PRIMARY CARE DEVELOPMENT CORPORATION

CLOSING THE BEHAVIORAL HEALTH INTEGRATION GAP

A NEW YORK CASE STUDY

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CONTENTS

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EXECUTIVE SUMMARY

SECTION 1.0

1.0 EXECUTIVE SUMMARY

For decades it has been well documented that individuals with co-occurring physical and mental health conditions, particularly those with serious mental illness (SMI) and substance use disorders (SUDs), face worse health outcomes and have mortality rates averaging 8 years lower than persons without behavioral health challenges and costs are an estimated two to three times higher.

In the United States (U.S.), health care is typically provided in silos with limited interaction or coordination between primary care and behavioral health providers. Although primary care providers are increasingly screening for and treating common behavioral health conditions such as depression and anxiety, they only reach a fraction of people who require services.[1] Meanwhile, those living with SMI, who are often seen in behavioral health settings, generally lack access to adequate primary care.[2,3]

One innovation to address the evident need to improve outcomes and reduce costs in the current delivery system is the integration of behavioral health and primary care for patients with mental and physical health comorbidities. The Agency for Health Care Research and Quality defines behavioral health integration (BHI) as "the systematic linkage of mental health and primary care providers and [requires] communication or coordination between providers to meet both the mental and general health needs of the patient."[4] BHI exists on a spectrum of care and may include coordinated care, co-located care, and fully collaborative care and management. There is no "correct" model or direction of integration — health providers must adapt and implement the most appropriate mode of care for their population and setting.

As an organization that has financed and supported the development and expansion of integrated care centers both locally and nationally, the **Primary Care Development Corporation (PCDC)** was interested in conducting a qualitative evaluation of BHI initiatives to better understand and advocate for solutions to push integration forward. To accomplish this, PCDC conducted a comprehensive review of existing models of integration and their implementation. PCDC then engaged in a case study of one example of organizational integration, and convened a roundtable of State-wide leaders and subject matter experts to determine an initial set of recommendations. These recommendations were shared with New York State (NYS) regulatory agencies and made public at a town hall that convened behavioral health, primary care, and regulatory stakeholders (Summit). The initial recommendations, combined with commentary and feedback from experts, culminated in this final set of recommendations focused on five key domains with complementary action steps for regulators, health centers, providers, and educational institutions.

This report focuses on the integration of primary care into behavioral health, where the gap between chronic health conditions and medical care is perhaps most profound. While the call to integrate behavioral health and primary care to better serve patients has resonated widely, there are still significant barriers to successful, widespread implementation.

This report serves as a framework for providers, policymakers, and other stakeholders to consider as they implement and advocate for programs and policies that support BHI.

Recommendations

Simplify integrated facility requirements

- Simplify and streamline state regulatory and licensure requirements for co-located primary care and behavioral health facilities

Establish integrated systems to share patient information

- Develop mechanisms for information sharing — both at the point of care and for population health management — using available and effective high- and low-technology tools
- Advocate for the federal government both to consider integrated care needs when certifying electronic health records (EHR) and to promote greater interoperability
- Streamline and reduce duplicative systems and reporting requirements across funding streams and payers

Promote a collaborative team-based approach to care

- Create and implement joint organization policies, protocols, and procedures that reflect a shared vision and culture
- Implement effective bi-directional care transitions, including warm hand offs and same-day visits, and build the necessary schedules, processes, and organizational culture to ensure access and information sharing
- Establish joint responsibility for key physical and behavioral health outcomes and metrics

Ensure bi-directional workforce education

- Develop training and certificate programs to support the pipeline of qualified staff needed for integrated care
- Include integrated, interprofessional care competencies early in graduate and medical training to ensure a foundational understanding of primary and behavioral health care
- Incorporate cross-discipline training in the integration process

Expand financing and reimbursement options for integrated care

- Create financial incentives and mechanisms to increase provider uptake of integrated care models

CONTEXT AND MODELS FOR INTEGRATION

SECTION 2.0

2.0 CONTEXT AND MODELS FOR INTEGRATION

Across the U.S., one in five people have a mental illness and 5 percent of the adult population have a SMI. Individuals living with SMI have higher rates of both acute and chronic medical conditions and adults with SMI die approximately eight years earlier than those without, most often due to treatable medical conditions.[4,5] In addition to overall worse health outcomes, the cost of care for individuals with co-morbid behavioral and physical health conditions can be 60-75% higher than for those without mental health conditions.[6] The need for affordable, accessible, and evidence-based treatments for behavioral health conditions remains high, and it has become increasing clear that the separation of physical and mental health prevention and treatment is not yielding improved health outcomes. BHI, or "the systematic linkage of mental health and primary care providers [that requires] communication or coordination between providers to meet both the mental and general health needs of the patient" is one strategy used to address the above health inequities.[4]

Models of integration can vary widely, ranging from distinct or co-located systems with minimal communication between providers, to comprehensive collaborations between providers and care teams.[5] Furthermore, integration can be bi-directional, integrating primary medical services into a behavioral health setting or behavioral health services into a primary medical setting. Two major models of integrating care have the strongest evidence-base: The Primary Care Behavioral Health (PCBH) model and the Collaborative Care Model (CCM). Along with these models of integration, federal and state reimbursement and grant initiatives have emerged in the past two decades that have shaped the integrated care landscape. Federal agencies including the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicaid and Medicare (CMS), and the Health Resource Services Administration (HRSA) have all developed initiatives aimed at promoting integrated services (e.g., the Primary and Behavioral Health Care Integration [PBHCI] grant program, Medicaid Certified Community Behavioral Health Clinics [CCBHCs] provider designations, and the National Committee for Quality Assurance Patient-Centered Medical Home [PCMH] Program). State agencies, foundations, and private organizations have also generated innovations and programs to further the integration of care, both financially and structurally.

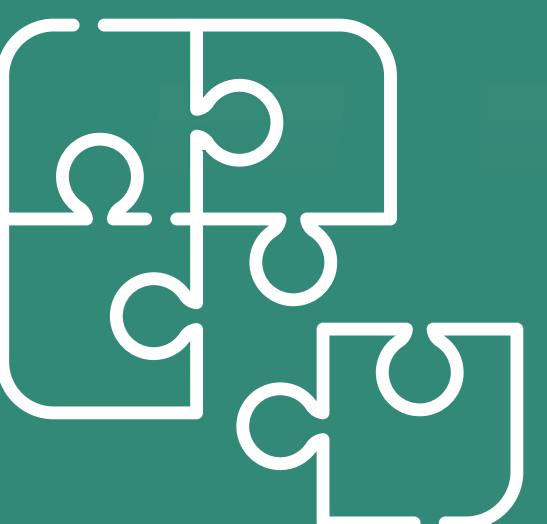
Ultimately, clinics must often blend components of models, and incorporate other care components and considerations (e.g., reimbursement structures, state and federal regulatory requirements) to meet the needs of their patients and communities. Providers and care teams across the country have worked to improve services for people living with mental illness and to improve disease management and preventative services. Yet, integrating medical services into behavioral health settings remains a significant challenge. With each organization that integrates services, more is learned about the path to blend models, develop sustainable fiscal infrastructure, and deliver high-quality coordinated care.

MODELS OF INTEGRATION

*In the **Primary Care Behavioral Health (PCBH) model,** a behavioral health consultant is embedded within a primary care clinic to address a range of needs including depression and weight management, through a small number of brief visits as well as to consult with primary care staff.*

***The Collaborative Care Model (CCM)** is a population health model with a strong evidence base and involves using registries to track patients, typically those with depression, anxiety, or post-traumatic stress disorder, to monitor symptoms, reaction to medication, and engagement in treatment. A care manager- often a nurse-oversees the registry and touchpoints with patients, while a consulting psychiatric provider helps the primary provider make decisions about medications and other treatments.*

MULTIPLE AVENUES FOR INTEGRATION



SECTION 3.0

3.0 MULTIPLE AVENUES FOR INTEGRATION

There is no one "correct" model of integrated care. Organizations tailor models of BHI implementation to their available resources, partnership opportunities, and their communities' specific needs. Organizations have met integrated care needs by capitalizing on State and Federal funding mechanisms, demonstration projects, and internally initiated projects to combine or join services.

As part of this evaluation, PCDC conducted an in-depth profile of the East New York Health Hub (the Hub), an integrated care project in which PCDC served as a key financer. PCDC also worked with leaders from other local health centers currently implementing integrated care to better understand barriers to implementation and potential areas of opportunity.

3.1 EAST NEW YORK HEALTH HUB

At the Hub, which opened in October 2018, the Institute for Community Living (ICL) and Community Healthcare Network (CHN) operate in an integrated but independent partnership in co-located facilities. They work collaboratively to provide team-based care to patients with a shared vision to provide trauma-informed, recovery-oriented, integrated, and person-centered care.

> *The goal is to create a place where two organizations can bring to the same physical location the things that they do really well, and present it in a way that's seamless for clients of either one of the agencies."*
>
> – ICL STAFF

ICL is a New York-based, Article 31 (NYS Office of Mental Health [OMH]-licensed behavioral health center) nonprofit, human services organization that provides counseling, rehabilitation, housing, and other support services for adults and children with SMI, developmental disabilities, or SUDs. CHN, which operates freestanding diagnostic and treatment centers designated as federally qualified health centers (FQHC), is licensed under Article 28 (NYS Department of Health [DOH]-licensed primary care center) and provides a broad range of services to a largely medically underserved population throughout NYC.

In 2016, ICL began work on a project to consolidate several health and community-based programs into one location for the integrated provision of services to more effectively serve the multi-faceted needs of its patient population in East New York. PCDC, the Corporation for Supportive Housing (CHS), and Deutsche Bank provided facility financing and technical assistance to ICL and their tenant, CHN, for a 44,600 square foot, comprehensive service delivery center in East New York. The building is owned and operated by ICL.

The Hub employs a team of interdisciplinary staff including psychiatrists, primary care providers, nurse practitioners, social workers, registered nurses, and substance use, employment, peer, and family specialists.

It's my hope is that we've created a physical space that represents a shared responsibility for everybody that walks in the door."

– ICL LEADERSHIP

Goals of the Hub:

- *Integrate mental health and primary care services in a single facility with two operating organizations working in partnership*
- *Improve overall population health*
- *Reduce adverse events and emergency room visits*
- *Facilitate better communication and care across providers of health and social services*
- *Increase culturally and linguistically appropriate care*

The Hub provides a variety of services including:

- *Personalized Recovery Oriented Services (PROS)*
- *Assertive community treatment (ACT)*
- *Primary care services for adults, teens, and children*
- *Nutrition counseling*
- *OB/GYN and women's health care*
- *Care for pregnant women and new mothers*
- *Family planning and health education*
- *Podiatry health care*
- *LGBT health care, programs, and services*
- *Tobacco cessation services*
- *Wellness and self management*
- *Basic living skills and community integration*
- *Employment services*
- *Integrated dual disorder treatment (mental health/ SUDs)*
- *Psychiatric and nursing services*
- *Home and community-based services*

"Shortly after the Hub opened, the dialysis center across the street called saying they had a patient who was homeless, on dialysis, needed primary care services, and self-reported symptoms of depression. We were asked to help him and within an hour and a half we were able to mobilize our teams. Do all the background checks, enroll him in our Health Home, introduce him to his care coordinator, and find a shelter with medical services available because of his conditions.

We were also able to provide a MetroCard for him to get to the shelter, schedule an appointment with a therapist for his depression, and get him an appointment for primary care all in the same initial visit. That's what makes integrated care and the Hub so special, we can provide all those services at once and ensure people don't fall through the cracks."

-ICL Staff

East New York

Designated as a medically underserved area by the Health Resources and Services Administration (HRSA), East New York is among the five poorest NYC community districts, with 30% of residents living below the federal poverty level. Forty-six percent of residents receive Medicaid and/or other income assistance and 14% of residents reported going without necessary medical care in the last 12 months.

In East New York, 2,245 adults per 100,000 had an avoidable hospitalization, more than double the citywide rate. In addition, East New York ranked 7th highest out of 59 community districts regarding adult psychiatric hospitalizations and the life expectancy for residents is 2.6 years shorter than for NYC residents overall.[7]

3.2 PATHWAYS TO PRIMARY CARE

Joining together primary and behavioral health services can be accomplished in many ways depending on resources available and the needs of the community. Some NYC examples include:

Urgent Care + CCBHC: One NYC-based social service agency operating Article 31 licensed clinics identified a need to offer limited acute medical services to their patients on a walk-in basis, which were currently lacking in the community resulting in an overreliance on emergency services. Using funding provided via a SAMHSA grant, the organization opened an urgent care center integrated within their Article 31 facility. The organization furthered its integration approach by successfully entering into the CCBHC demonstration, which expanded services via a prospective payment mechanism and required primary care screening and monitoring. Organizational leadership noted many similar barriers to integration including services limited by licensing regulations, complex license application processes to provide both behavioral health and primary care services, technology barriers prohibiting the sharing of information between staff, and financial sustainability. Meeting integrated care needs does not always necessitate comprehensive medical services; in this and other settings, a more graduated approach to targeted primary care can be appropriate and realistic.

Multiple Licenses: In another high-need area of northern NYC, a third organization identified a need for nearly all their patients to gain access to primary medical services. Building upon their existing Article 31 license, they applied for an additional Article 28 license. This enabled a sole organizational entity to join services within the same building, via a single, unified leadership and staff. While a multi-licensed approach provided greater ease regarding a shared medical record, one source for organizational procedures and protocols, and shared metrics and priorities, it also came with barriers. Applying for two different licenses was a lengthy process and required the organization to be monitored by separate state agencies. Billing by multiple provider types during a single episode of care was also identified as a barrier. Despite these barriers, multiple licenses may provide an organization greater flexibility and programmatic control.

While the above examples highlight a variety of methods and partnership structures used by organizations to integrate behavioral health and primary care, barriers to successful implementation often transcend the particulars of any given integration implementation type.

RECOMMENDATIONS

SECTION 4.0

4.0 RECOMMENDATIONS

Following a comprehensive review of existing models of integration and their implementation, PCDC engaged in a case study of organizational integration initially focusing on one integrated clinic. Interviews were also conducted with other integrated care clinics around NYC. PCDC convened a roundtable of statewide leaders and subject matter experts to determine an initial set of recommendations focusing on five core areas that independently and collectively have significant impact on the success of integrated care clinics.

These recommendations were shared with New York State (NYS) regulatory agencies and made public at a town hall convening behavioral health, primary care, and regulatory stakeholders. The initial recommendations, combined with commentary and feedback from the Summit, culminated in this final set of recommendations focused on five key domains with complementary action steps for regulators, providers, and educational institutions.

Final recommendations were developed to address barriers noted within these domains and further categorized based on proposed level of intervention: state and federal policy, organizational practice, or workforce education.

Simplify state-regulated health care facility requirements

Simplify and streamline state regulatory and licensure requirements for co-located primary care and behavioral health facilities

In the U.S., individual states develop and implement licensing requirements and regulations for health care facilities. FQHCs have additional federal regulations —not usually facility related—with which providers and health centers must comply. Some states have created simplified systems allowing for easier integration of behavioral health and primary care.

> *We had to put up a wall and create another exit because of Article 28 requirements. Everybody comes in the same door, but if there's a fire they have to be able to get out of separate doors. I'm probably over-simplifying it, but it cost us $200,000 to do that, for no particular benefit to the client."*
>
> – CHN STAFF

While New York has distinct facility licenses required for providers and health centers to receive Medicaid reimbursement rates , in recent years, State agencies have considered new regulations intended to ease requirements for integrated and co-located facilities. This includes the DSRIP integrated care license, the integrated outpatient services model, discussion of a new fully-integrated "Article 99" facility license, and limited care and accessory care clinic designations for small clinics and health centers.[8] This evaluation found several barriers to current approaches in the State process including limited uptake of the DSRIP integrated care license, utilization thresholds that do not meet the needs of larger health centers and practices, and service/ billing limitations as well as administrative requirements that are not feasible for many health centers and providers to navigate.

> *I have run a behavioral health center for 25 years and can't figure out some of the licensing regulations. Either we need several different licenses with different regulating agencies and distinct reimbursement requirements, or we have to try to get an integrated license that doesn't correspond to how we deliver care. Neither option truly addresses our needs or those of our patients"*
>
> - Behavioral Health Clinic Leadership

Establish integrated systems to share patient information

Develop mechanisms for information sharing — both at the point of care and for population health management — using available and effective high- and low-technology tools (e.g., referral forms, health information exchange data, and bi-directional EHR access)

Advocate for the federal government to both consider integrated care needs when certifying EHRs and to promote greater interoperability

Streamline and reduce duplicative systems and reporting requirements across funding streams (e.g., DSRIP, Health Homes) and payer types (Medicaid, Medicare, commercial plans)

A key issue for all models of BHI is information sharing to coordinate and deliver care within and across services and teams, particularly when care is provided by two distinct organizations. Patient privacy, levels of clinical access, and bi-directional information sharing were frequently cited as concerns when considering best practices. A release of information from one organization to another does not equate to full, ongoing EHR access. In addition, stakeholders noted EHR needs unique to provider type. For example, a behavioral health provider with a supportive housing program may require their EHR to document housing related needs in addition to behavioral health treatment plans, which primary care EHR vendors may not be able to integrate.

> *We should have access to each other's records. You have to consider people's workflows, and what is actually going to give them the information they need at the point of care. We have an Excel registry of jointly served individuals. Even if it's not the most technologically sophisticated method, it might be the only one that people actually use."*
>
> – CHN STAFF

As a result, providers have been forced to create manual workarounds including use of duplicative paper records and referral tracking via spreadsheets. These provisional solutions can result in potentially unsecure patient information, time loss and workflow interruptions for staff, and an inability to appropriately track patient- and population-level data. Health information exchanges are another tool that could support bi-directional information sharing at the point-of-care. A single, shared EHR is optimal to streamline information sharing, data collection, risk stratification, and population health management, but may not be feasible.

> *From our experience with our EHR and our vendor, it has been very difficult to integrate with another system or create another solution for easier integration across organizations."*
>
> – ICL STAFF

Promote a collaborative team-based approach to care

Create and implement joint organization policies, protocols, and procedures that reflect a shared vision and culture

Define effective bi-directional care transitions, including warm hand offs and same-day visits, and build the necessary schedules, processes, and organizational culture to ensure access and information sharing

Establish joint responsibility for key physical and behavioral health outcomes and metrics

> *A shared treatment plan for every patient would be ideal"*
>
> – ICL STAFF

A commonly cited issue in both the initiation and maintenance of BHI is the development of a collaborative, patient-centered approach to care. Organizational differences between behavioral health and primary care may be evident in language (e.g., client vs. patient, treatment plan vs. problem list, session vs. appointment), as well as clinical policies and procedures. Decisions such as leadership configuration (e.g., does a primary care provider supervise all clinical staff, does a behavioral health provider supervise only behavioral health staff) are important to consider.

> *When you're trying to "fix" a whole person, but you're only addressing part of their reality, it's doomed, particularly for people with complex problems in their lives. A whole bunch of singular solutions almost adds to the burden rather than helping to address it."*
>
> – ICL LEADERSHIP

Another key component of clinical collaboration is the referral process between providers and the troubling phenomenon of patients "lost to follow-up". Discussions with stakeholders highlighted the importance of providing a strong referral mechanism for patients to ensure they are connected to the next step in their care. Warm-handoffs are one method used in integrated care to ensure a successful transfer of care and build trust between patients and care teams. Other options include team care-conferencing and huddles to discuss patient care and treatment plans. Unfortunately, in many cases, the activities required to provide high quality integrated care including team huddles and care conferencing are not billable for providers, nor sufficiently resourced in value-based payment arrangements.

Shared Metrics

Many organizations have identified data and measurement-driven care as imperative to successful patient outcomes. Developing, monitoring, and reporting on shared metrics and outcomes (e.g., medical outcomes such as hypertension or behavioral outcomes such as percent of patients with a depression diagnosis engaged in treatment) can help foster shared goals and movement towards coordinated results. In integrated settings, both medical and behavioral health providers can periodically select one new metric or outcome to mutually track and examine methods to improve. For example, an integrated clinic may determine that its population's colorectal cancer screening rate needs improvement. As primary care providers work with patients to initiate screenings, behavioral health providers support efforts by addressing barriers such as trauma or procedure-related anxiety. Both track and review changes in the metric over time and adjust practice as needed to improve patient outcomes.

In New York, a health center participating in PCMH, receiving a SAMHSA PBHCI grant, seeing Medicaid-insured patients contracted with several different managed care organizations, as part of DSRIP PPS, and engaged in Health Homes, may be required to track and report unique metrics at different frequencies via distinct systems for each program in which they participate."

– PCDC STAFF

A focus on shared metrics must also acknowledge the multiple, and at times burdensome, reporting requirements that may already exist and be required by numerous funding and regulatory bodies. As part of many grant projects, demonstration studies, and insurance reimbursement structures, providers are required to document and report patient- and population-level outcomes and metrics to a multiplicity of funding agencies and organizations. Providers without administrative support may opt out from programs and funding streams that would allow for integrated care as the data and reporting requirements are not feasible.

Ensure bi-directional workforce education

Develop training and certificate programs to support the pipeline of qualified staff needed for integrated care

Include integrated, interprofessional care competencies in graduate and medical training to ensure a foundational understanding of primary and behavioral health care

Incorporate cross-discipline training in the integration process

Complementary or shared expertise among staff is one method to ensure enhanced whole-person, team-based care. In integrated care systems, primary care staff must have competency in managing psychiatric medications and understanding the impact of trauma on clinical outcomes, while behavioral health providers benefit from basic knowledge of common medical conditions and behavioral interventions that can improve clinical outcomes such as cognitive-behavioral therapies for weight management and insomnia, and familiarity with basic lab results and medications. Cross-team trainings and in-services are important opportunities for improving capacity and professional development while also creating a shared vision and culture for the organizations.

*I need to hire someone who knows how it works **here,** because it's much different, the flow is different, the culture is different, and I'm trying to build a culture here that's different than other clinics, because it needs to be for the population we serve."*

– CHN STAFF

In current clinical and behavioral health education programs, there is limited emphasis on team-based care and cross-training on integrated care principles. While some level of training can be provided at the organization-level, development and introduction of curriculum and training programs in residency and educational programs will ensure a pipeline of qualified staff prepared to provide high-quality integrated care.

Consultation time and discussions between providers about a patient are not billable. That's probably the biggest issue."

– ICL STAFF

Expand financing and reimbursement options for integrated care

Create financial incentives and mechanisms to increase provider uptake of integrated care models

Both primary care and behavioral health are consistently underfunded in the health care realm related to need, resulting in gaps in service.[8] In response, providers have used grant funding from organizations such as SAMHSA, HRSA, and other federal agencies to hire personnel, provide clinical services, and develop infrastructure. Grant funding, while beneficial, does not address long-term financial sustainability. In addition, current Medicaid and Medicare billing structures do not allow for reimbursement of core integrated care services such as provider consultation time and care team meetings, and value-based payment for NYS providers does not yet fully cover these and other integration costs. Together, these financing and reimbursement barriers are a disincentive to introducing and expanding BHI.

Part of our assessment process, which is not reimbursed, includes healthy living questionnaires or outcome assessments that capture a lot of these physical health issues."

-CHN Staff

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SECTION 5.0

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ABOUT PRIMARY CARE DEVELOPMENT CORPORATION

SECTION 6.0

Primary Care Development Corporation

PCDC IS A NATIONALLY RECOGNIZED NONPROFIT THAT CATALYZES EXCELLENCE IN PRIMARY CARE THROUGH STRATEGIC COMMUNITY INVESTMENT, CAPACITY BUILDING, AND POLICY INITIATIVES TO ACHIEVE HEALTH EQUITY.

IN NEW YORK STATE, PCDC HAS WORKED WITH HUNDREDS OF PRIMARY CARE ORGANIZATIONS TO EXPAND ACCESS TO HIGH-QUALITY PRIMARY CARE.

As a Community Development Financial Institution (CDFI), PCDC provides low-interest capital and expertise to build, renovate, and expand community-based health care facilities, supporting providers in delivering quality care to their patients in settings that promote dignity, respect, and wellness. PCDC also provides expert consulting, training, and coaching to help primary care practices adopt patient-centered models, care coordination, and integrated services; improve operations; incorporate coordinated care; leverage health information technology; and boost patient health outcomes.

PCDC works with key policy makers, trade associations, primary care practices, and industry leaders to advance policy initiatives that strengthen, sustain, and expand access to quality primary care. In a rapidly evolving health policy environment, PCDC brings both policy expertise and a quarter century's experience investing in and strengthening primary care practices in New York State.

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APPENDIX

SECTION 7.0

7.0 APPENDIX

In 2018, PCDC was awarded a NYS Health Foundation grant to conduct a case study of the Hub, part of PCDC's ongoing effort to facilitate access to integrated behavioral health and primary care services. The case study consisted of four components:

1. A comprehensive literature review including peer-reviewed literature, grey literature, white papers, and organizational reports. Together, these sources provided background and context to the global issues plaguing integrated care and aided in the development of core sectors within integration implementation that required further research and attention.
2. Semi-structured interviews with 21 stakeholders involved in the funding, development, and implementation of the Hub. Organizations represented included ICL, CHN, Corporation for Supportive Housing, Dattner Architects, and PCDC.
3. Roundtable discussion on local and national barriers to integration and opportunities for improvement
    - PCDC convened a group of multisector experts from behavioral health organizations, primary care, insurance, academia, funders/lenders, and foundations to share feedback on initial recommendations, project scope, and other relevant considerations.
4. Integrated Care Summit convening a panel of experts to present initial recommendations and solicit feedback
    - Panelists included:
        - **Joan Cleary-Miron, MPH,** Director of Health Care Facility Transformation Program-Implementation Team, NYS DOH
        - **Louise Cohen, MPH,** CEO, PCDC
        - **Robert Hayes, JD,** President and CEO, CHN
        - **AnnMay Hoyte-Nelson,** Deputy Regional Program Director, NYS DOH
        - **Patricia Lincourt, MSW, LCSW,** Associate Commissioner for Addiction Treatment and Recovery, NYS OASAS
        - **Andrew Philip, PhD, LP,** Senior Director of Clinical and Population Health, PCDC
        - **Tom Smith, MD,** Chief Medical Officer, NYS OMH
        - **David Woodlock, MS,** President and CEO, ICL

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