Intervention, Universal Pre-K and Early Learning sites; and other child-serving systems.
- **Technical Assistance Center for Children's Behavioral Health Providers:** OMH is actively seeking a contractor to develop a dedicated training and technical assistance center focused on assisting New York's behavioral health providers with enhancing care quality for children. The award for this RFP was expected in July 2024, but it has not yet been issued and no recent updates have been provided.

Relevant City and State Policy Priorities and Initiatives

Following the COVID-19 pandemic, increasing access to behavioral health care and improving behavioral health outcomes were key priorities at both the city and State levels. However, sustained funding and attention to these priorities is challenged by competing priorities, such as the State's new 1115 waiver program (called "NYHER" and discussed below) that largely focuses on health-related social needs, and longstanding issues with safety net hospital financing and managed long term care enrollment and costs. All of this is exacerbated by the drastic cuts to federal funding for New York's healthcare programs, as noted above. This loss of funding, paired with other changes in the federal OBBBA legislation, will result not only in significant coverage losses but also State and local policymakers needing to focus their more limited resources on minimizing those coverage losses and implementing new program requirements (e.g., increased redeterminations, work requirements in Medicaid, potential changes to the Essential Plan). Still, the State has made several recent investments in behavioral health worth noting:

State-Level Initiatives

- **$1 Billion Mental Health Investment:** Initially allocated in the Fiscal Year 2024 State budget, this initiative aims to combat past underinvestment in behavioral health and seeks to expand access, reduce wait times, and ensure appropriate levels of care. Funds are being distributed through OMH-administered RFPs.
- **New York Health Equity Reform (NYHER) 1115 Waiver Amendment:** The waiver amendment was originally approved in January 2024, with many of the waiver initiatives beginning implementation in early 2025. While the waiver did not include any behavioral health integration-specific initiatives, it includes $694 million for workforce

investment and retention for primary care and behavioral health providers, administered through two programs:

  - Career Pathways Program (CPT) a new program designed to build the healthcare workforce—including Licensed Mental Health Counselors, Masters of Social Work, Community Health Workers, and Patient Care Managers—by funding training and education for both career advancement and new careers.
  - Loan repayment for providers who meet certain metrics regarding serving Medicaid and uninsured members.

Of note, the future of New York's 1115 waiver, which is due for renewal in April 2027, is also at risk of being terminated or not renewed by the federal government. The Trump Administration has already taken steps to scale back CMS' Making Care Primary model that New York sought to leverage as a complement to its 1115 waiver, as well as steps to curtail certain waiver funding mechanisms used by New York (e.g., elimination of the use of Designated State Health Program (DSHP) to help finance the non-federal share of the cost of the 1115 Waiver). We understand that DOH is in the process of drafting the next iteration of its 1115 waiver amendment and plans to release it for public comment in late fall 2025. While the scope of innovative initiatives will likely be scaled back in the State's next waiver application, it is possible that the 1115 waiver renewal process will offer an opportunity to raise the importance of integrated primary and behavioral health care for Medicaid enrollees, including children, youth and their families.

- **Patient Centered Medical Home (PCMH):** PCMH is New York's main primary care innovation model and has been the primary vehicle for distributing supplemental payments to primary care providers over time. Under the NYHER waiver amendment, PCMH practices can receive enhanced payments for demonstrating improvement on a suite of quality measures, including some related to behavioral health integration.

City-Level Initiatives

- **Care, Community, Action: Mental Health Plan for New York City:** New York City's strategic plan prioritizes children, youth, and families, emphasizing prevention, early intervention, and coordinated care. However, implementation timelines and measurable outcomes remain unclear.

TEAM UP's model is well aligned with these policy priorities, offering a concrete way to make integrated care a reality for many of New York City's children and their families, as well as potentially assisting with the workforce challenges and other issues that have slowed progress on integrated care in the past.

Financing Strategies for Integrated Behavioral Health Efforts

To ensure the TEAM UP model is both scalable and sustainable in New York City, Manatt encourages TEAM UP to consider pursuing a dual-track financing strategy that addresses immediate implementation needs while laying the groundwork for long-term structural support.

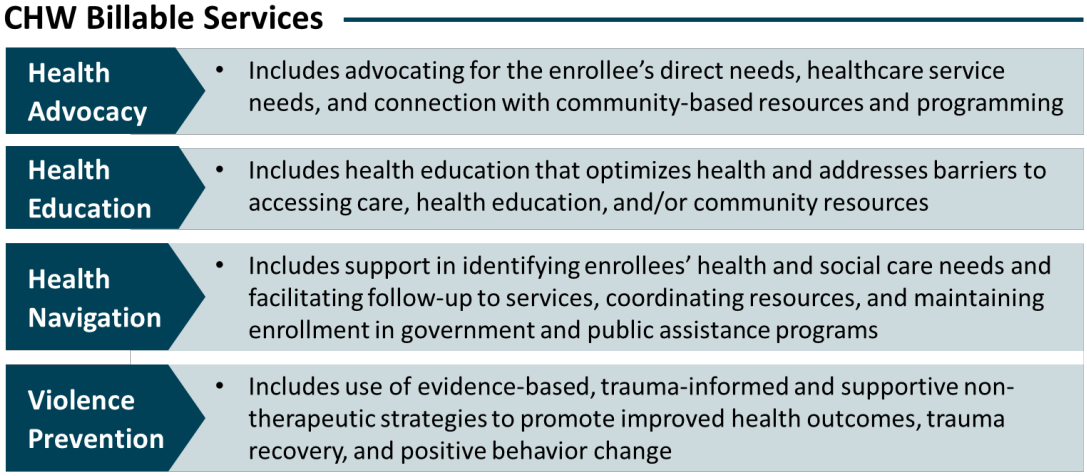
Near-Term Strategies

In the near term, TEAM UP could look to existing Medicaid reimbursement pathways and regulatory flexibilities to support core components of the model. These mechanisms offer

immediate opportunities to fund workforce capacity, service delivery infrastructure, and care coordination functions.

Community Health Worker and Behavioral Health Clinician Services

Community Health Worker (CHW) Services. Since January 2024, New York Medicaid has reimbursed CHW services for a range of non-clinical activities including health advocacy, education, navigation, and violence prevention. These services, described in more detail in the figure below, are available to children under 21 and other high-need populations. A licensed clinician must supervise the service in order for it to be billed. CHW services can be delivered under the supervision of providers within Article 28 clinics and FQHCs, though there are specific considerations for how CHW services should be billed (i.e., they are carved out of PPS rates when delivered as a standalone service, but when delivered as part of a "comprehensive encounter," where other services are also provided, the FQHC should bill the PPS rate). See the Working Session 2 slide deck for additional resources on specific billing codes and rates for CHW services. While the population eligible for CHW services and the number of participating providers have expanded since January 2024, MMC plans report limited uptake of CHW services to date.



Services Provided by Behavioral Health Clinicians. Behavioral health clinicians — including Licensed Clinical Social (LCSW) Workers, Licensed Masters Social Workers (LMSW) acting under supervision, and Licensed Mental Health Counselors (LMHC) — can be reimbursed under New York's Medicaid program for a broad array of services, such as psychotherapy, crisis intervention, and psychosocial rehabilitation services (see figure below). Reimbursement rates vary by provider type and service duration, and billing requirements differ by setting. See the Working Session 2 slide deck for additional information and resources on specific billing codes and rates.

We recommend TEAM UP prioritize partnerships with providers that are already positioned to bill for CHW and behavioral health clinician services and could enhance these partnerships by offering technical assistance aimed at optimizing billing practices and maximizing revenue capture.

New York State-Funded Collaborative Care Medicaid Program (CCMP)

The CCMP offers monthly case payments to physical health providers, serving enrollees age 12 and older, that implement the Collaborative Care Model (CoCM) for depression and anxiety treatment. Eligible practices must meet staffing and infrastructure requirements (see below).

CCMP Practice Eligibility

Reimbursement open to **physical health providers**, **serving enrollees 12 years and older** (i.e., Pediatrics, Family Medicine, Internal Medicine, Women's Health). Does not include Article 31 clinics.

To qualify, practices must have appropriate team members and resources in place, including:

- Behavioral Health Care Manager (recommended to be a licensed clinician)
- Designated Program Lead
- Data Manager
- Billing Lead
- Psychiatric Consultant and a minimum of 1 hr/week designated for consultation
- Registry to manage your Collaborative Care Caseload
- Standardized screening process using the PHQ-9
- Warm connection to the Behavioral Health Care Manager

Practices must apply to OMH and be accepted for program participation in order to bill Medicaid for CCMP reimbursement. TEAM UP could consider assessing the feasibility of adapting its model to meet CCMP eligibility criteria and support partner practices in applying for and operationalizing CCMP using the TEAM UP model.

Regulatory Authorities Supporting Integrated Care

New York has taken regulatory actions that provides new opportunities to pay for integrated care in Medicaid. As of April 2023, Medicaid reimburses for preventive mental health services — including individual, group, and family psychotherapy services — for children without a formal behavioral health diagnosis and their caregivers. Z-code Z65.9 is used to indicate medical necessity for the specified services for Medicaid enrollees under 21 who do not have a behavioral health diagnosis.

In October 2024, New York implemented regulation to allow primary care providers to deliver up to 30% of their visits as behavioral health services without having to acquire additional licensure from OMH or OASAS, reducing administrative barriers to integration.

We recommend that TEAM UP consider how to leverage these regulatory flexibilities in the implementation of its model and identify ways to support practices in using these options to promote access to and reimbursement of integrated care.

Long-Term Strategies

To ensure the TEAM UP model is financially sustainable beyond initial implementation, it is critical to pursue more durable funding mechanisms that use a combination of State-level investment, payer partnerships, and alignment with broader system transformation initiatives. As a result of the OBBBA, and the substantial cuts to Medicaid and public coverage funding, New York will be operating in a constrained fiscal environment for the coming years and policymakers will likely be focused on implementing cost-saving provisions and identifying efficiencies in the Medicaid program. Given these priorities, we recommend TEAM UP highlight the cost effectiveness of its model as it lays the foundation for long-term funding for integrated care.

State-Driven Financing

TEAM UP may wish to pursue targeted State appropriations to support model adoption and scale. This approach has precedent: HealthySteps and Project TEACH have secured long-term funding through targeted State appropriations. While promising, this strategy is subject to the uncertainties of the annual State budget process and federal funding dynamics and, importantly, requires significant investments in sustained advocacy over years — to build legislative champions and effectively "make the case" to the Executive that the model is cost-effective, scalable and needed to achieve desired outcomes.

TEAM UP could consider whether to adopt a multi-year advocacy strategy focused on securing State appropriations in the future. Advocacy efforts could also include identifying opportunities to build coalitions with interested stakeholders and aligning TEAM UP's approach with existing State initiatives. An advocacy strategy would also be bolstered by data from pilot projects that demonstrate the positive impacts of TEAM UP.

Payer-Led Initiatives

We recommend TEAM UP also explore opportunities to integrate into existing or new payer-provider arrangements, including:

- Value-Based Payment (VBP) arrangements — While no longer mandated by State policy, VBP arrangements remain active in several systems (e.g., NYC H+H) and could support integrated care delivery. Some provider partners may have relevant experience using VBP to drive integrated care, as behavioral health integration for the adult population was part of several previous DSRIP VBP projects.
- In Lieu of Services (ILS) authority — ILS allows Medicaid plans to propose cost-effective alternatives to traditional, State Plan-covered benefits. Using ILS to support integrated care would be a new use of the authority in New York (which has approved 3 ILS programs since 2019), but TEAM UP could look into how such a program could be structured for approval in the future and engage in conversations with targeted

stakeholders (plans, provider partners, DOH or OMH) to understand the level of openness to develop such a program. This, too, would take some time and effort to determine and potentially advance.

We recommend TEAM UP engage key MMC plans to identify potential opportunities to help plans advance their priorities *through* TEAM UP interventions, as plans may have other programs available that could fund TEAM UP activities.

Multi-Stakeholder Initiatives

TEAM UP may also align with the New York City Behavioral Health Centers of Excellence (COE) program, which incentivizes Medicaid plans and providers to expand behavioral health capacity and improve quality. The model is primarily focused on individuals with higher level of need but there are components of the programs focused on enhancing outpatient care and behavioral health provider capacity that align with TEAM UP's priorities. This initiative offers a potential platform for TEAM UP to demonstrate impact and secure performance-based funding.

TEAM UP could consider initiating conversations with NYC H+H, and other COE participants, to explore pathways for integrating the model into COE quality improvement activities and funding streams.

Implications for TEAM UP

We recommend that TEAM UP aim to advance its model in New York through strategic partnerships that will demonstrate the model's *value* to providers, payers and the State, aligned with the key interests of each group. When looking toward piloting and scaling the program, we recommend TEAM UP consider the following recommendations.

Strategic Partnership

TEAM UP could consider positioning its model as the platform for system integration for school-aged children. The model's alignment with Medicaid billing, regulatory reforms, and collaborative care infrastructure positions it as a scalable platform for integrated behavioral health delivery in pediatric primary care.

TEAM UP could also consider leveraging strategic partnerships to accelerate adoption and generate early data demonstrating the model's impact. We recommend TEAM UP work with NYC H+H to deploy TEAM UP for school-aged children who are not currently served by existing programs; leveraging H+H's familiarity with integrated care to facilitate initial implementation and to serve as a pilot for demonstrating the model's efficacy in New York City. TEAM UP could also consider partnering with one FQHC provider where the TEAM UP model can support the center's adoption of integrated care for children.

Diversified Funding Streams

We recommend TEAM UP aim for an approach that relies on multiple fundings streams and supports progress toward long-term, sustainable funding. In the near term, TEAM UP could consider working with identified partner practices to maximize funding for the model by leveraging — and, where possible, expanding on — existing payment arrangements or reimbursement pathways.

Over time, we recommend TEAM UP pursue an advocacy strategy aimed at securing targeted State funding through budget appropriations to support adoption of the model and

complementary billable services. Additionally, TEAM UP could consider engaging DOH, OMH and Medicaid plans on new opportunities to fund opportunities to advance integrated care, including through the Behavioral Health COE program and/or plan financing opportunities.

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Please do not hesitate to contact the Manatt Team with any questions: Jocelyn Guyer (JGuyer@manatt.com), Hailey Davis (HDavis@manatt.com), and Alex Singh (ARSingh@manatt.com)

Appendix 3. Practice-Level Needs Assessment

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.

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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:

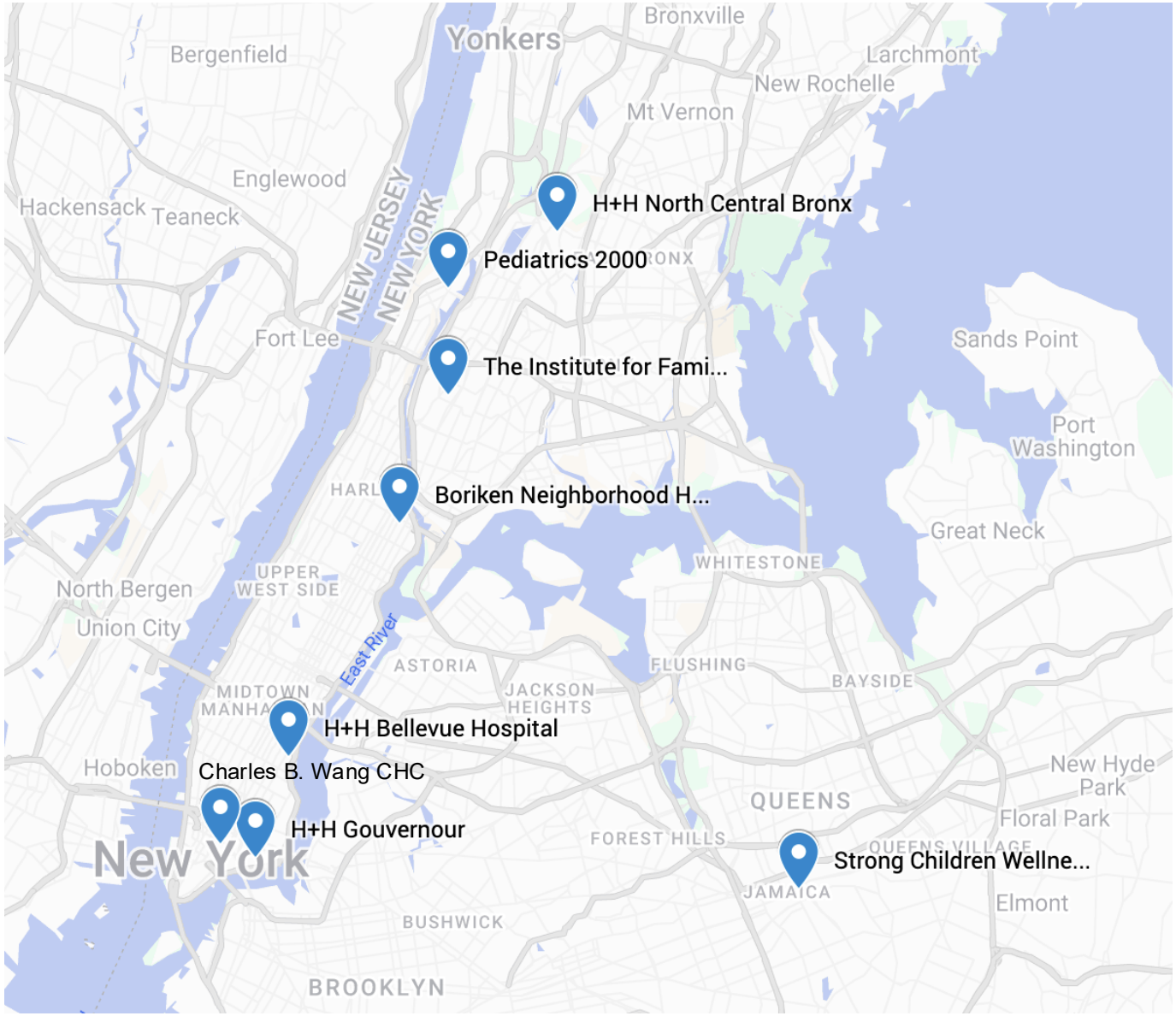
- What the practices have in common:
  - More than 2000 children in the practice's patient panel, in pediatrics or family medicine*
  - Willing to participate and motivated to further expand on integrated BH and population health capabilities
  - A majority of their pediatric panel is on Medicaid and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

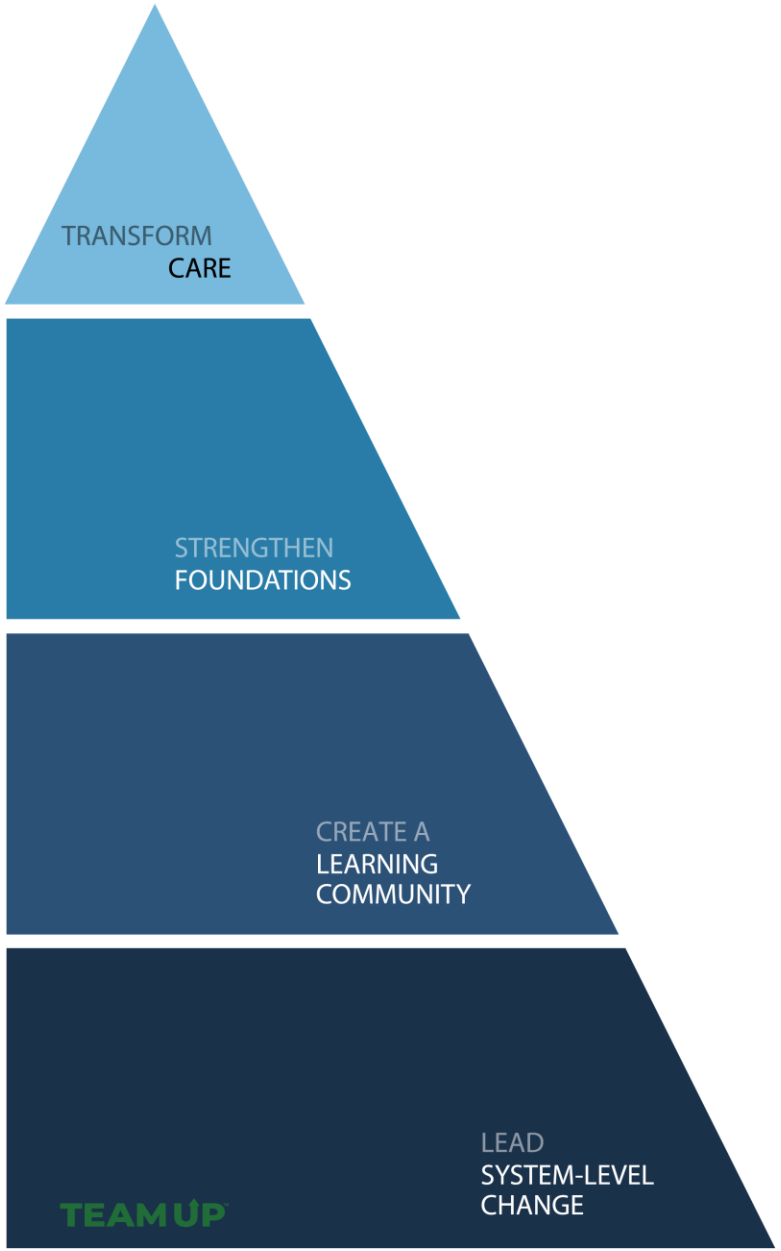
Practice Name	Type of Practice	Pediatric Patients	% of Total Patients	Key Population Served	Public vs. Private Payers
H+H Bellevue	Health and Hospitals	9,988	29%	68% Hispanic/Latino 14% Black/African American	76% Medicaid 4% Commercial
H+H North Central Bronx	Health and Hospitals	10,753	25%	53% Hispanic/Latino 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

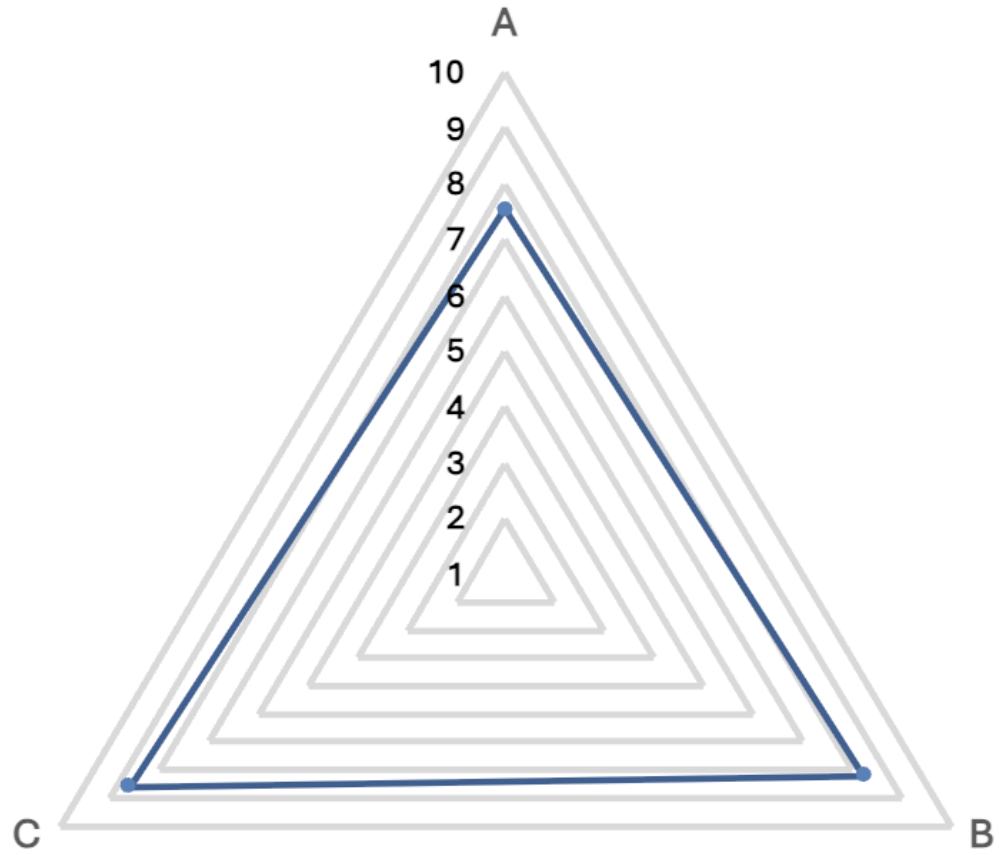
Questions Asked of Leadership

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

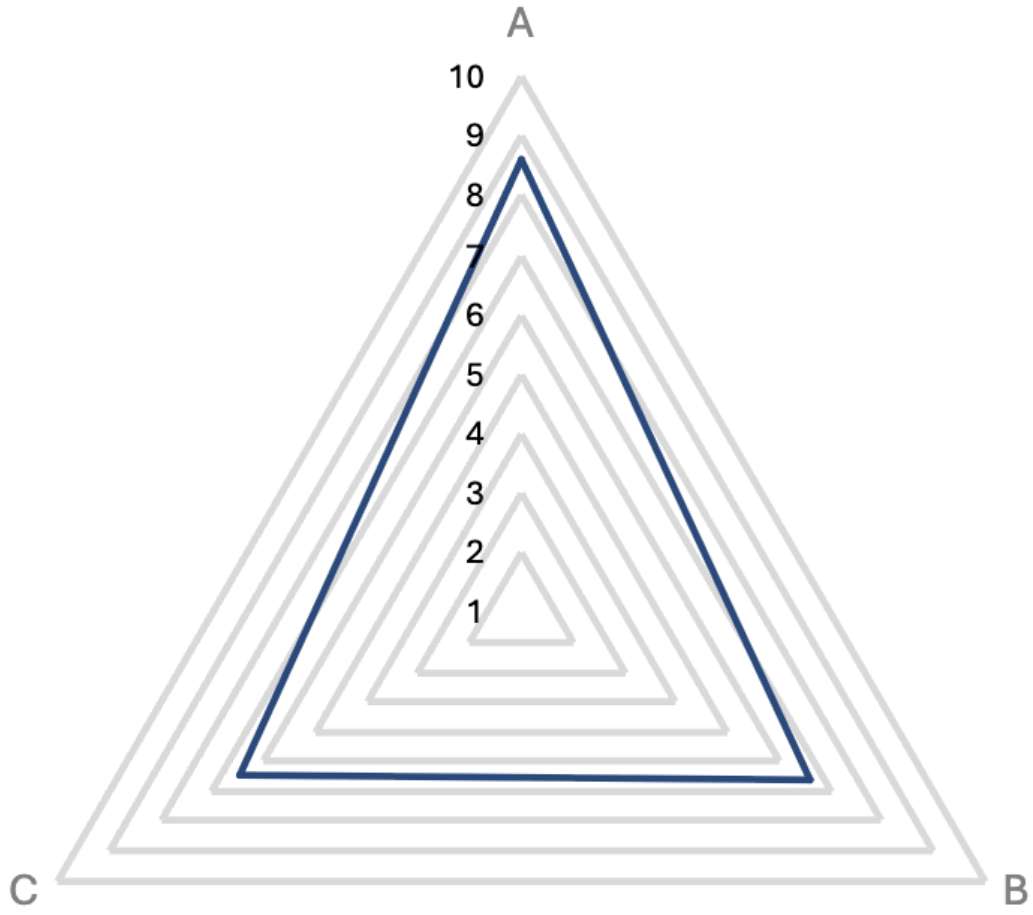
Questions Asked of Leadership

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



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

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."

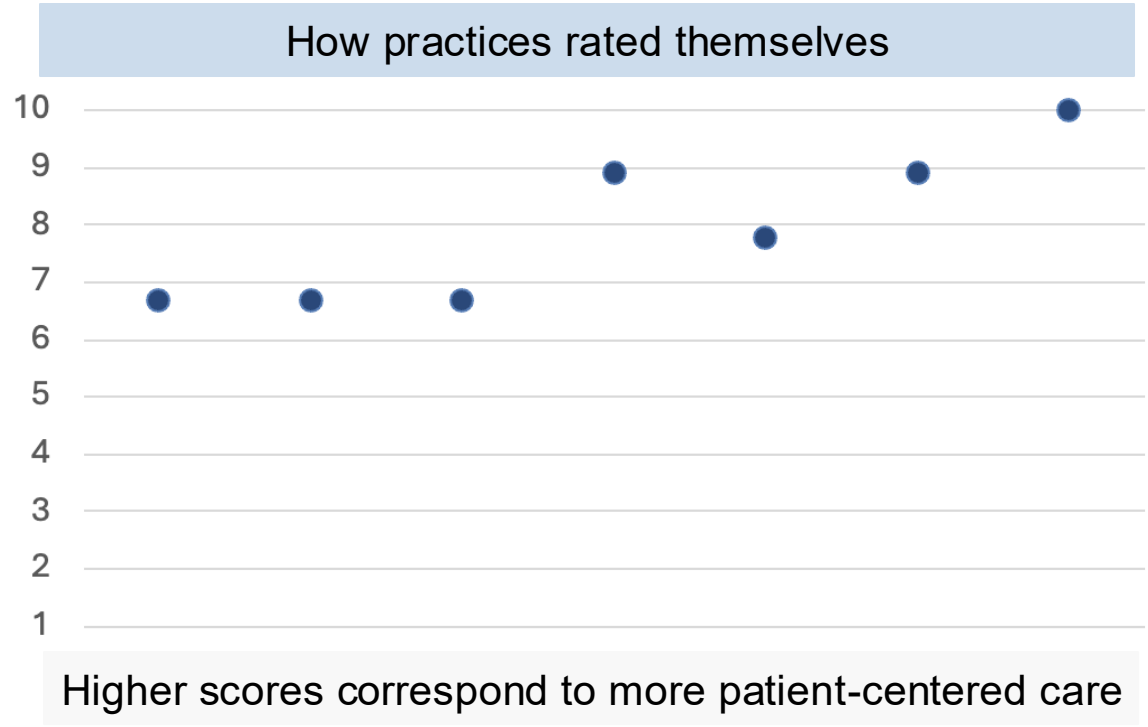
Patient Centered Care

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



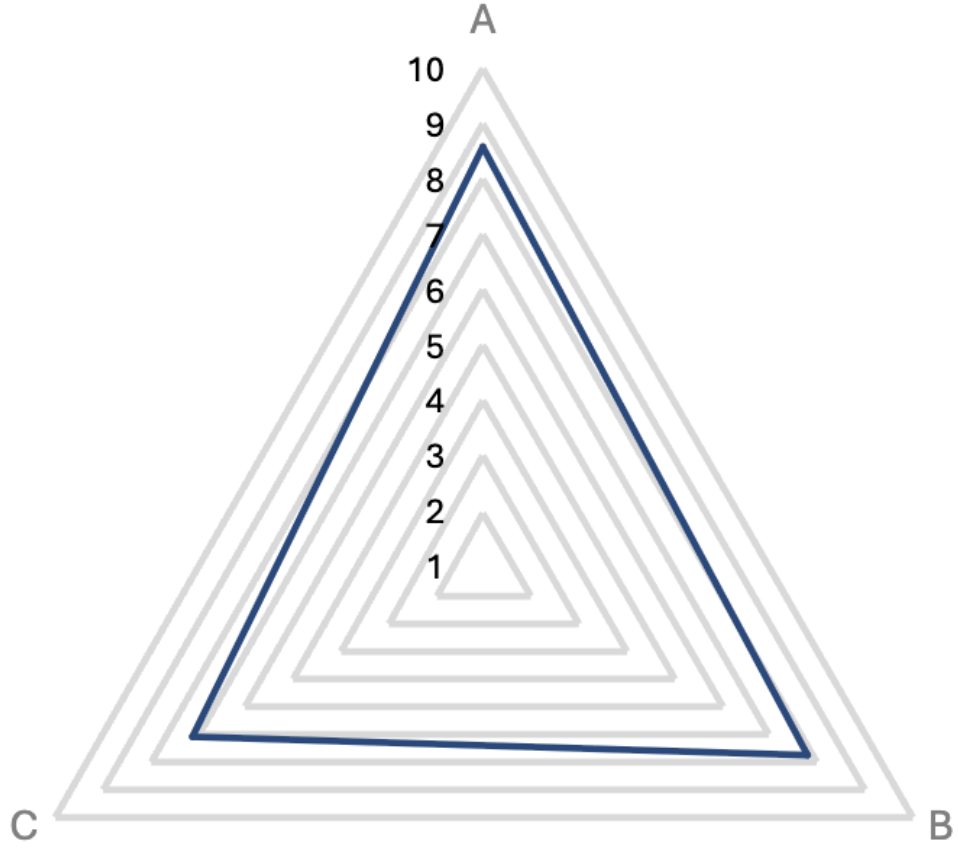
Section 2: Population Health and Clinical Model

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…”

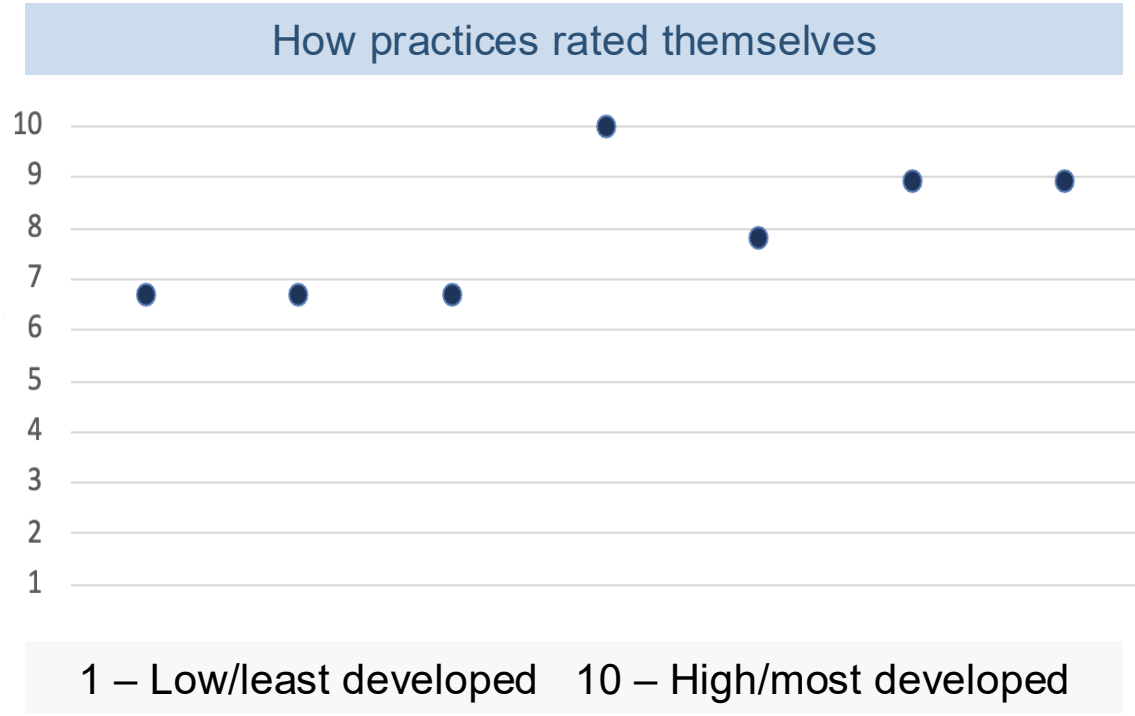
Section 3: Data and Quality

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



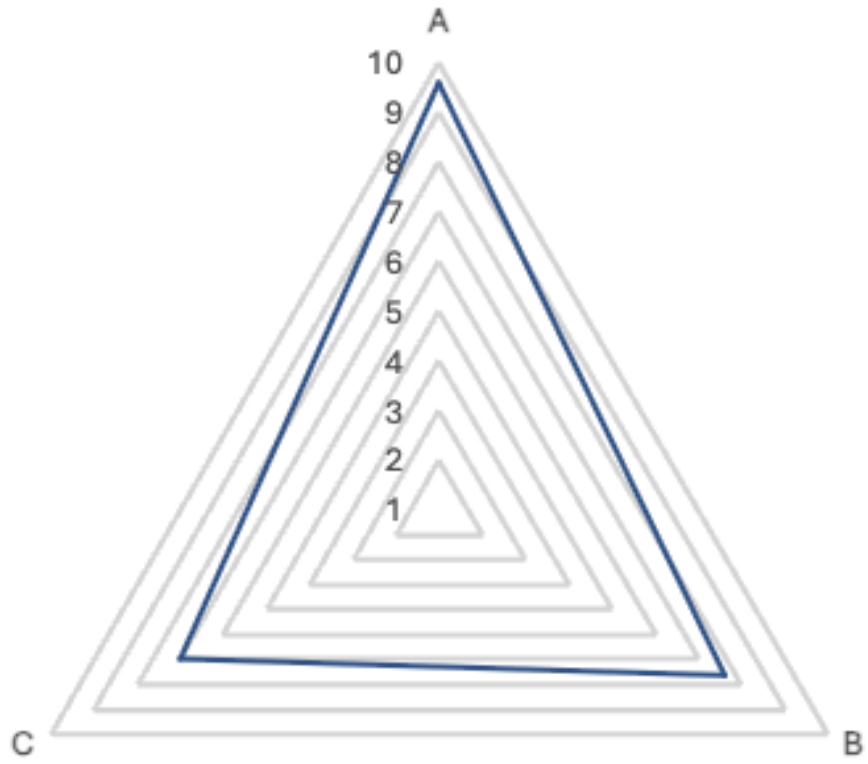
"It is encouraged and required but there is a need for quality work on the quality of the projects [in the field]."

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



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

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."

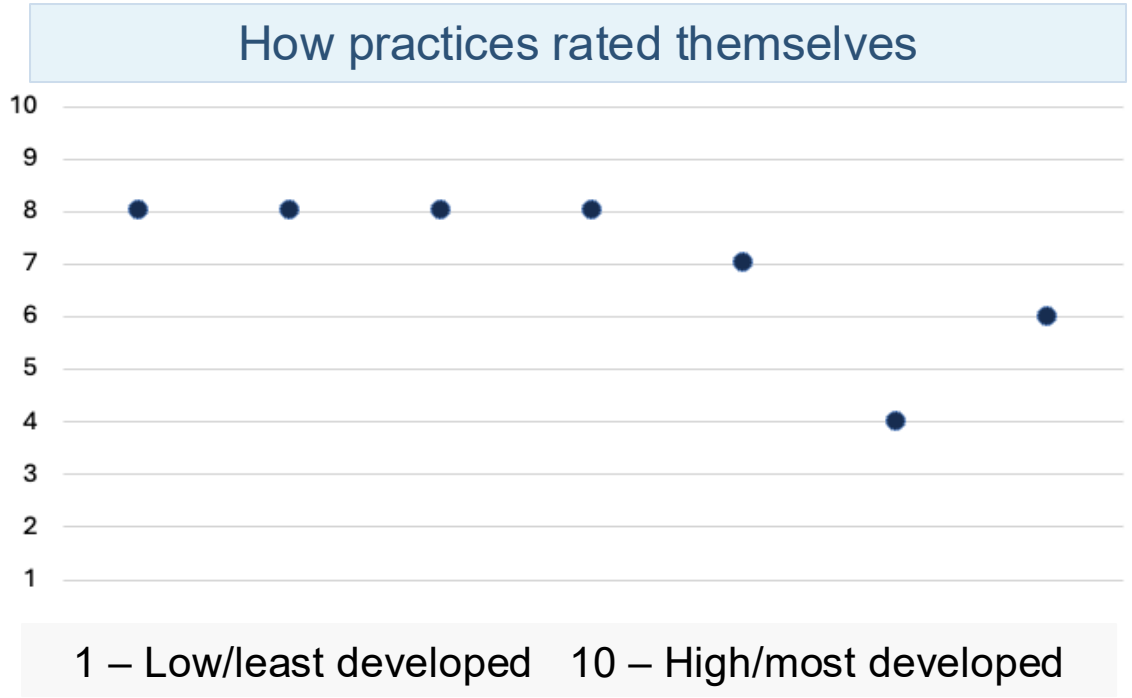
Practice Data Capacity

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).

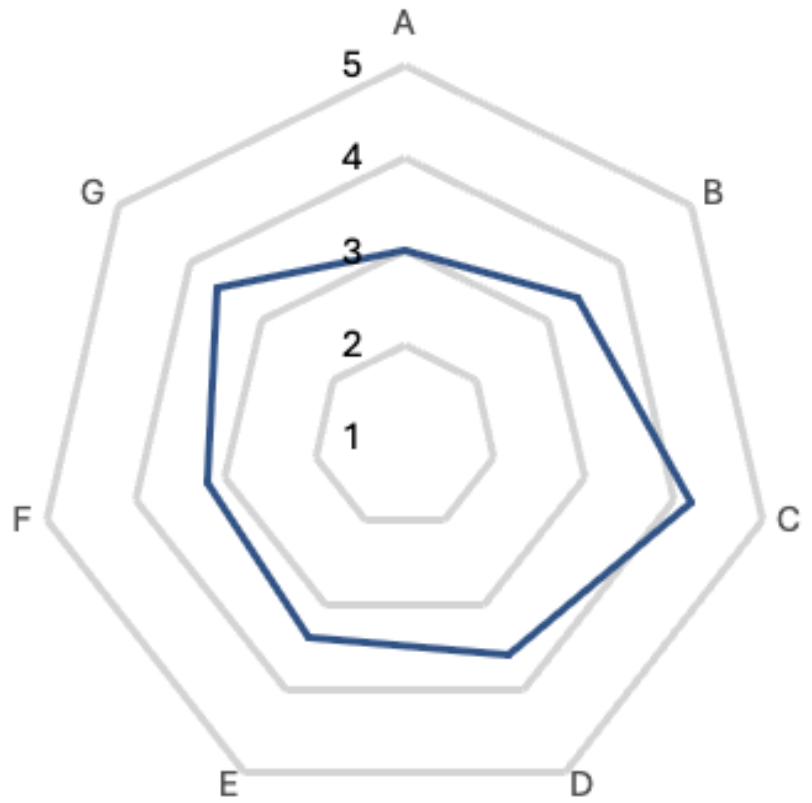
D. PCPs and BHSs do “warm hand-offs” according to patient needs.

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



1 – Low/least developed 5 – High/most developed

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.

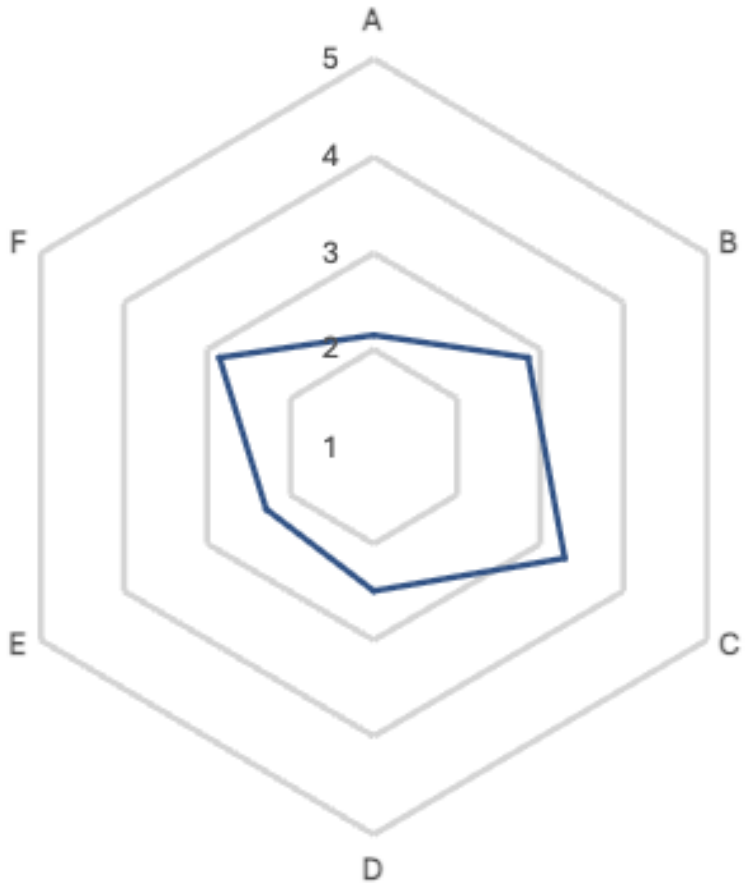
C. The CHWs and peers share access to the electronic medical record (EMR)/patient chart with the primary care providers (PCPs).

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



1 – Low/least developed 5 – High/most developed

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.”

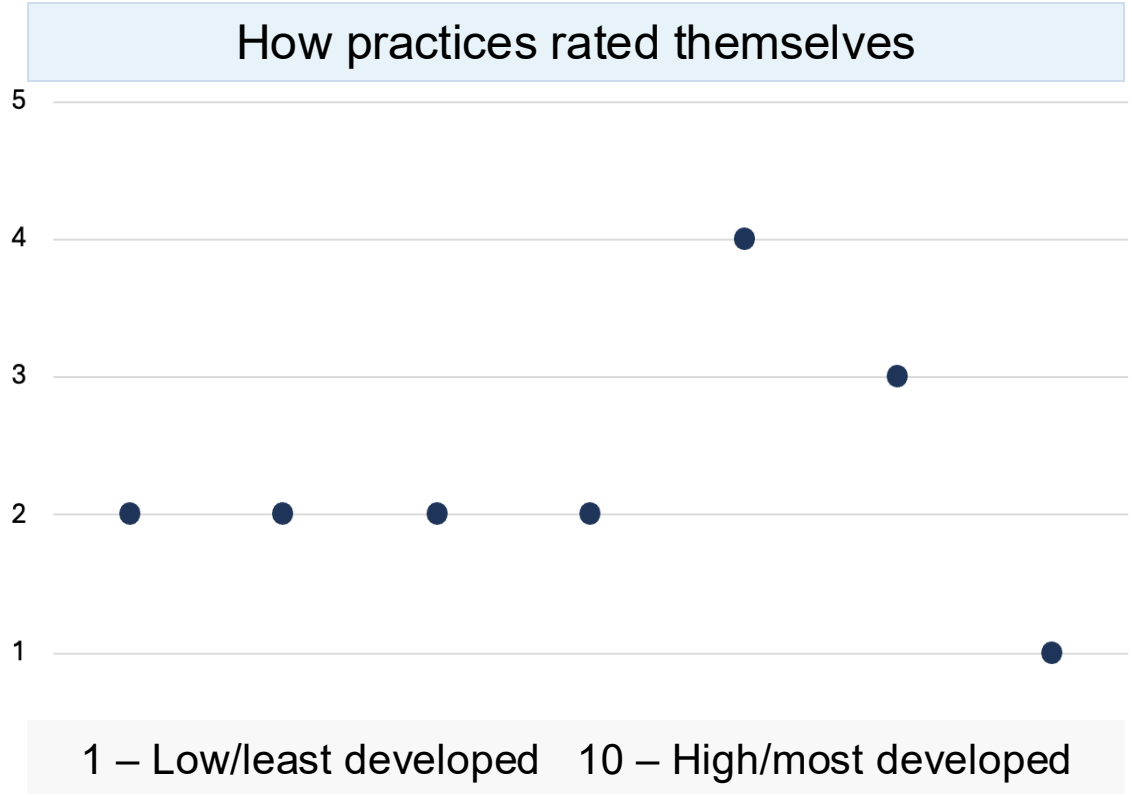
Integrated Care Training

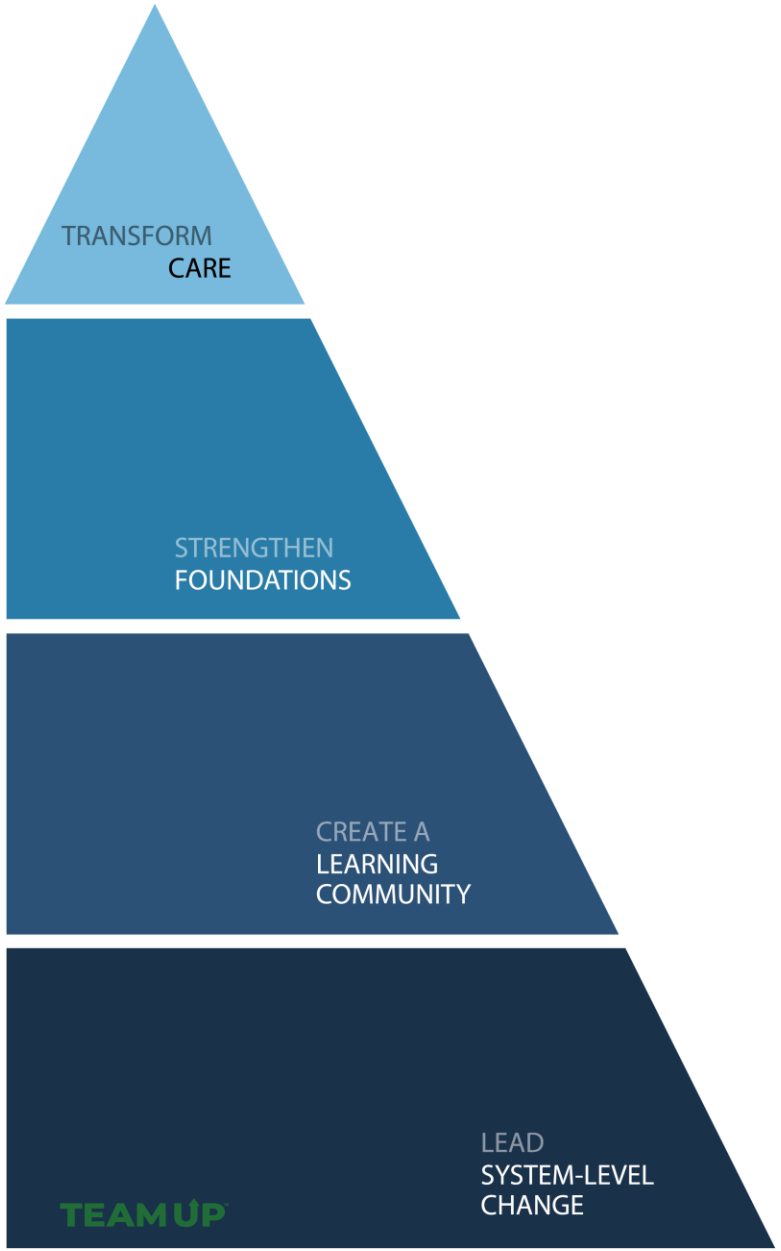
Patterns and Themes

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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Appendix 4. Stakeholder Perspectives

TEAM UP | SCALING & SUSTAINABILITY CENTER™

Exploring Opportunities to Expand Behavioral Health Services in New York City

New York City Stakeholder Perspectives on Pediatric Behavioral Health

BOSTON MEDICAL CENTER

August 2024 – August 2025

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

TABLE OF CONTENTS

INTRODUCTION

This report will summarize the key findings of the New York City (NYC) stakeholder interviews conducted by the TEAM UP Center. The interviews were part of a year-long project to assess the NYC behavioral health landscape and opportunities for TEAM UP to contribute to the wellbeing of NYC children and youth. We interviewed 14 organizations spanning NYC government agencies, hospital systems, Medicaid Managed Care Plans, and philanthropic organizations. Interviews were open ended with the purpose of understanding investments in pediatric behavioral health as well as opportunities for impact. We describe a broad set of themes that reflect our findings. In brief, we identified significant investments made in clinical care - through the implementation of clinical models such as HealthySteps, in clinical training through the offerings of Project TEACH; and in workforce development through Montefiore's CHW training institute and the Careers Pathways Training program. Several of the current programs are sponsored by the Office of Mental Health (OMH) to support the prevention and early identification of emerging issues in youth across the state. Although these investments have expanded the capacity of primary care to serve the developmental and behavioral health needs of children, we nonetheless identified gaps and specific areas where further investment could impact the quality of and access to behavioral health service for children and youth in NYC. Figure 1 below depicts the four major themes explored in this report on Stakeholder Perspectives.

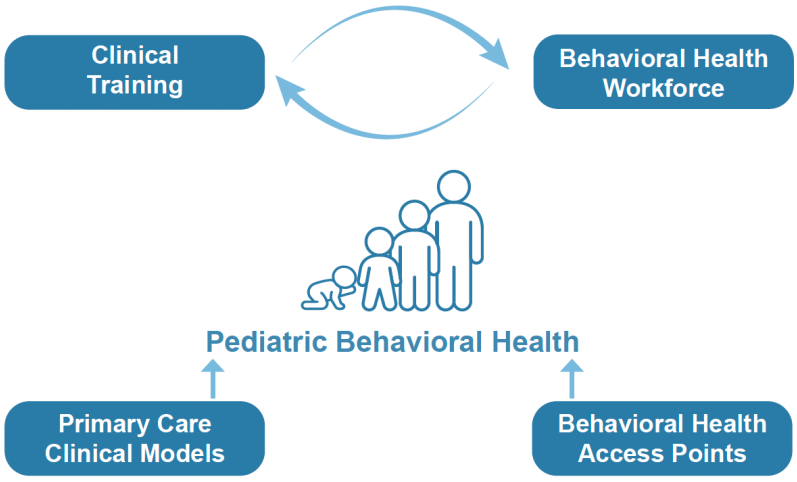

Figure 1. An overview of major themes from stakeholder interviews

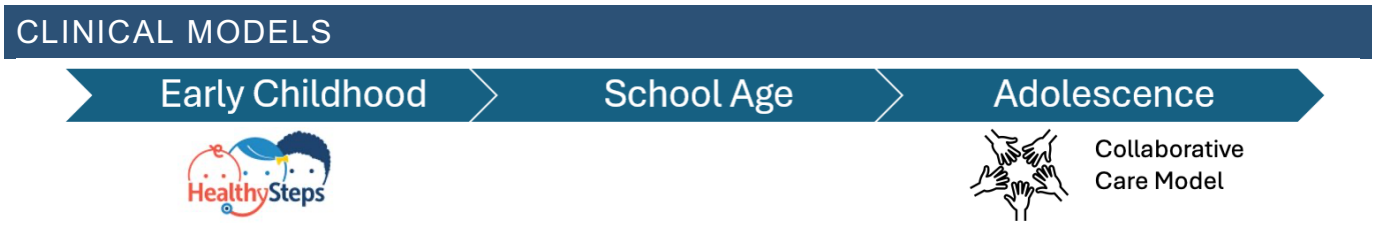

Figure 2. Pediatric Primary Care Clinical Models

Through our discussions with stakeholders, we became familiar with pediatric primary care clinical models, their implementation, their relative strengths, and potential opportunities for investment. We describe major investments in early childhood mental health through HealthySteps and the adoption of the Collaborative Care Model to address the behavioral health needs of a subset of adolescents. Although these programs serve an important role, gaps in services remain – particularly for school age children and adolescents with emerging concerns. Figure 2 above depicts these two primary care clinical models and the populations they serve.

Early Childhood -- HealthySteps

HealthySteps is an evidence-based model that integrates child development and behavioral health guidance and services in primary care for children from birth to three years of age. Services are delivered by a HealthySteps specialist, who is generally a master's level clinician. The HealthySteps model is a risk-stratified population-based model that begins with screening and family support for all infants and toddlers within the primary care practice. For more information, visit the HealthySteps website.

HealthySteps is currently funded through the NYS OMH and has over 50 sites across the state. In 2024, Governor Hochul announced more than $24 million to expand HealthySteps to 50 additional sites across the state. These long-term investments will offer crucial support to thousands of families in early childhood.

While HealthySteps provides a very strong foundation for early childhood services, we identified two areas where additional support is needed: support to address health related social needs (HRSNs) and specialty referral support for children with complex needs who need more intensive treatment. HealthySteps specialists are not trained to address health related social needs although some sites have augmented their team with a CHW to meet these needs. Relative to complex clinical concerns, HealthySteps specialists serve as the go-to person for all concerns for children 0-3 and their families. They may not have the bandwidth or training to support families who have experienced extensive trauma and family disruption, which is not uncommon in many immigrant communities.

Adolescence -- Collaborative Care Medicaid Program (CoCM)

The Collaborative Care Medicaid Program (CCMP) in collaboration with the NYS OMH provides primary care practices the opportunity to implement the Collaborative Care Model. CoCM is an integrated behavioral health program that provides mental health and substance use services to patients 12 years old and above. This is a team-based approach that includes the primary care provider, a behavioral health care manager and psychiatric consultant to

support patients who meet diagnostic criteria of a covered mental health disorder – most commonly depression and anxiety. The CoCM supports patients following diagnosis and assesses symptom improvement through measure-based monitoring with an appropriate tool (e.g. PHQ-9 for depression; GAD-7 for anxiety) to determine the intensity of support needed to meet a target goal. Patients with intensive needs are referred to long-term services. Although CoCM meets the needs of patients with the covered diagnosis, there remain opportunities for early identification of emerging needs before a diagnosis is made. Behavioral health services in practices with the CoCM are limited to a subset of patients and are unable to address the needs of patients who do not meet diagnostic criteria. Expansion of integrated behavioral health services for these patients could provide opportunities for early intervention and prevention through prompt access to therapeutic services.

3-2-1 IMPACT

The 3-2-1 IMPACT (Integrated Model for Parents and Children Together) model is a primary care-based model that was developed and piloted within the NYC Health+Hospital system. 3-2-1 IMPACT brings together three separate clinical models, HealthySteps, Reach Out and Read and the Video Interaction Project. These three models were responsive to the needs identified during a universal assessment of pregnant people and newborns. Families who participated in the 3-2-1 IMPACT model also received connection to Community Health Workers for access to community resources. The model spanned two generations with early identification of maternal behavioral health concerns and formal support throughout the postpartum period by a team of psychiatrist and social workers. Overall, this model aimed to address the needs of parents and their child in the critical periods of pregnancy and early childhood. For more information, please review the publication linked here.

Article 28 vs. Article 31 Clinics

The programs described in this section exist under two common licensing models for healthcare facilities relevant to the provision of primary care and behavioral health services. Article 28 clinics provide primary care services and Article 31 clinics provide outpatient mental health services. Recent changes at the New York State Office of Mental Health (NYS OMH) have allowed for further provision of mental health services in primary care as an effort to expand integration. Now 30% of the service delivery in primary care can be mental health focused without requiring them to obtain an Article 31 license. Although Article 31 clinics can provide an expanded set of behavioral health services especially to the adult population, there are difficulties in smaller practices supporting the work needed to meet the requirements and operate expanded staff. The new expansion of mental health services provided in primary care can allow for these sites to begin offering support to their patients without undergoing the prohibitive process of an Article 31 license.

PEDIATRIC BEHAVIORAL HEALTH SERVICE ACCESS POINTS

Major players in the provision of healthcare to children across NYC include hospital-based clinics (e.g. Health and Hospitals, Montefiore, Mount Sinai, Northwell) and Federally Qualified Health Centers (FQHCs) (e.g. Institute for Family Health, Urban Health Plan, Sunset Park Health Council). Private practices also play an important role in primary care services across the city, some which may be part of Independent Physician Associations (IPAs) (e.g. SOMOS). Further descriptions of the key players in the NYC care delivery system are described in the System-Level Landscape Analysis by Manatt Health. In this section, we describe additional access points for behavioral health across the city, as depicted in Figure 3 below.

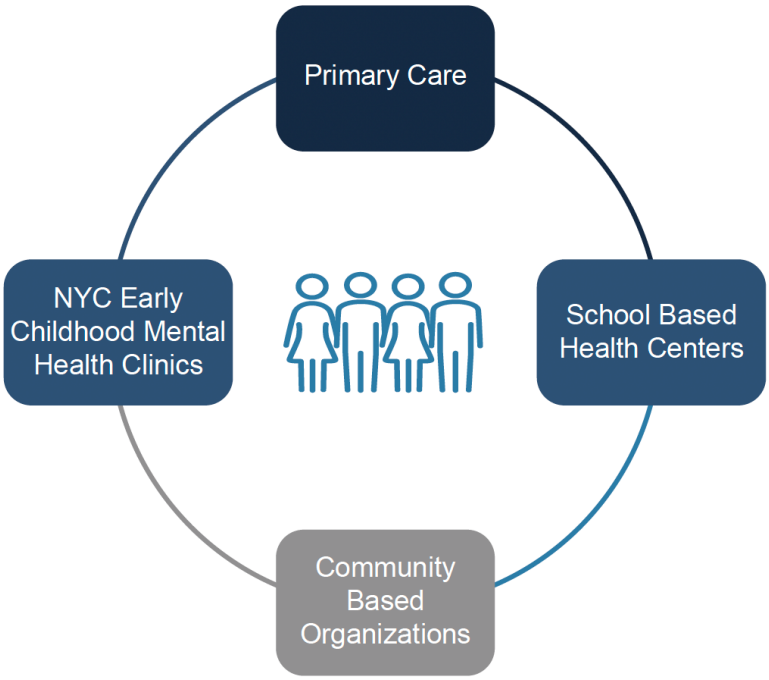

Figure 3. Pediatric Behavioral Health Access Points

School Based Health Centers (SBHCs)

According to the 2023 NYS Department of Health (DOH) data, there are 145 approved operating SBHCs in the five boroughs of NYC with most being in high schools and middle schools. SBHCs are sponsored by local hospitals, medical centers and FQHCs. Sponsors provide administrative oversight including staffing, billing, claims and care outside of the SBHCs. Major sponsors include Montefiore Medical Center, Morris Heights Health Center and NYU Langone Family Health Centers; each sponsor manages multiple sites. The city sponsors 34 of the 145 sites and covers their expenses.

Usually, students are primary care patients at the sponsoring site and can receive additional services in their main locations. SBHCs are Article 28 clinics which provide primary care services but could also include satellite Article 31 clinics which provide mental health services. If a SBHC does not have an Article 31 designation, students are still able to receive some mental health services. SBHCs are staffed depending on their size; larger sites include a pediatrician or adolescent medicine physician, medical assistants, health educators, licensed

social workers, psychologists, and provide comprehensive services. Of note, SBHCs have received funding to train mental health clinicians in therapeutic modalities such as Eye Movement Rapid Desensitization and family therapy to increase their capacity to address behavioral health issues.

NYC Early Childhood Mental Health Clinics

NYC Early Childhood Mental Health Clinics are a network of organizations with locations in each of the five boroughs (shown in Figure 4) to serve the behavioral health needs of children under five. The clinicians receive training through the NY Training and Technical Assistance Center in evidence-based interventions like Child-Parent Psychotherapy (CPP), Circle of Security and perinatal mental health evidence-based interventions. The clinics receive referrals through partnership with systems such as preschools, birthing centers, and foster care agencies. A noted difficulty which spans across other systems is finding bilingual bicultural clinicians who have an interest in early childhood.

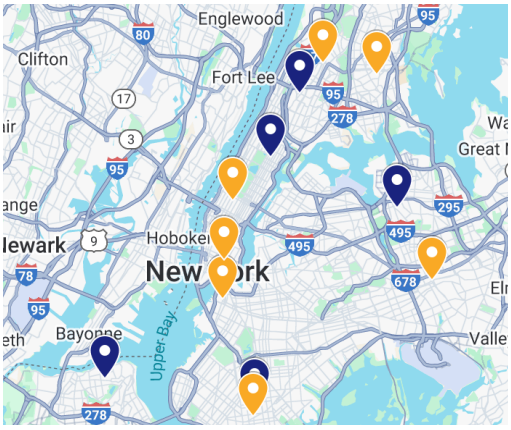

Figure 4. Map of Early Childhood Mental Health Clinics

Community Based Organizations (CBOs)

CBOs across NYC provide behavioral and developmental services to thousands of children. Through our interviews, we were able to identify a few key service providers such as the Child Center of NY, the Jewish Board of Family and Children's Services and University Settlement. There are many other providers across the city; however, primary care practices have difficulty identifying the most appropriate referral site and are further challenged by referral processes that vary across organizations. Closed referral loops are rare, resulting in families who are lost in the hand off from their primary care provider to the organization that could provide needed services. The New York 1115 Waiver includes provisions to strengthen closed referral loops through the UniteUs platform. This platform allows providers to submit referrals to partnering CBOs around the city and offers a dashboard to track the referral. Widespread implementation has the potential to impact primary care providers and their patients in accessing behavioral health services.

CLINICAL TRAINING

Several clinical training programs were identified, each focusing on a particular area of BH service provision. These programs were accessed by different members of the care team; of note, Project TEACH was mentioned to be a helpful resource for primary care providers across our assessment. The Perinatal and Early Childhood Mental Health Network serves a specific early childhood focus where trained providers offer support to mothers and children in community-based organizations. Montefiore CHW Institute is focused on training CHWs in HRSNs for adults. Overall, these resources make up part of the patchwork of BH care in NYC and are further described below.

Project TEACH

Project TEACH is a NYS OMH sponsored program that is designed to support pediatric primary care providers to deliver care to patients with mild-to-moderate mental health concerns. Through prescriber-to-prescriber education and case consultation, this program is intended to inform and strengthen primary care providers' confidence to assess common mental health conditions such as depression, anxiety, and ADHD, and, if needed, prescribe first line medications. Project TEACH provides virtual and on-site trainings at practices that can include medical providers and other members of the care team. The program also offers expert consultations which focus on patients with more complex conditions, including Autism Spectrum Disorders, Substance Use Disorders, and Sexual Conduct Disorders. Following the service disruptions caused by the COVID pandemic, Project Teach expanded their services to provide one-time face-to-face patient consultation to assist with assessment and care planning. Project TEACH provides information about therapeutic service providers in the patient's community, waitlist times, and accepted health insurance plans.

Perinatal and Early Childhood Mental Health Network

The Perinatal and Early Childhood Mental Health Network has two important components: the Training and Technical Assistance Center (TTAC) and the Early Childhood Mental Health Clinics (described in the service access section above). The TTAC is funded through the NYC Department of Health and Mental Hygiene (DOHMH) and is supported through a collaboration between the New York Center for Child Development and the NYU McSilver Institute. This network aims to equip licensed mental health clinics, educators and early childcare settings with the skills they need to support healthy social emotional development. Trainings and resources are available online through an open access library. The webinars also offer continuing education hours for several provider types. TTAC is an opportunity to continue supporting families and children in early childhood by fostering the skills providers need to do the work.

Montefiore

Montefiore CHW Institute

Montefiore has established a CHW institute that provides comprehensive training to community health workers. The core two-week program provides specific content focused on HRSN as well as training in motivational interviewing and other patient engagement strategies. Once CHWs complete their training, they meet Medicaid billing requirements to obtain reimbursement for their services. The Montefiore CHW Institute currently focuses trainings on the HRSNs of community members residing in the Bronx. One important aspect of CHWs trained in Montefiore CHW Institute is that they track referrals to external resources and are able to identify when successful connection to services is made. Montefiore CHW Institute provides important training to CHWs and is well positioned for an expansion of training across different boroughs of NYC and additional content specific training including pediatric behavioral and developmental needs.

Figure 5. Pediatric Behavioral Health Workforce

Community Health Worker

The figure above depicts the core care team roles in integrated BH models. Community Health Workers (CHWs) are defined by the NYS Medicaid manual as providers who offer trusting relationships and serve as a link to services, reduce barriers to care and serve to educate and advocate for their patients. The CHW is meant to reflect the community being served through identity, lived experience or shared diagnosis and serve as a liaison between the patient and other institutions. The CHW service is determined to be a preventative health service so it must be recommended by a physician or other licensed health care provider. NYS Medicaid covers these services for individuals under NYS Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) members who are under 21 years old, pregnant, in the 12-month postpartum period, among other populations. There are three reimbursement codes for a 30-minute interaction with a patient that is limited to 12 units for adults and 24 units for pediatric population annually.

While reimbursement for support provided by CHWs offers an opportunity to expand CHW services across pediatric and adult care settings, interviewees shared that the reimbursement rate is not sufficient to sustain the salary for a CHW. In addition, the CHW benefit has been underutilized, possibly reflecting a difficulty to implement and sustain. We see the CHW benefit as a promising step and would advocate for an increase in reimbursement rates and coverage of some collateral work which takes a substantial amount of CHW time.

Careers Pathway Training Program (CPT)

The CPT was established by the new NYHER 1115 waiver approved on January 9, 2024. In an announcement made by Governor Hochul, a $646 million dollar award to the Workforce Investment Organization (WIOs) will focus on developing the health, mental health, and social care fields in the state of New York for the next 3 years.

The New York City area programming will be overseen by the 1199 SEIU Training and Employment Funds (TEF). The approved professional titles fall under three categories: professional technical, nursing, and frontline public health worker, which includes CHWs. Detailed professional titles are outlined in Figure 6. The CPT program offers financial assistance which covers all tuition, training, books and administrative fees for qualifying participants.

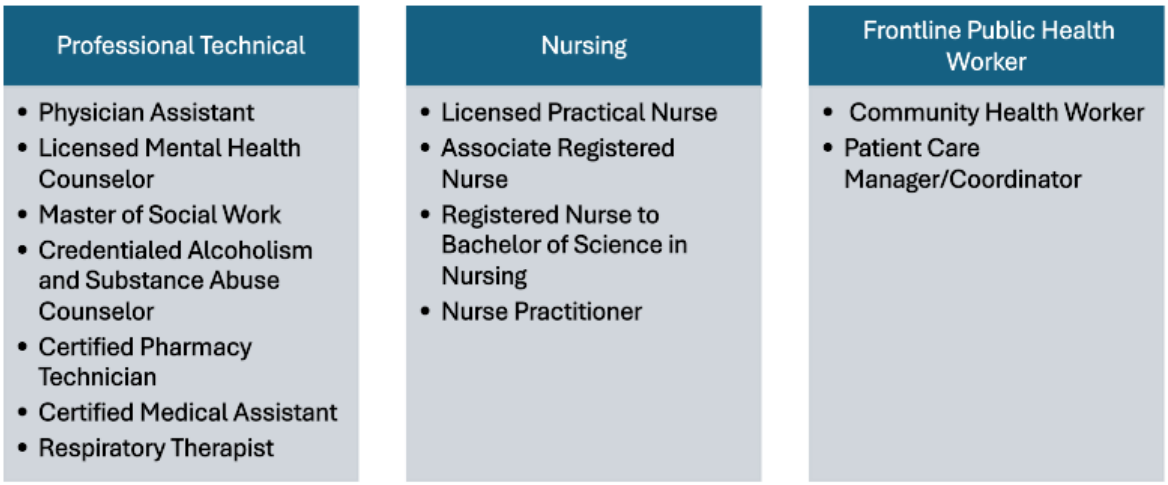

Figure 6. List of the CPT Approved Professional Titles

When reviewing the employers that are partnering with the SEIU 1199, notably the majority of employer types are categorized as nursing home/long-term care facilities and home care agencies. Although the initiative does not directly address which populations will be served by the workforce development efforts, given the partnering organization breakdown, there seems to be an emphasis on the adult population, and specifically within that, the elderly population. As the program continues, there is an opportunity to better understand the impact on workforce availability for the pediatric population specifically.

Workforce Considerations

Across several systems a common theme emerged regarding high workforce turnover due to salary competition. Service providers note that it has been difficult to maintain full staffing, which leads to long waitlists and less capacity to meet the needs of children in NYC.

CONCLUSION

As noted throughout this report, we have seen substantial investments in the behavioral health of children across NYC. Both state- and city-wide fiscal investments have supported the sustainability of programs like HealthySteps, investments in SBHCs and CBOs, while also implementing policy changes to allow the expansion of integrated behavioral health in primary care. We have also noted a few areas where further investment can greatly impact the wellbeing of children across NYC – specifically, more robust screening in primary care particularly for school age children, more direct provision of BH services within primary care, and expanded reimbursement for CHWs. The current investments in development of the behavioral workforce through the CPT program could also be leveraged to meet the significant behavioral health needs of children in addition to the adult population. In particular, further expansion of the CHW reimbursement benefit could support the expansion of this workforce in primary care to support children and their families.

While we anticipate that there is still more to learn, these interviews provided us with a comprehensive view of the resources, initiatives and care providers in the city. We believe that this initial assessment has provided a broad overview of key stakeholders in NYC and has developed a foundation for potential future collaborations.

ACKNOWLEDGEMENTS

A sincere thank you to all the stakeholders who participated in an interview. Your perspectives were incredibly valuable to our understanding of the NYC landscape.

Stakeholder interviews were completed by the TEAM UP Center. In particular, Anita Morris, Executive Director and Dr. Emily Feinberg, Director of Emerging Projects, led this work with support from Rocio Nunez-Pepen.

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Dr. Myla Harrison	Assistant Commissioner of Bureau of Mental Health

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If there are any questions regarding the findings of the NYC TEAM UP Roadmap, please contact TEAMUPCenter@bmc.org.


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