2024
Fall Provider Symposium

Evolving Models of Care: Bridging the Gap Between Behavioral Health and Primary Care

Friday, November 15, 2024

Virtual Conference

healthfirst®
Health Insurance for New Yorkers

AGENDA

8:30AM – 8:55AM	Welcome and Introductions **Moderator: Susan J. Beane, MD, FACP** *Executive Medical Director, Health System Transformation, Healthfirst* Primary Care and Behavioral Health: Better Together **Jin Hee Yoon-Hudman, MD, FAPA** *Assistant Vice President Medical Director, Behavioral Health, Healthfirst*
	Panel 1
8:55AM – 9:35AM	Project TEACH: What New York State's Psychiatry Access Program can do for you! **Rubiahna Vaughn, MD, MPH** *Director of Psychiatry - Einstein Division, Director of the Division of Women's Mental Health* *Program Director of the Consultation-Liaison Psychiatry Fellowship Associate Professor of Psychiatry and Obstetrics & Gynecology* *Montefiore Medical Center - Albert Einstein College of Medicine* Harlem United Mobile Medical Van **Betty Lee, AGNP-BC, AAHIVS, CARN-AP** *Primary Care/Mobile Health Provider* *Harlem United*
9:35AM – 9:55AM	Question and Answer Session
9:55AM – 10:05AM	10-Minute Break
	Panel 2
10:05AM - 11:05AM	Montefiore's HealthySteps Program **Polina Umylny, PhD** *Director, HealthySteps at Montefiore* *Assistant Director, Behavioral Health Integration Program (BHIP)* *Assistant Professor, Academic General Pediatrics* Housing Works CONNECT Program in East Harlem **Melissa Lanspery, LCSW** *Program Manager for Clinical Integration* *CONNECT, Behavioral Health Services, Housing Works* Behavioral Health Integration at Northwell **Manish Sapra, MD, MMM, FAPA** *Executive Director Behavioral Health Service Line* *Northwell Health*
11:05AM - 11:20AM	Question and Answer Session
11:20AM - 11:30AM	Final Remarks and Adjournment

Susan J. Beane, MD, FACP

Executive Medical Director, Health System Transformation, Healthfirst

Dr. Susan J. Beane joined Healthfirst in 2009, bringing with her extensive professional experience in managed care. As Executive Medical Director at Healthfirst, Dr. Beane focuses on transforming the delivery of care and optimization of medical outcomes through provider and community partnerships. Her interest and passion is collaboration across the healthcare delivery system to design and implement programs that improve access and equity for Healthfirst members and their communities. Dr. Beane is a graduate of Princeton University and Columbia University Vagelos College of Physicians and Surgeons.

Jin Hee Yoon-Hudman, MD, FAPA

Assistant Vice President, Medical Director, Behavioral Health Healthfirst

Dr. Yoon-Hudman is Medical Director for Behavioral Health and the Health and Recovery Program at Healthfirst. She combines experience in direct service delivery settings in behavioral health well as expertise in managed care to focus on behavioral and physical health integration, access, equity, and quality of care with a population health perspective with emphasis on improving clinical outcomes.

She is a board-certified psychiatrist who works closely Healthfirst's clinical staff and provider community, develops and oversees Behavioral Health programs and integration initiatives. She has over 20 years of experience as a provider in the community, treating high risk populations in New York City. Dr. Yoon-Hudman received her medical degree from New York Medical College, was trained and served as chief resident at the Zucker Hillside Hospital. She is a fellow of the American Psychiatric Association.

Rubiahna Vaughn, MD, MPH

Director of Psychiatry - Einstein Division, Director of the Division of Women's Mental Health
Program Director of the Consultation-Liaison Psychiatry Fellowship
Associate Professor of Psychiatry and Obstetrics & Gynecology
Montefiore Medical Center - Albert Einstein College of Medicine

Dr. Rubiahna Vaughn is an Associate Professor of Psychiatry and Behavioral Science and Obstetrics and Gynecology at the Albert Einstein College of Medicine. She is the Director of Psychiatry at Montefiore Medical Center – Einstein Division and the Founding Director of the Division of Women's Mental Health. Dr. Vaughn also serves as the program director for the Consultation-Liaison Psychiatry Fellowship at Montefiore. She completed undergraduate studies in Human Biology with a minor in African and African American Studies at Stanford University, graduating with interdisciplinary honors. Dr. Vaughn completed a master's in public health at Columbia University and received her medical doctorate from the University of Washington. She subsequently completed psychiatry residency training and a chief resident year at New York University Medical Center. As a resident, she was awarded the APA/SAMHSA Minority Fellowship and the Laughlin Fellowship by The American College of Psychiatrists. She completed fellowship training in Psychosomatic Medicine at The Massachusetts General Hospital/Harvard Medical School. Dr. Vaughn was named a 2020-2021 Harvard Macy Institute Scholar in the Program for Educators in Health Professions which has supported her commitment to innovation in education and curriculum development. Her interests include global mental health, reproductive psychiatry and neuropsychiatry.

Betty Lee, AGNP-BC, AAHIVS, CARN-AP

Primary Care/Mobile Health Provider
Harlem United

Betty Lee, NP is a primary care provider, HIV specialist and certified addictions advanced provider. Over the past five years she has focused on harm-reduction based models of care, including low threshold buprenorphine treatment and low barrier medical care. Since joining Harlem United in 2023 she has extended the organization's reach as a provider
on the mobile medical unit engaging people experiencing homelessness and housing instability in primary care and substance use treatment.

Prior to Harlem United, Betty worked on a street outreach MAT program in the South Bronx and was part of the ACT teams in East Harlem and Brooklyn, where she focused on the challenges of psychiatric dual diagnoses, substance use, and housing instability.

Betty earned her Bachelor of Science in nursing from Wesley College, her Master of Science in nursing from Hunter College and is a Board-Certified Nurse Practitioner through the American Association of Nurse Practitioners.

Polina Umylny, PhD

Director, HealthySteps at Montefiore
Assistant Director, Behavioral Health Integration Program (BHIP)
Assistant Professor, Academic General Pediatrics

Dr. Polina Umylny is the Director of Montefiore's HealthySteps program, an Assistant Director of Montefiore's Behavioral Health Integration Program (BHIP) and an Assistant Professor within the Department of Academic General Pediatrics of the Children's Hospital at Montefiore (CHAM).

Dr. Umylny received her BS in Psychobiology from Binghamton University and a doctorate from the Clinical Psychology program (Community and Child Track) at George Washington University.

She joined Montefiore's HealthySteps program in 2013, bringing her experience working with young children and families affected by poverty, violence, and involvement in the foster care system to an integrated behavioral health setting. Dr. Umylny oversees clinical, research and administrative components of Montefiore's HealthySteps program, including a focus on financial sustainability, and is spearheaded Montefiore's post-Covid HealthySteps re-expansion, to ensure that 24,000 of Montefiore's youngest patients have access to high quality early childhood behavioral health services. This expansion project involves the development of an Infant Mental Health training curriculum for master's level HealthySteps providers. Recent projects have focused on increasing universal screening touchpoints for developmental concerns, social emotional challenges and Autism, as well as screening for postpartum depression and Adverse Childhood Experiences for caregivers of young children. Dr. Umylny works closely with HealthySteps National to support the expansion of HealthySteps programming and early childhood workforce development.

Melissa Lanspery, LCSW

Program Manager for Clinical Integration
CONNECT, Behavioral Health Services, Housing Works

Melissa Lanspery, LCSW joined the Housing Works team in 2023 as Program Manager for Clinical Integration at Housing Works' CONNECT (Continuous Engagement between Community and Clinic Treatment) Program in Harlem.

Prior to coming to Housing Works, Melissa had over thirteen years of experience working in non-profit leadership, social work, and community engagement in New York City, and most recently as Assistant Director for the organizations Breaking Ground and University Settlement, both in Manhattan's Lower East Side. She received her master's degree in social work from Fordham University at Lincoln Center, and a BA from Western Connecticut State University. Melissa is also a RYT-200 certified Yoga teacher and currently teaches Yoga in Queens.

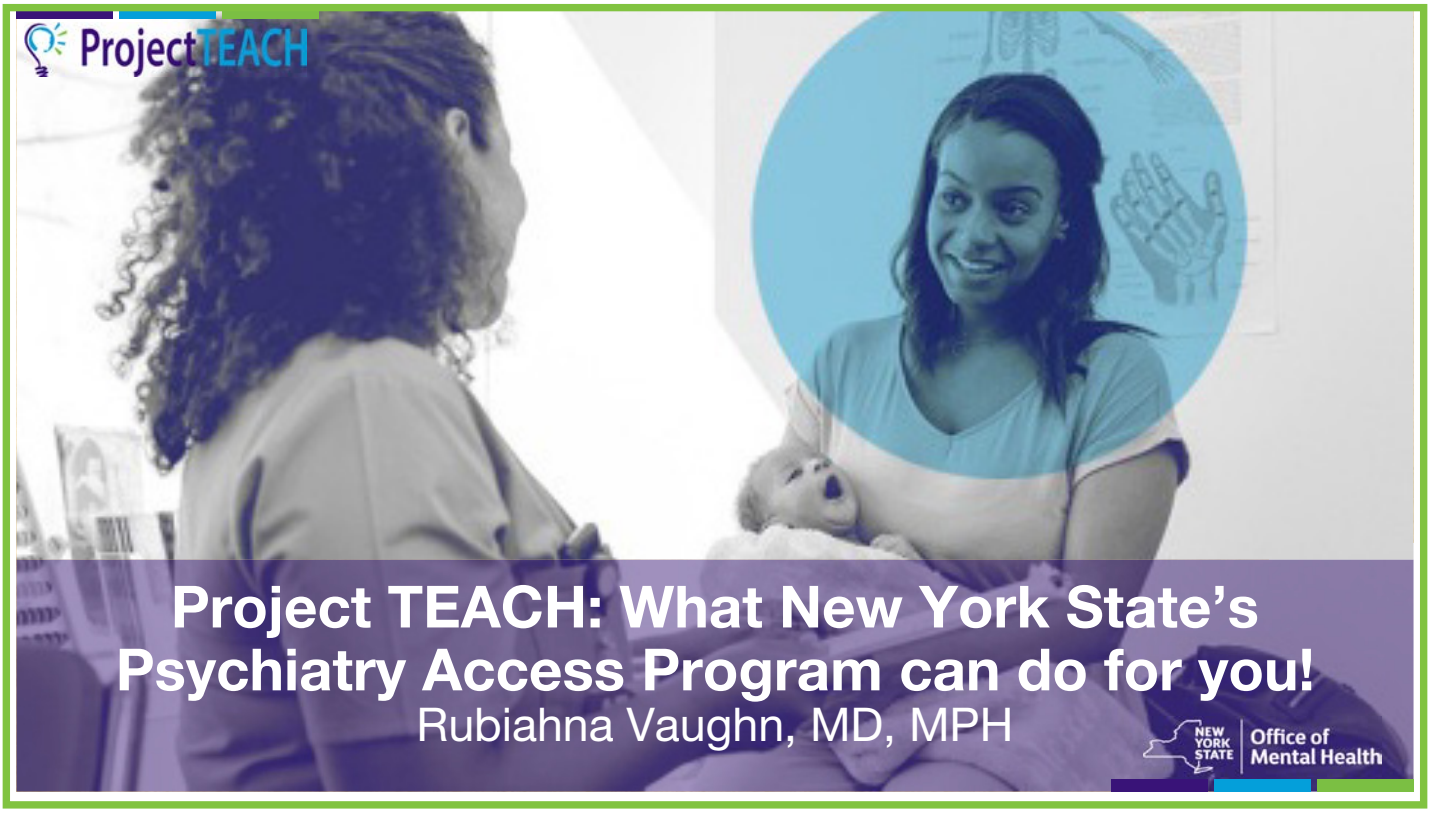
Manish Sapra, MD, MMM, FAPA

Executive Director, Behavioral Health Service Line
Northwell Health

Dr. Manish Sapra is Executive Director of the behavioral health service line at Northwell Health. He oversees strategic clinical program development and physician management for all mental health and substance use disorder programs at Northwell. Dr. Sapra joined Northwell in 2017, initially focusing on developing various population health programs, including behavioral health integration in primary care practices. Dr. Sapra has been instrumental in efforts to modernize behavioral health services by developing new ambulatory tele-psychiatry applications, implementing advanced use of data analytics and exploring value-based purchasing arrangements.

Prior to joining Northwell, he was associate chief of clinical services for behavioral health and senior director of community psychiatry at the University of Pittsburgh Medical Center (UPMC), where he directed physician management and business development for its ambulatory and acute-care services and medical education programs related to community psychiatry.

Dr. Sapra is the immediate past president of the American Association for Psychiatric Administration and Leadership, a fellow of the American Psychiatric Association and an active member of the Group for Advancement of Psychiatry, a leading psychiatric think tank. He graduated from Seth G. S. Medical College, University of Mumbai. He completed his residency in psychiatry at St. Elizabeth Medical Center in Boston and has a master's in medical management from Carnegie Mellon University.



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Disclosures

- Dr. Vaughn: none

ProjectTEACH

Mission

As New York State's Child/Adolescent & Perinatal Psychiatry Access Program, it is our mission to strengthen and support:

1. Pediatric primary care clinicians to deliver care to children and families who experience mild-to-moderate mental health concerns.
2. Obstetric and other maternal health clinicians to expand their ability to assess and manage maternal mental health concerns.

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Supporting Agencies & Organizations

New York State Academy of Family Physicians

ACOG The American College of Obstetricians and Gynecologists

NYS AAP American Academy of Pediatrics Dedicated to the Health of All Children

NEW YORK STATE | Department of Health

NYS Conference of Local Mental Hygiene Directors, Inc.

NEW YORK STATE | Office of Mental Health

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History of Project TEACH

- **2010**: Founded and funded from beginning by NYS OMH
- Initial mission of Project TEACH was focused on child and adolescent mental health.
- **2018**: Project TEACH added a limited Maternal Mental Health Initiative (MMHI).
- **2022**: Project TEACH fully integrated CAP and MMH services/teams and expanded reach to 100% of NYS (62 counties).
- Clinician facing program whose target audience is New York State prescribers who provide ongoing treatment to:
  - Children and adolescents 0-21 in primary care settings and
  - Perinatal individuals in any setting
- All Project TEACH services are ***free, fast and friendly!***

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The Case for Perinatal Psychiatry Access Programs

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Perinatal mental health disorders are common

- Perinatal mental health disorders (i.e., depression, anxiety disorders, OCD, PTSD, bipolar disorder) affect more than **1 in 5 perinatal individuals** and are among the most common complication of pregnancy and the year after delivery (Wisner KL et al, 2013; Fawcett EJ et al, 2019; Masters GA et al, 2022).
  - number of births in US (2022): 3,661,220 (Hamilton BE et al, 2023 CDC National Vital Statistics System)
  - estimated 500,000 pregnant women in the US to experience a mental disorder either prior to or during pregnancy, with unipolar depression and anxiety the most common diagnoses
- Rates are higher in adolescents, disabled, military veterans and those marginalized by racism and socioeconomic disadvantage. (Melville JL et al, 2010; Dinwiddie KJ et al, 2018).

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Perinatal depression is under-diagnosed and undertreated

- U.S. Preventative Services Task Force (USPSTF) and American Psychiatric Association (APA) recommend screening for depression in pregnant and postpartum individuals (JAMA 2016; APA position statement 2018;
- ACOG recommends screening individuals for depression and anxiety symptoms using a standardized, validated tool at the initial prenatal visit, later in pregnancy and at a postpartum visit (ACOG Clinical Practice Guideline June 2023, Obst Gynecol)
- AAFP recommends that pregnant women should be screened for depression at least once during pregnancy and consider screening again 4-8 weeks after delivery using a validated screening instrument (O'Connor E et al, AHRQ 2023)
- AAP recommends screening the mother at the 1-, 2-, 4- and 6-month well-child visits (Earls MF et al, 2019)
- 30.8% of women with PPD are identified in clinical settings; 15.5% receive treatment; 6.3% receive adequate treatment; 3.2% achieve remission (Cox EQ et al, 2016)

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Perinatal mental health disorders are associated with adverse maternal, obstetrical, infant and child developmental outcomes

- Decreased maternal functioning (Field, T, 2010)
- Psychosis, suicidal ideation, homicidal ideation and suicide attempt are psychiatric emergencies that lead to psychiatric hospitalization, maternal death (Rodriguez-Cabezas et al, 2019)
- Bidirectional relationship between depression and gestational diabetes mellitus (Fischer et al, 2023)
- Preterm labor (Bansil P et al, 2010),preterm birth (Grigoriadis S et al, 2013), stillbirth/neonatal death and hypertensive disorders of pregnancy (Staub et al, 2012, Thombre et al, 2015, Delanerolle et al, 2022)
- Increased requirement for surgical delivery interventions (Wang SY & Chen CH, 2010) and cesarean delivery (Bansil P et al, 2010)
- Inadequate maternal-infant bonding prenatally and post-delivery (Rossen et al, 2016; Betcher et al, 2020, Dagher et al, 2021)
- Lactation failure or unplanned weaning (Dennis CL & McQueen K, 2009; Stuebe AM et al, 2014)
- Impaired child cognitive development (Tuovinen S et al, 2018)
- Impaired child behavioral and emotional development (Leis JA et al, 2014; Pearson RM et al, 2013)
- Impaired child brain development/antenatal stress from mental illness is associated with accelerated development of offspring neural networks via fetal (developmental) programming (Schinost D et al, 2016; Rotem-Kohavi, N et al, 2020)

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Mental health conditions are the most common cause of pregnancy-related deaths in the US, 3rd most common in NYS

The top three causes of pregnancy-related deaths (data from Maternal Morbidity Review Committees in 36 states, 2017-2019; CDC 2022)

- mental health conditions: 22.7%
- hemorrhage: 13.7%
- cardiac and coronary conditions: 12.8%

Among 41 pregnancy-related deaths, the most common underlying causes of death in NY state:

- embolism-thrombotic (non-cerebral): 20%
- hemorrhage (excluding aneurysms or CVA): 20%
- mental health conditions: 15%

Mental health conditions include deaths of suicide, overdose/poisoning related to substance use disorder, and other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder.

Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022.
New York State Department of Health. New York State Maternal Mortality Review Report on Pregnancy-Associated Deaths in 2018. Albany, NY: New York State Department of Health. 2022.

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Telephone Consultations

Project TEACH was established for family medicine, psychiatric, pediatric and maternal health prescribers to speak on the phone in real time with child and adolescent psychiatrists and reproductive psychiatrists.

Ask questions, discuss cases, or review treatment options.

Whatever clinicians need to support their ability to manage their patients.

1-855-227-7272

Monday-Friday • 9:00am – 5:00pm

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CAP/RP Consultations are for Prescribers

- Prescribers: physician, NP, PA, Resident, Fellow
- Practicing in OBGYN, MFM, Family Medicine, Internal Medicine, Neurology, Pediatrics, Med/Peds, Psychiatry…
- Location: Inpatient, outpatient, ER, private practice, etc.

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What happens when you call?

- Prescriber, *or other staff,* can start the consultation **1-855-227-7272**
- Liaison Coordinator answers the call and takes down clinician info and summary of patient case.
- Perinatal or child/adolescent psychiatrist calls back prescriber at the preferred phone number/time (within 30 minutes or at convenience of the caller).
- We welcome repeat calls so that we may help you manage psychiatric disorders in your patients over time.

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Examples of consultative questions

- Preconception counseling on use of psychotropic medications
- How to screen for and diagnose common mood/anxiety disorders
- How to assess patient risk of harm to self/other
  - My patient scored a “2” on Q10 of the EPDS, what do I do next?
- How to start/maintain/transition psychotropic use in gestation and lactation
  - My patient is prescribed lithium, should I tell her to stop it?
  - My patient wants to breastfeed, is it OK to start her on fluoxetine for depression?
  - Should I reduce my patient’s SSRI dose prior to delivery to reduce risk of PNAS?

We welcome repeated calls so that we may help you manage mental health disorders in your patients across the perinatal period.

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Referrals and Linkages

Our Liaison Coordinators (LCs), are experts in helping primary care clinicians and families identify and access community mental health and support services including:

- Clinical treatment
- Care management
- Patient and family support

Project TEACH provides referrals to primary care clinicians for

- Children and adolescents (up to age 22)
- Women with maternal mental health concerns.

NOTE: We do not interface directly with patients.

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Training

Project TEACH offers free, CME trainings in several different formats for primary care clinicians serving children and adolescents as well as peripartum individuals with mental health concerns.

These programs support the clinician's ability to assess, treat and manage mild-to-moderate mental health concerns in their practices.

www.projectteachny.org

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Webinar Wednesday Series

Child and Adolescent Webinars • Noon – 1 pm • 1.0 CME

Dec. 18th **"Are You Saying It's All in My Head? Addressing Somatic Symptom Disorder and Related Conditions in Primary Care"**
Presented by Michael Scharf, MD

Maternal Mental Health Webinars • Noon – 1 pm • 1.0 CME

Nov. 20th **"Substance Use Disorders in Pregnancy and Peripartum: Principles of Management"**
Presented by Seetha Ramanathan, MD and Tolani Ajagbe, MD, FASAM

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Click Here to Register for the Webinar Series!

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Stay in touch with us, access resources and register for no-cost CME

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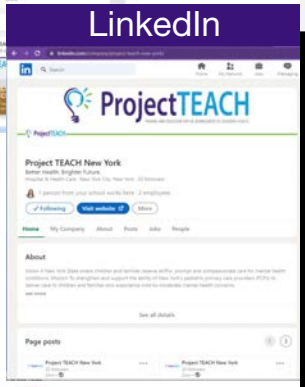

Website - www.ProjectTEACHny.org

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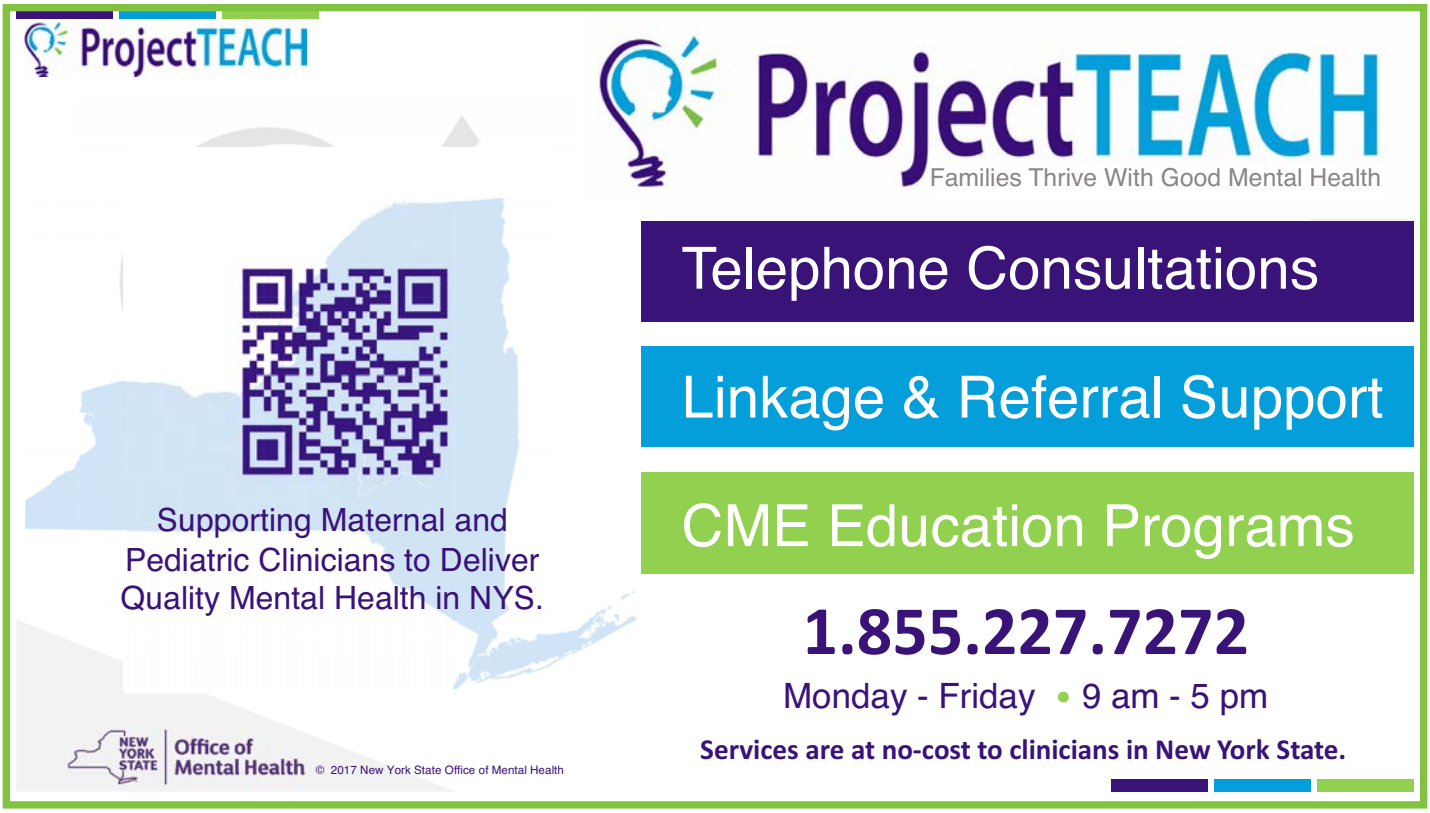
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Families Thrive With Good Mental Health
Telephone Consultations
Linkage & Referral Support
CME Education Programs
Supporting Maternal and Pediatric Clinicians to Deliver Quality Mental Health in NYS.
1.855.227.7272
Monday - Friday • 9 am - 5 pm
Services are at no-cost to clinicians in New York State.
NEW YORK STATE
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HARLEM UNITED

Advancing health equity since 1988

HARLEM UNITED

- Healthcare
- Housing
- Integrated Harm Reduction
- ...and More

Mobile Medical Unit
Serving our community

What We Do

- Low-threshold medical services
- Chronic disease management
- STI testing and treatment
- Low-threshold substance use treatment
- Street outreach
- GYN
- Immunizations
- Connection to brick-and-mortar primary care

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Key Populations

- Unstably housed
- People who use drugs
- Uninsured, underinsured

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Goals

- Provide quality care to vulnerable populations
- Harm Reduction
- Stable presence in the community
- Collaboration with other community-based organizations

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Filling in the Gaps

- Rates of positive TB Quantiferon higher on mobile unit (16%)
- Newly arrived migrants, people living in congregate settings
- What does this signal to us as providers?

Column Labels				
INDETERMIN	NEGATIVE	POSITIVE	Grand Total	
1	162	16	179	9%
1	102	6	109	6%
	45	7	52	13%
	41	6	47	13%
	65	7	72	10%
3	200	39	242	16%
4	171	17	192	9%
1	83	14	98	14%
4	362	36	402	9%
14	**1231**	**148**	**1393**	11%

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Filling in the Gaps

Clinic Locations

Bronx	
Morrisania Chest Center	1309 Fulton Avenue, First Floor 718-838-6876
Brooklyn	
Fort Greene Chest Center	295 Flatbush Avenue Extension, Fourth Floor 718-249-1468
Manhattan	
Washington Heights Chest Center	The Washington Heights Chest Center remains closed at this time.
Queens	
Corona Chest Center	34-33 Junction Boulevard, Second Floor Jackson Heights 718-396-5134

- For uninsured patients, chest xray options are limited
- Lack of locations
- "financial counseling" appointments at H&H before any appointments if uninsured

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Where We Are Now

- Re-launch of mobile unit after COVID-19 pandemic
- Full-time mobile unit provider with a driver/POA
- Mobile unit in the field 3 days per week
- Rotating and evolving calendar with CBOs

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Challenges

- Mobile units are big, unique, motor vehicles
- Parking
- Equipment
- Finding staff that fits our needs
- Task designation
- Shifting model of care as a provider while on the mobile unit
- Eventual need for connection to "traditional" care or specialty

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Next Steps

- Our re-relaunch :)
- Permanence of locations for extended period
- Stable flow of care (labs, vaccines, etc)
- Build a team that is passionate about mobile health, health equity, and committed to non-traditional forms of care

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Get in Touch!

Betty Lee – blee@harlemunited.org
The Nest - 169 W 133rd Street
646-762-4950, C- 929-407-7631

General Support – intake@harlemunited.org

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References

- https://pmc.ncbi.nlm.nih.gov/articles/PMC8463055/#:~:text=11.1%25%20of%20ED%20patients%20had,does%20this%20improve%20population%20health%3F
- https://www.cdc.gov/mmwr/volumes/72/wr/mm7242a6.htm#:~:text=The%20rate%20of%20visits%20to,2021%20compared%20with%202018%E2%80%932019.
- https://www.cdc.gov/mmwr/volumes/73/wr/pdfs/mm7312a4-H.pdf

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Thank you

More information at harlemunited.org

montekids.org

Montefiore's HealthySteps Program

Polina Umylny, PhD
Director, HealthySteps at Montefiore
Montefiore Medical Center
11/15/2024

HealthySteps
PEDIATRIC CARE • SUPPORTING • PARENTING

The Children's Hospital at Montefiore

THE PEDIATRIC HOSPITAL FOR:
EINSTEIN
Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Who we are

Montefiore's HealthySteps program provides preventive behavioral health services to families with children 0-4yrs who receive care at a MMG primary care practices.

HealthySteps is an evidence-based, interdisciplinary program that places a behavioral health provider into Pediatrics to support families raising babies and toddlers, with an emphasis on families living in low-income communities.

HealthySteps promotes improved outcomes in 4 priority areas: well-child visit adherence, child growth & development, maternal depression management & early relational health.

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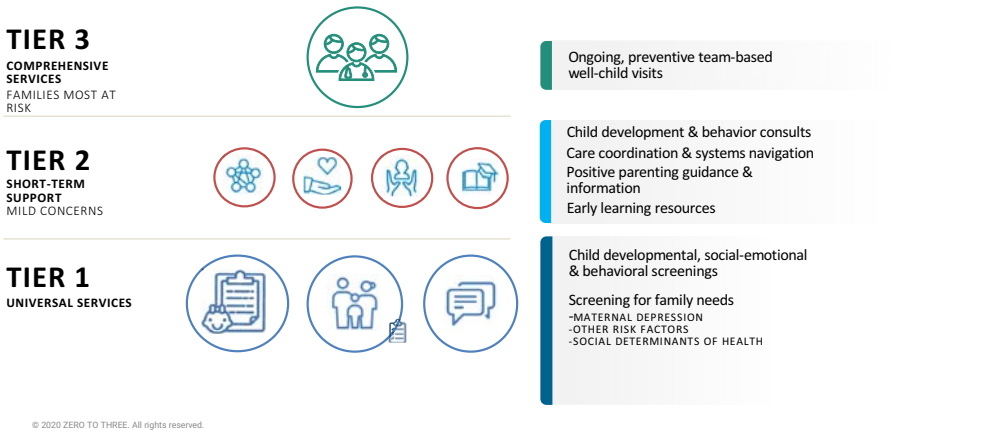
HealthySteps

2

HealthySteps Tiers of Intervention



HealthySteps

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Context

- Montefiore serves 16,174 pts aged 0-4 across 19 primary care practices in the Bronx and lower Westchester County
  - Social emotional, developmental, autism, parental needs screenings at well child visits
  - On site HealthySteps Services or case management
- 41% of all MMG patients have Medicaid (FFS & Managed), which is comparable to 43% of Bronx County
- Compared to HS pts across NYC, Montefiore's HS patients more likely to be Black & Hispanic, with higher rate of NICU use and complex chronic conditions.

HealthySteps

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Rationale

- 87% work hard to be a better parent
- 73% say parenting is their greatest challenge
- 69% say that if they knew more positive parenting strategies, they would use them
- 54% wish they had more information about how to be a better parent
- 52% say they don't get the support they need when they are overwhelmed or stressed

Parents Want More Help (ZERO TO THREE Parenting Survey, 2016)
Tuning In: Parents of Young Children Speak Up about What They Think, Know and Need, 2016

Why Start So Young?

Toxic stress derails development, disrupts brain architecture & is related to negative infant & early childhood mental health outcomes

Facilitating supportive adult-child relationships (attachment), with consistent & responsive caregivers, supports resilience, which can make toxic stress "tolerable"

Changing Developmental Trajectories

Exposure to Trauma

- Children aged 0-3 are most likely to be exposed to violence
- An estimated 2-3x more preschool-aged children in the U.S. exhibit trauma-related impairment than are diagnosed

Developmental Delay & Disability

- 25% children < 5 yrs are at risk for developmental delay or disability
- Less than 50% of these kids are identified before school age
- 21% of 3-5year olds have an IEP in the Bronx, compared to 12% citywide

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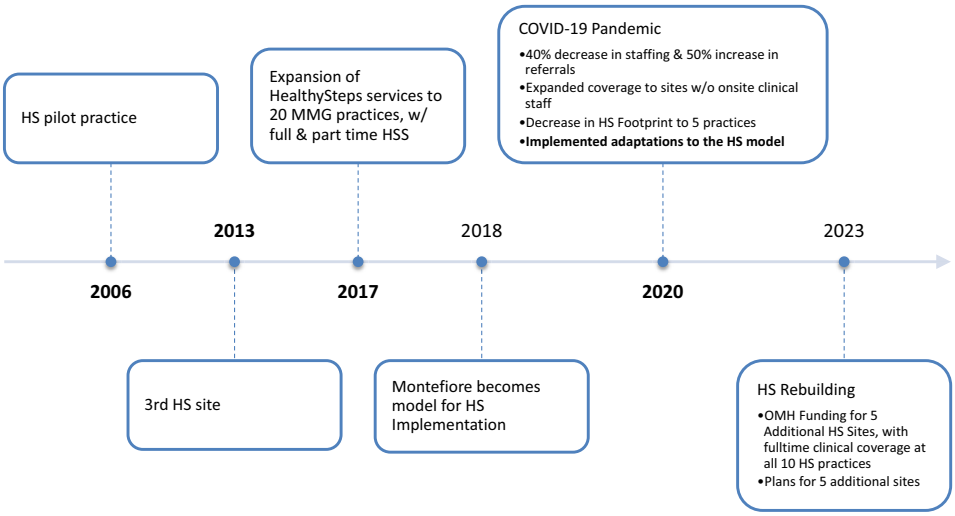
History of HealthySteps at Montefiore



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The Innovation

- Expand HealthySteps services across all MMG practices
  - In person on site clinician
  - Virtual groups
  - Case management services for sites w/o on site clinician
  - EI referrals through Epic

HealthySteps

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Key elements of the Innovation

- Increase applicant pool for HealthySteps Specialist and build an Infant Mental Health workforce
- What has been tried before?
  - Full & part time HS model
  - Limit to doctoral level providers
- Why this approach is unique and innovative?
  - Provides training & reflective supervision as part of full-time clinical position
- If this is a collaboration, who are the partners?
  - NYS-AIMH
  - HS National

HealthySteps

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Key Elements of the Innovation

- Hire clinicians to expand on-site full-time HS clinical support to 15 MMG practices
- Improve screening for social-emotional and developmental concerns, Autism and family needs (e.g., PPD) across all practices
- Track and improve rates of connection to community resources, including completed EI evaluations for referred patients
- Offer virtual groups for parents (i.e., ASD parent support group, prenatal HS group)
- Work with billing/finance team to better understand reimbursement, as part of sustainability efforts

HealthySteps

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Healthfirst 2012 Fall Symposium
Effective Care for Children

Milestones

Starting in 2023, recruited 7 masters level clinicians, with 10 HS practices	Clinicians receive didactics & individual and group supervision
Rolled out additional screening touchpoints, with all 0-3 pts receiving social-emotional & developmental screening annually	
Expanded EHR-EI referral process to all MMG practices	
Implementing Epic build intended to track metrics important to HS services	

Results to Date

- Children whose mothers reported childhood trauma scored better on social-emotional screening after receiving HealthySteps services
- HealthySteps children at risk of social-emotional challenges had significantly lower rates of obesity at age 5 than comparable children not participating in HealthySteps
- Children who screened positive on 18 mos MCHAT had median diagnosis age of 2 yrs, 2 mos, compared to national average of 4yrs, 4mos
- Mothers of Montefiore's HS pts had higher rate of SNAP use and more likely to have poor baseline health status, including higher rates of mental illness.
- HS associated with greater engagement in primary care & continuity at WCV

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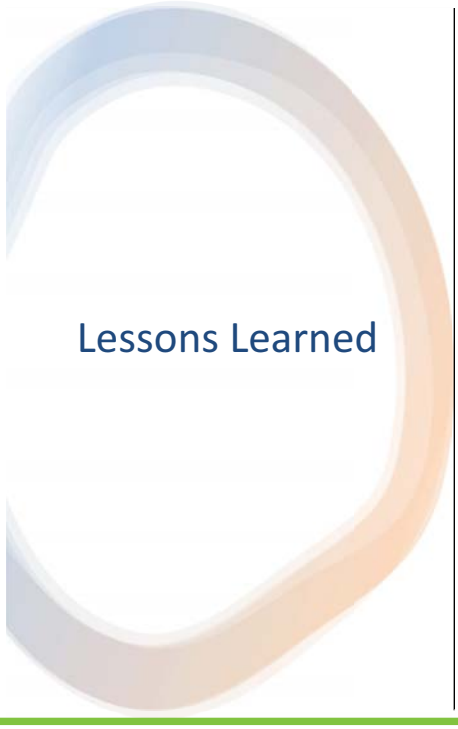


- A summary of lessons learned thus far
  - What worked!
    - Collaboration across disciplines
    - Support of MMG leadership to build infrastructure (e.g., Epic builds, supervisory staff, designate time for training)
  - Challenges that arose
    - Office space
    - Stressors of primary care
    - Contracting/logistics
  - What might have been done differently
    - Expanding infrastructure for supervision/training earlier in the process

HealthySteps

Montefiore
THE UNIVERSITY HOSPITAL FOR ALBERT EINSTEIN COLLEGE OF MEDICINE

14

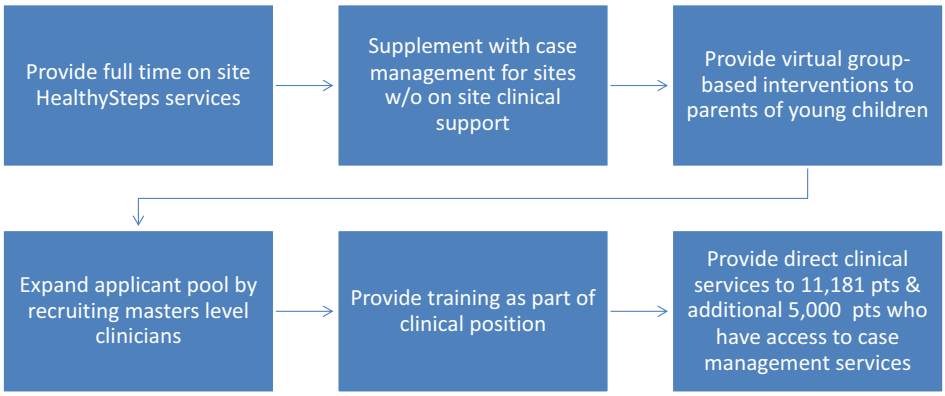
Big Picture

- Providing population-based health to a high-needs community requires flexibility, collaboration and leadership support

Implication & Next Steps

- Full-time HS support provides on site clinical infrastructure
  - Clinicians are available for risk assessments, consultations with medical staff, etc.,
  - Can work with older children, when/if schedule allows
- Teaching/training can be built into a clinical position, with leadership support
- Next Steps
  - Track metrics for current 10 practices, continue to improve care
  - Assess potential for sustainability of services through reimbursement
  - Continue expansion

Summary of Montefiore's HealthySteps Innovation



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Contact information

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  - Montefiore Medical Center
  - 929-687-3984
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HOUSING WORKS COMMUNITY HEALTHCARE

HOUSING WORKS

CONNECT

PEOPLE HEAL IN COMMUNITY

Presented by Melissa Lanspery, LCSW
Program Manager for Clinical Integration
CONNECT, Behavioral Health Services
Housing Works

HOUSING WORKS COMMUNITY HEALTHCARE

CONNECT

What is CONNECT?

- Continuous Engagement between Community and Clinic Treatment- CONNECT is a community-based program that expands the capacity of existing licensed OMH /Article 31 mental health programs by engaging the clinic's surrounding community in the development and design of enhanced services.
- CONNECT seeks to empower through education, intervention, and connection.
- Department of Health and Mental Hygiene (DOHMH) Demonstration Project
- Began in July 2021
- Demonstration project

HOUSING WORKS COMMUNITY HEALTHCARE

- CONNECT works to address elevated mental health needs across NYC
- More demand than capacity for clinic and mobile treatment
- CONNECT aims to reduce waitlist time for mental health treatment across clinic and mobile treatment, increase engagement and retention for persons leaving jail
- CONNECT Programs expand through Harlem, Lower Manhattan, Brooklyn, and the Bronx
- Our CONNECT program is currently located in Harlem

HOUSING WORKS COMMUNITY HEALTHCARE

CONNECT conducted a community needs survey in 2022 and asked the question, "What are some of the challenges you see in your community?"

Out of 130 individuals surveyed, the greatest challenges are listed below:

- Substance use
- Housing
- Homelessness
- Community safety
- Unemployment

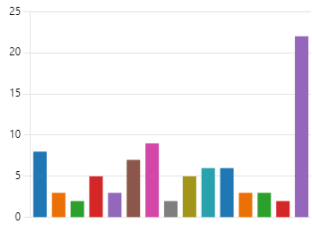
HOUSING WORKS COMMUNITY HEALTHCARE

CONNECT CE 2023 Q2 Summary
Harlem Findings (pulled from Microsoft Survey Forms):

2. What are some of the most prominent challenges that you see in your community? (You can select multiple answers and/or write your own in the "other" field).

More Details

Community Safety	8
Healthcare	3
Unemployment	2
Sanitation	5
Socialization	3
Housing	7
Mental Health	9
Cost of Living	2
Substance Use	5
Homelessness	6
Lack of Resources	6
Food Scarcity/Quality	3
Information Sharing	3
Poverty	2
Other	22



HOUSING WORKS COMMUNITY HEALTHCARE

Community Connection

The value of this project to empower communities through education, intervention, and connection. One of the aims of the program is to reduce mental health stigma, reduce barriers to care, and increase access to care to populations that have historically been underserved or have been less likely to seek traditional clinic services.

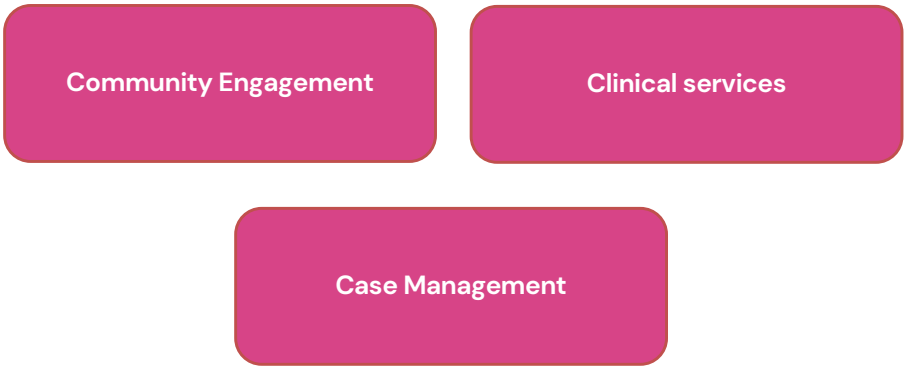
HOUSING WORKS COMMUNITY HEALTHCARE

CONNECT target population

- Person 18 or older
- Resident of Harlem
- Diagnosis or experience of emotional health concerns and/or distress
- Recently released from jail or prison
- Stepping down from mobile treatment services (ACT, FACT, SPACT, IMT) • Awaiting services or as a diversion for other SPOA services (ACT, FACT, SPACT, IMT, Care Coordination)
- CONNECT serves all eligible individuals regardless of immigration and insurance status.

HOUSING WORKS COMMUNITY HEALTHCARE

CONNECT Services



HOUSING WORKS COMMUNITY HEALTHCARE

Community Engagement

- Engages the clinic's surrounding community in the development and design of clinic services (initial and ongoing conversations with the community)
- Provides non-clinical support services identified by the community as important to community mental health and quality of life
- Community needs survey
- Wellness workshops and groups

HOUSING WORKS COMMUNITY HEALTHCARE

Clinical services

- Psychotherapists conduct in home, tele-health, community, and in office sessions with clients who live in the Harlem catchment area
- Provide all "traditional" clinic services both inside the real/virtual clinic and in the field.
- Less barriers to treatment
- Development of workshops based on needs of the community

HOUSING WORKS COMMUNITY HEALTHCARE

Case management

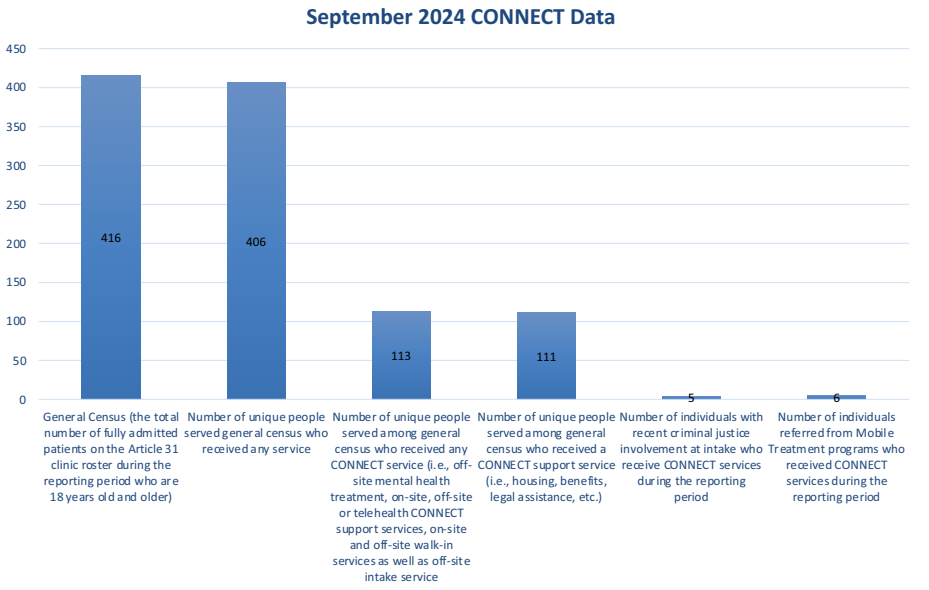
- Conduct field/community engagement and outreach, case management services, peer, family, employment and education supports.
- Case managers support clients with various needs to help clients connect to resources in their community. These needs can vary from housing, gaining medical and mental health providers, finding food resources and help with gaining benefit assistance.
- Carter Richmond Assessment Tool for assessing client current needs and service plan
  - Score of In Crisis (1)- Thriving (5)
  - Assessment of the following areas: Housing, Health and Medical Adherence, Substance Use, Income, Education, Income, and ADLS

HOUSING WORKS COMMUNITY HEALTHCARE

What is the effectiveness?

- The demonstration project has shown to be effective in all program areas (Clinical, Case Management, and Community Engagement).
- Clients have consistently stayed with CONNECT services since the start of the program in 2021.
- Community engagement activities continue to expand.
- Increase in referrals from internal providers

HOUSING WORKS COMMUNITY HEALTHCARE



HOUSING WORKS COMMUNITY HEALTHCARE

Number of unique people among community (not in general census and who are 18 years and older) who received a CONNECT service (e.g., pending or not fully admitted patients, article 32 patients, community members): **518**

HOUSING WORKS COMMUNITY HEALTHCARE

Key next steps:

- Continue to grow our outreach efforts
- Continue to survey the community for ongoing needs
- 2025: RFP

HOUSING WORKS COMMUNITY HEALTHCARE

Lessons learned

- Communities has responded positively to programming with limited barriers by addressing the needs they are identifying.
- There is an ongoing need for community-based mental health and wellness services.
- Wrap around mental health and wellness services support reduces wait time lists for ACT stepdown clients and overall access to mental health services.

HOUSING WORKS COMMUNITY HEALTHCARE

CONNECT aims to empower through education, intervention, and connection. The benefits of CONNECT include providing services in the field (from home or non-clinic community location). Services include psychotherapy, medication management, crisis intervention, case management, and outreach.

CONNECT serves all eligible individual regardless of immigration or insurance status.

HOUSING WORKS COMMUNITY HEALTHCARE

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HOUSING WORKS CONNECT
PEOPLE HEAL IN COMMUNITY

HOUSING WORKS COMMUNITY HEALTHCARE

Photo caption

HOUSING WORKS COMMUNITY HEALTHCARE

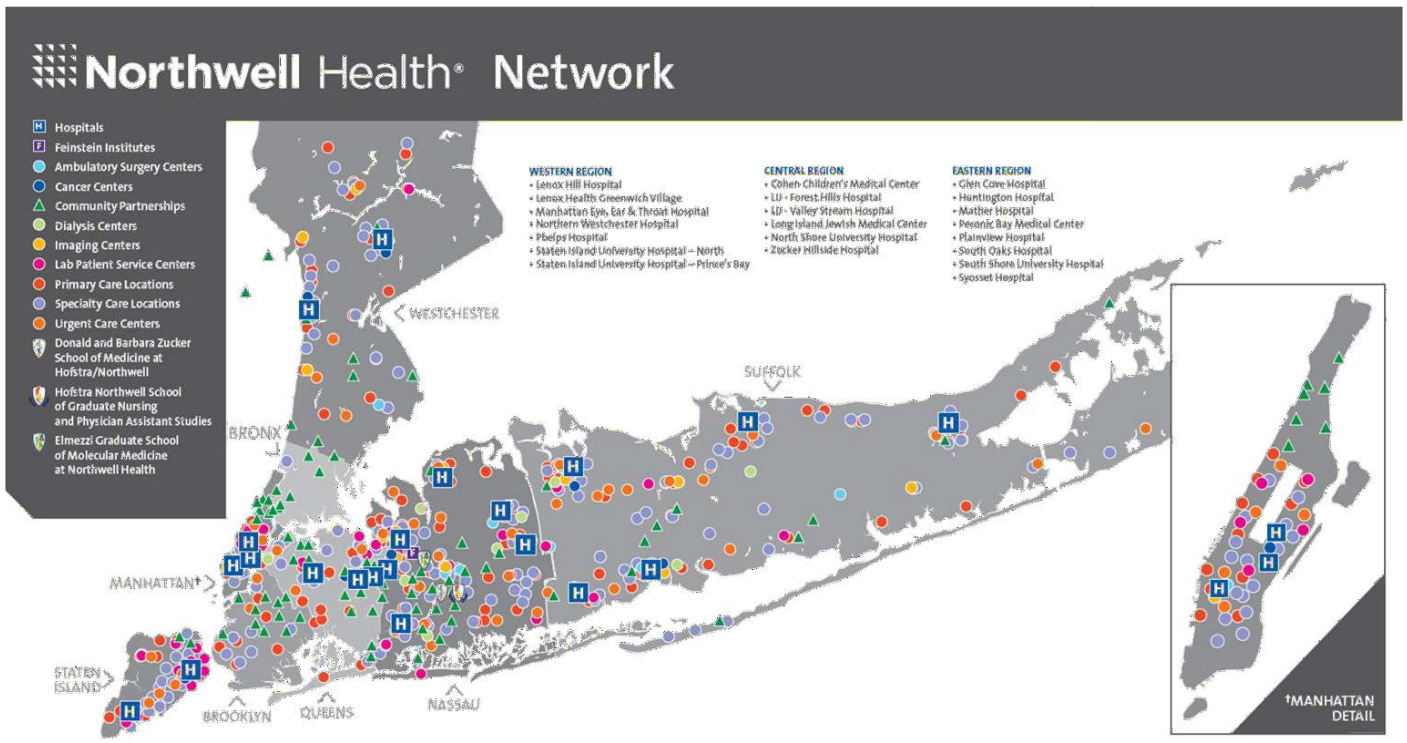
Thank You!

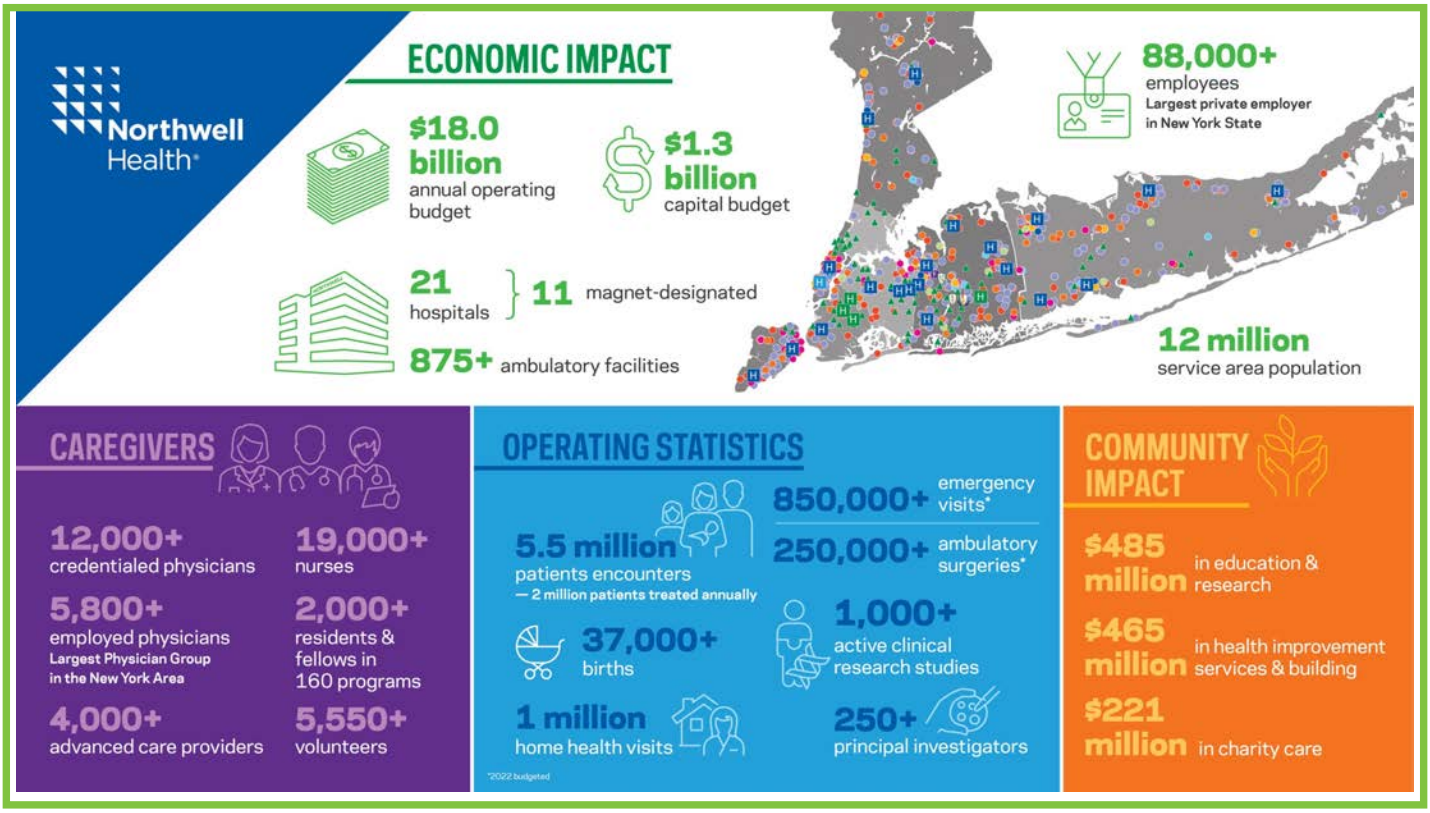
Q&A

BEHAVIORAL HEALTH INTEGRATION AT NORTHWELL

Manish Sapra, MD,MMM, FAPA
Executive Director
Behavioral Health Service Line
Northwell Health

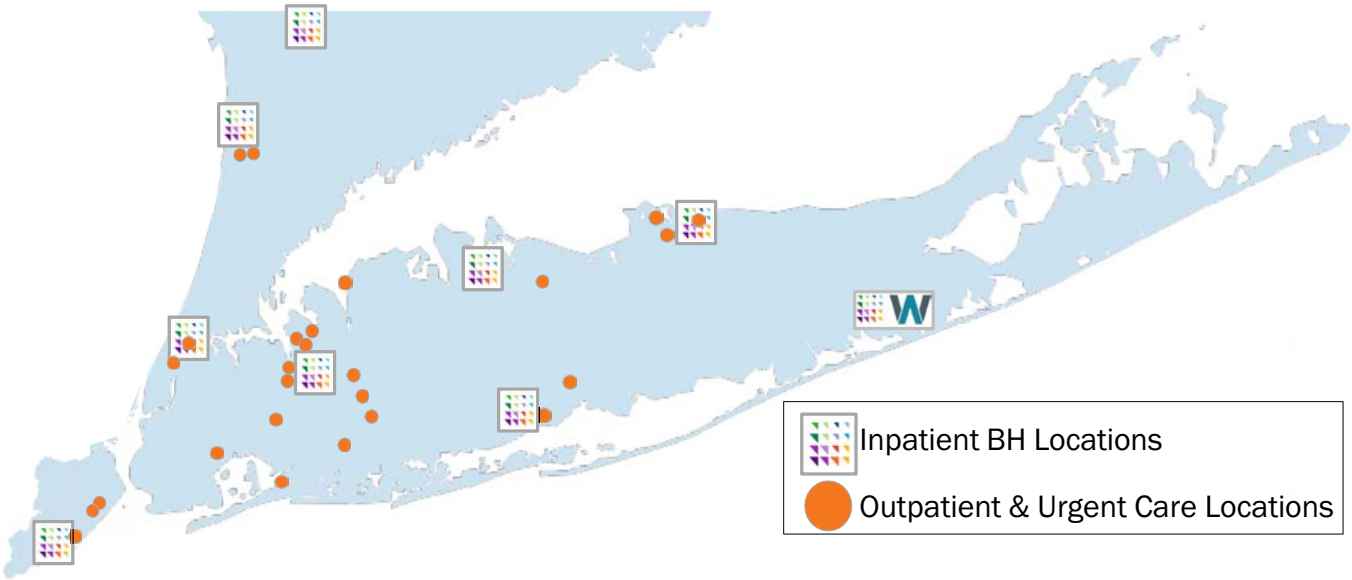
November 2024



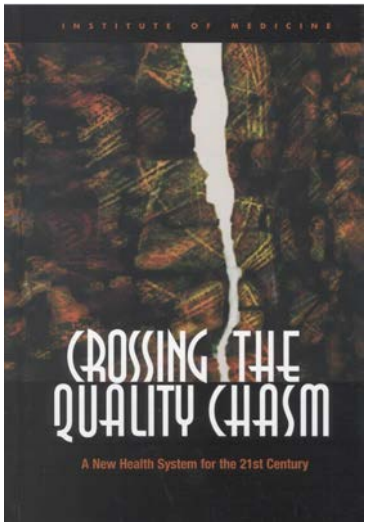


THE NORTHWELL HEALTH PSYCHIATRY LANDSCAPE

Inpatient and Outpatient Behavioral Health Locations



THE CRISIS AT HAND: ACCESS



- Some bright spots of truly outstanding care but many areas of sub-optimal care
- Lack of translation of best practice and research findings to everyday care
- Limited uptake of evidence-based treatment and measurement-based treatment (particularly in behavioral health)
- Outdated clinical models and methods of training

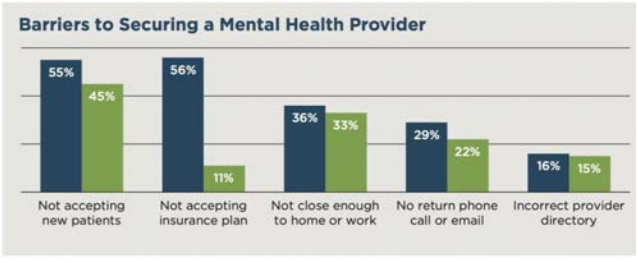
THE CRISIS AT HAND: ACCESS


The New York Times

'Nobody Has Openings': Mental Health Providers Struggle to Meet Demand

With anxiety and depression on the rise during the pandemic, it has been challenging for people to get the help they need.

https://www.nytimes.com/2021/02/17/well/mind/therapy-appointments-shortages-pandemic.html



https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out

THE CRISIS AT HAND: EQUITY

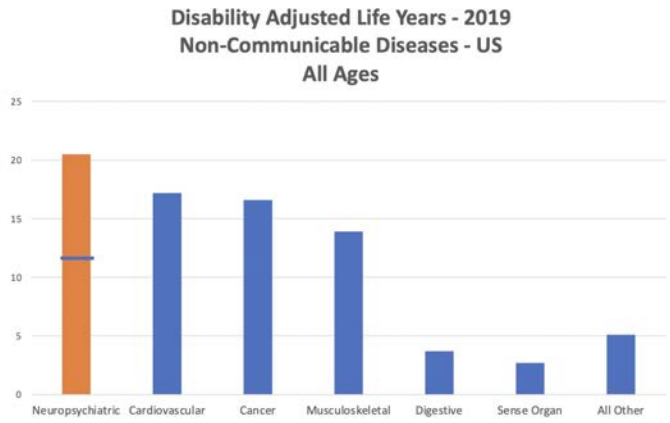


Fig 1.1 Disability adjusted life years (DALYs) yield a single number that combines years lost to premature death and chronic disability. The y-axis represents DALYs (in millions) for non-communicable (non-infectious) diseases in the U.S. in 2019. Neuropsychiatric combines mental disorders, substance use disorders, and neurological disorders. The line on this bar represents mental disorders and substance use disorders together. Data from Institute of Health Metrics and Evaluation. https://vizhub.healthdata.org/gbd-compare/

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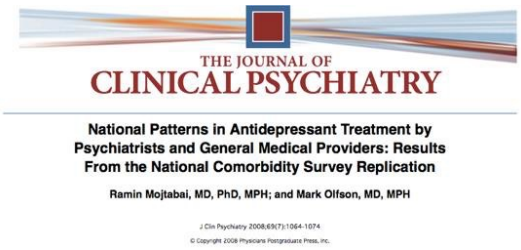
THE PRIMARY CARE ADVANTAGE

Why Primary Care?

- Large volume of patients
- Longitudinal relationship and trust
- Decreased burden of stigma
- Accessibility


THE JOURNAL OF
CLINICAL PSYCHIATRY

National Patterns in Antidepressant Treatment by Psychiatrists and General Medical Providers: Results From the National Comorbidity Survey Replication

Ramin Mojtabai, MD, PhD, MPH; and Mark Olfson, MD, MPH

J Clin Psychiatry 2008;69(7):1064-1074

Primary care physicians, rather than psychiatrists prescribe a majority of psychotropic medications in the United States. Those treated by PCP's less likely to meet criteria for mood or anxiety disorders or to continue medication beyond the first month. Quality improvement initiatives should focus on better targeting and continuity of depression medications.

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EFFECTS OF BH INTEGRATION ON COST

- Patients participating in the IMPACT trial of depression collaborative care for older adults had lower mean total health care costs than patients who received usual care over the four-year period. The IMPACT study suggested that up to $6 are saved in long term health care costs for patients **for every dollar spent on collaborative care, a return on investment of 6:1**

Jurgen Unutzer et al., "Long-term Cost Effects of Collaborative Care for Late-life Depression", *American Journal of Managed Care* 14, no. 2 (2008): 95-100.

- In a study of adult patients with **diabetes and depression**, researchers found that those who received depression collaborative care had an incremental **net benefit of $1,129 over two years of treatment**. The study concluded that this intervention is "a **high-value investment for older adults with diabetes.**" Collaborative care was associated with high clinical benefits at no greater cost than usual care.

Wayne Katon et al., "Cost-Effectiveness and Net Benefit of Enhanced Treatment of Depression for Older Adults with Diabetes and Depression," *Diabetes Care* 29, no. 2 (2006): 265-70.

VIEWPOINT

COVID-19: BEYOND TOMORROW

Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19

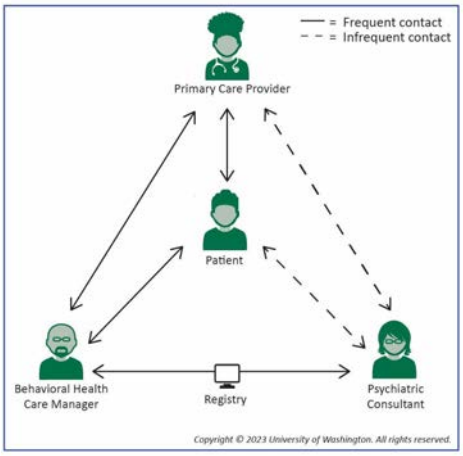
*"To meet the increased mental health service needs during COVID-19, health care systems nationwide must being to quickly implement integrated mental health delivery models that are scalable, flexible and sustainable.... **CoCM should form the backbone of our mental health care response** to this pandemic and the challenges that lie beyond it."*

Carlo, Andrew D., Brian S. Barnett, and Jürgen Unützer. "Harnessing collaborative care to meet mental health demands in the era of COVID-19." *JAMA psychiatry* 78.4 (2021): 355-356.

Table. COVID-19 Mental Health Challenges and CoCM-Driven Solutions

COVID-19 mental health challenge	CoCM-driven solution
Hospitals and health care systems need evidence-based, scalable treatment models to manage the increased incidence of mental health problems in the wake of the COVID-19 pandemic	CoCM is a scalable population health intervention that has been shown to be effective in >80 randomized clinical trials across diverse settings, diagnoses, and populations[2]
COVID-19 has exacerbated existing disparities in health care, particularly for racial/ethnic minorities and vulnerable populations	Implementation of CoCM has been shown to reduce racial/ethnic depression outcome disparities in primary care[4]
In the era of COVID-19, primary care mental health needs have increased, and mental health problems require substantial time and coordination for proper diagnosis and effective treatment	CoCM enables PCPs to deliver higher-quality mental health treatment by supplementing existing services with a designated team[2]
COVID-19 has created a rapidly growing need for trauma-focused treatment, but the number of specialty-trained clinicians is limited	CoCM has been shown to be effective for posttraumatic stress disorder in multiple randomized clinical trials (including through telehealth delivery)[3]
Provision of in-person mental health services is challenging in this era of social distancing guidelines, and much of primary care has transitioned to virtual delivery	Research has shown that CoCM is effective through remote telehealth delivery[3]; CoCM billing codes account for services delivered virtually between in-person visits and are billed in the name of the PCP (partially mitigating specialty mental health insurance network adequacy problems)[3]
COVID-19 survivors may have complex neuropsychiatric symptoms and require coordinated medical, neurologic, and mental health treatment	CoCM is an inherently integrated, multidisciplinary strategy for treating chronic physical and mental health problems in the primary medical setting[2]
A need exists for proactive outreach to high-risk populations to screen for common mental health problems in the era of COVID-19 and beyond	The CoCM behavioral health care manager uses a population health approach[2] that can easily be directed toward high-risk populations, such as frontline health care workers or patients recovering from COVID-19 infection

BEHAVIORAL HEALTH COLLABORATIVE CARE PROGRAM: OVERVIEW



Target Population

Adult, Pediatric and OB patients enrolled in primary care practices and
A) experiencing mild-moderate symptoms of depression and/or anxiety or
B) experiencing any other behavioral health symptoms requiring clinical intervention

Care Team

Behavioral Health Counselor, supervised by a psychiatrist and working in collaboration with PCP

Clinical Interventions

-Assessment
-Medication Management
-Short term psychotherapy
-Telepsychiatry
-Care Coordination/Linkage

Key Performance Measures

Clinical improvement in depression and/or anxiety.
Successful linkage to long term BH providers

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COLLABORATIVE CARE MODEL

Assessment	Brief Therapy	Collaborative Med. Mgmt	Tele psych Consultation	Care Coordination
Targeted clinical and needs assessment; rating scales (PHQ, GAD) for any BH need	6-8 session time limited psychotherapy (CBT, PST, MI) for mild moderate depression, anxiety, ADHD	Med rec. and co-management; curbside consultation for mild moderate depression, anxiety, ADHD	Telehealth consultation and bridging treatment for Moderate-Severe: Depression, Anxiety, ADHD, Other	Linkage to appropriate BH supports for any BH need
# Referrals	**Improvement Rate**			**# Referrals** **% Successful linkages**

35 Pediatric Embedded Practices

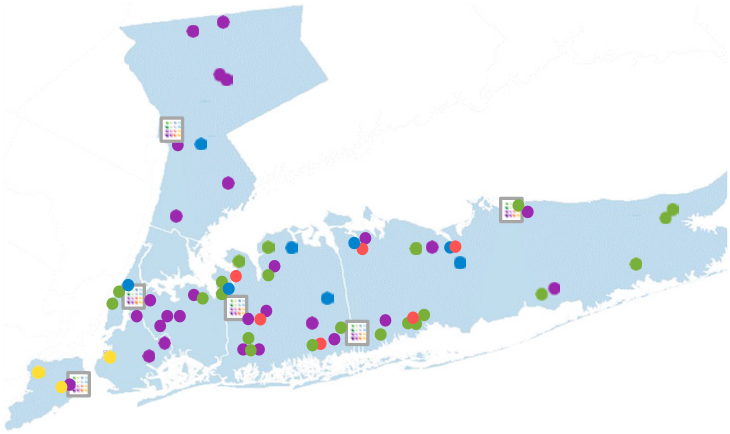
26 Adult Care Coordination Practices

12 Adult Embedded Practices

8 OB/GYN Embedded Practices

3 Adult UPG Practices

30,358 Patients seen since inception (November 2017)



Year	Total Unique Pts	Total Pt Visits
2023	9117	16087
2024 (Jan - Aug)	7171	12771

- 60.8% average improvement rate in depression (reduction in PHQ-9 by 50% or below 10) N= 200 patients

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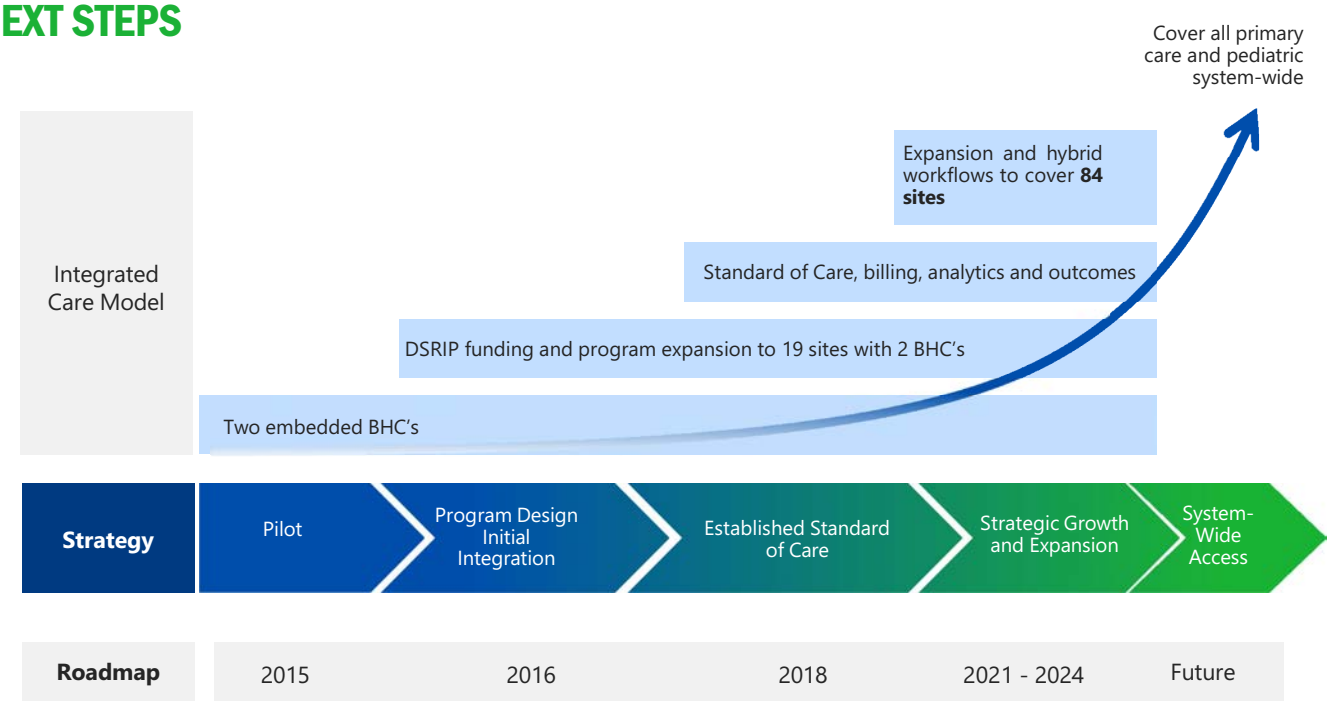
LESSONS LEARNED – COMMON COCM PITFALLS

- Inconsistent screening and data capture
- PCP's not participating in engagement/warm handoff
- Poorly defining target population and intervention
- Case managers acting primarily as therapists/ providing long term treatment
- Psychiatrist not consistently reviewing "non-responders"

NEXT STEPS



NEXT STEPS – STRATEGY TO GROW BH INTEGRATION

- Embedding behavioral health counselors into 3 faith-based organizations

HOPE & GRACE
Mental Health Center

Northwell Health®

SUMMARY

- Embedding behavioral health integration in primary care is a population health-based strategy
- Allows dissemination of psychiatric expertise to broader population without significant investment
- Collaborative care is a well studied evidence-based model
- Revenue models still need to catch up to support broad scaled collaborative care implementation

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THANK YOU!

About Healthfirst

Healthfirst is New York's largest not-for-profit health insurer, earning the trust of 1.9 million members by offering access to affordable healthcare. Sponsored by New York City's leading hospitals, Healthfirst's unique advantage is rooted in its mission to put members first by working closely with its broad network of providers on shared goals. Healthfirst takes pride in being pioneers of the value-based care model, recognized as a national best practice. For nearly 30 years, Healthfirst has built its reputation in the community for top-quality products and services New Yorkers can depend on. It has grown significantly to serve the needs of members, offering market-leading products to fit every life stage, including Medicaid plans, Medicare Advantage plans, long-term care plans, qualified health plans, and individual and small group plans. Healthfirst serves members in New York City and on Long Island, as well as in Westchester, Sullivan, and Orange counties. For more information about Healthfirst, visit healthfirst.org.

About Healthfirst Advance

Healthfirst ADVANCE represents a culmination of Healthfirst's 30-year commitment to value-based care and the belief that health equity can only be achieved when organizations work together to tackle systemic barriers. Healthfirst's health equity programs are only possible because of the hard work and collaboration with its invaluable provider and community partners. Read case studies, first-person health equity views, and more at ADVANCE | Healthfirst.

Thank you for attending Healthfirst's 2024 Fall Provider Symposium - Evolving Models of Care: Bridging the Gap Between Behavioral Health and Primary Care.

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