TTAC

Perinatal and Early Childhood Mental Health Network

Training and Technical Assistance Center

Perinatal + Early Childhood Mental Health Network

Evelyn J Blanck, LCSW

Director, TTAC

Shirley Berger, DrPH

Bureau of Children, Youth and Families and Developmental Disabilities

NYC Department of Health and Mental Hygiene

Welcome and Objectives for Today

TTAC is pleased to welcome all to our first inaugural Resource Fair

- This is a one-stop event designed to connect all those working during the perinatal period and supporting families beginning during pregnancy to age five and their families.
- The fair features a wide range of programs, services, and resources for providers serving these populations.
- We seek to strengthen the connections and referral pathways between all early childhood, mental health and perinatal providers to provide a continuum of supports for families.

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Featured Presentations

- 9:15 AM - 9:35 AM: P+ECMH Network
- 9:45 AM - 10:30 AM: NYC Health Department Perinatal Partners
- 10:40 AM - 11:00 AM: Project TEACH
- 11:05 - 11:35 AM: Healthy Steps
- 11:40 - 12:00 PM: Mosaic Mental Health

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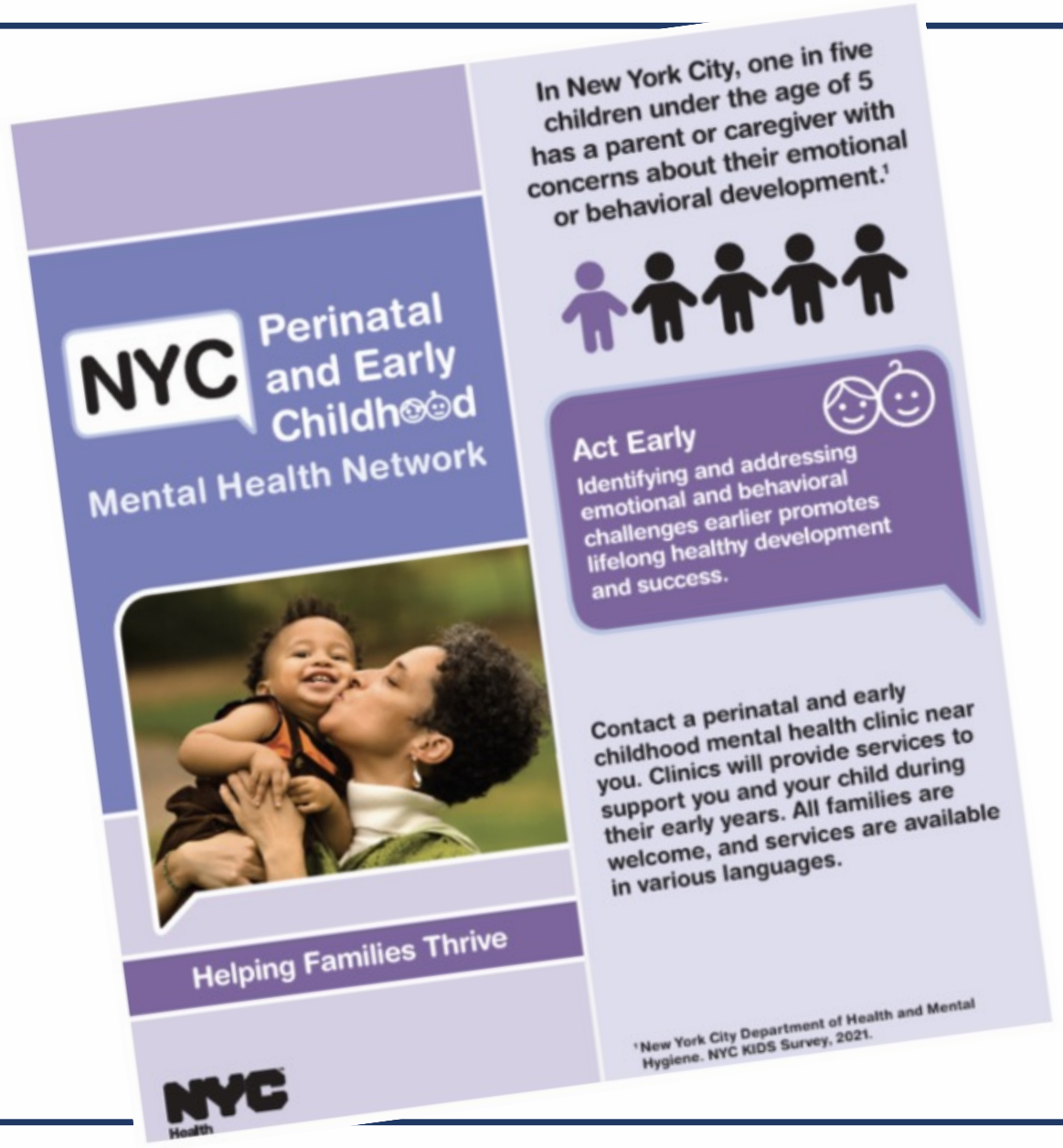
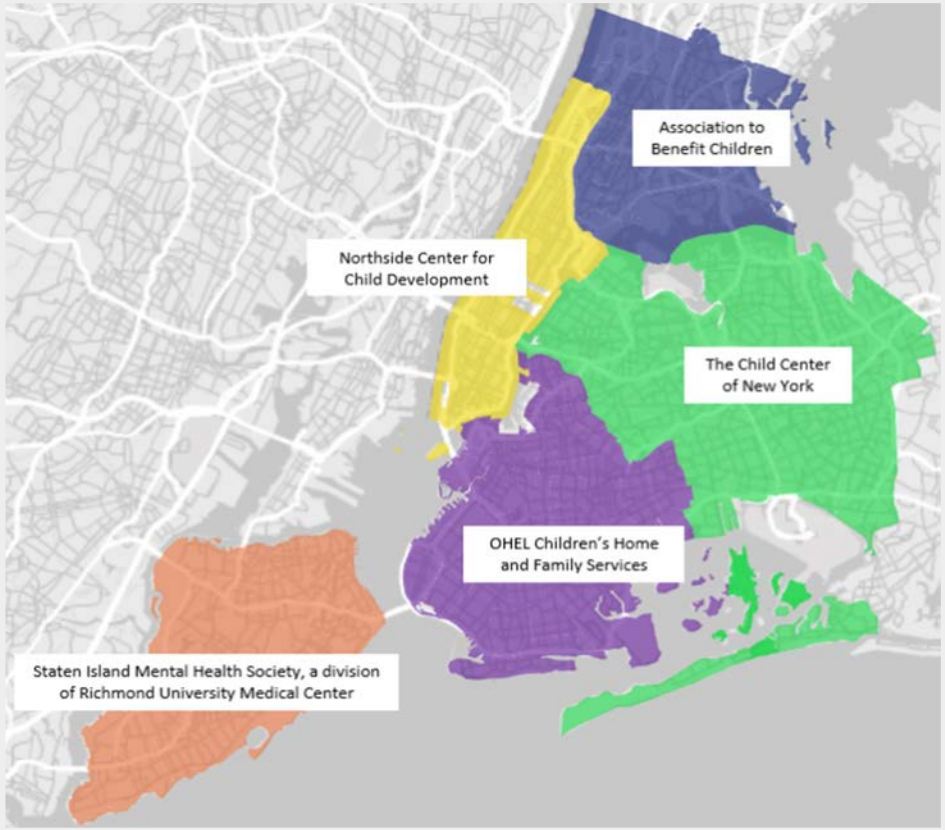


NYC Perinatal + Early Childhood Mental Health Network

NYC Health

Overview of the Perinatal + ECMH Network



The NYC Perinatal + Early Childhood Mental Health Network is funded by the NYC Department of Health and Mental Hygiene (since 2016) and consists of

- Five specialized outpatient **clinics** to address the mental health needs of children birth to five and their parents/caregivers as well as pregnant individuals
- A citywide **training and technical assistance center (TTAC)**.

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NYC Health

3 Main Clinic Services

- **Mental Health Treatment**
  - Young children 5 years and under, siblings, and parents/caregivers
  - Pregnant and postpartum individuals; parent and baby
  - Relational, trauma-informed therapy models
  - In person and virtual therapy sessions
- **Mental Health Consultation**
  - Capacity building support to staff at early care and education, perinatal, and community-based sites
- **Family Peer Support**
  - Family Peer Advocates with lived experience integrated into clinics to support parents/caregivers

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Integrating perinatal MH into the Network

- In 2023, DOHMH received funding to expand perinatal mental health services through the clinics and increase webinars and trainings in perinatal mental health through TTAC
- We partner with other DOHMH programs that provide crucial services to pregnant and parenting people
  - Home visiting programs (Newborn HV and Nurse-Family Partnership)
  - Citywide Doula Initiative
  - Family Wellness Suites

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NYC Health

Referring to the clinics

Referral information available: https://ttacny.org/clinical-services/

- Every clinic accepts referrals directly
- Download referral flyers in multiple languages

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Who We Are

The New York City Perinatal + Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Department of Health and Mental Hygiene (DOHMH).

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute for Poverty Policy and Research

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice

- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), Peer TAC, and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

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Goals of TTAC

- TTAC is tasked with building capacity and competencies of mental health professionals and early childhood professionals in family-serving systems to identify and address the social-emotional needs of young children and their families.

- TTAC's goal is that all who touch the lives of young children should be mental health informed and have the knowledge and tools to support the healthy development of New York's youngest children.

- TTAC partners with ACS, DECE, Early Intervention and other child serving systems

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Goals of TTAC

- Healthy social emotional development for infants and toddlers is dependent on the quality and consistency of their relationships with parents and caregivers.
- To address the mental health needs of infants and young children we need to support the health and mental health of the caregivers and support the parent child relationship
- All of our work is relationship based and trauma informed

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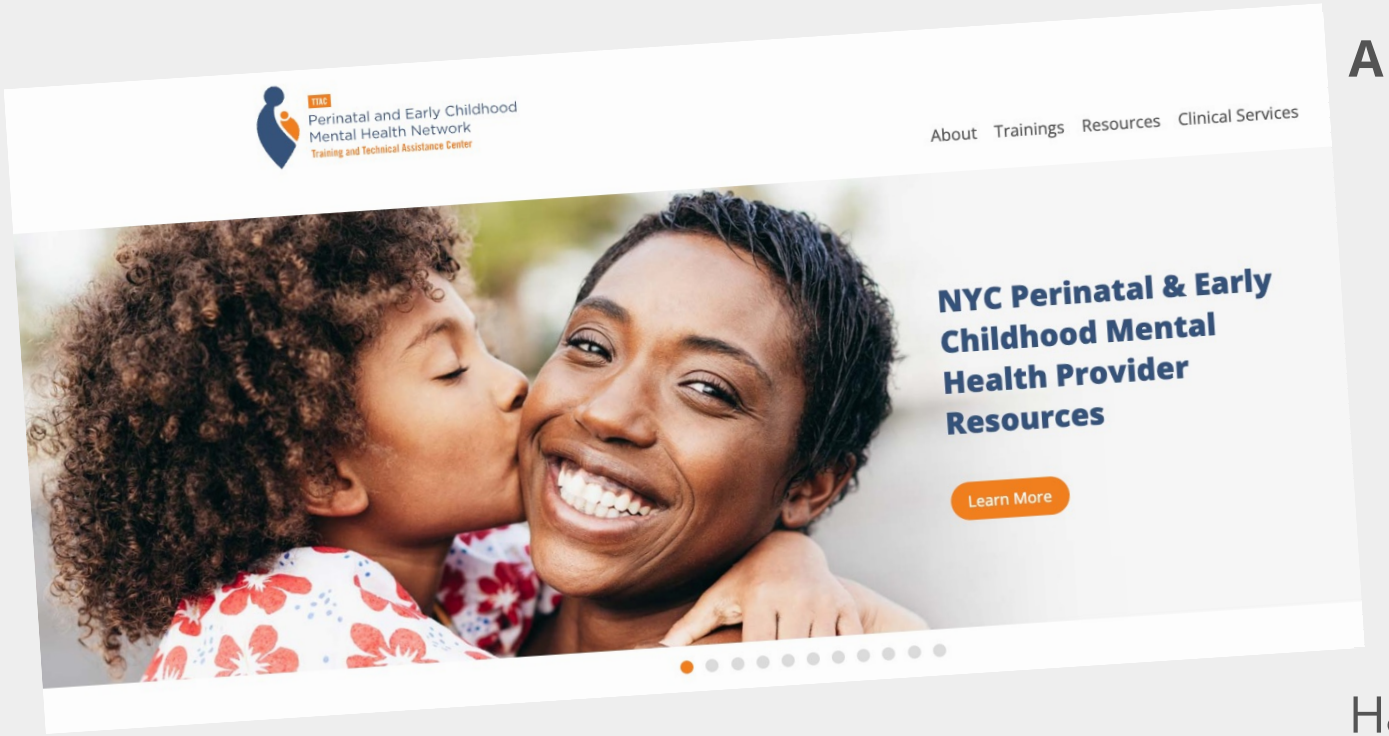
Visit the TTAC Website



A Variety of Features:

- View upcoming and archived content, trainings, and resources on the **Trainings page.**
  - Access videos, slides, and presenter information
- Contact the TTAC team by clicking on **Ask TTAC** and filling out our **Contact Us form**
- And more!

Have questions or need assistance? Please contact us at **ttac.info@nyu.edu** and we'll be happy to assist you

Explore all the provider resources at ttacny.org

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Models we train practitioners in:

Child Parent Psychotherapy (CPP) is a dyadic model for children ages birth to 5 who have experienced traumatic events and/or mental health, attachment and/or behavioral problems.

Perinatal Child-Parent Psychotherapy (P C-PP) is an application of Child-Parent Psychotherapy to the perinatal period, for expecting mothers who have experienced trauma or significant stress.

Interpersonal Therapy (IPT) is an empirically validated treatment for a variety of affective disorders in adults used for parental depression and anxiety, and adapted for perinatal depression

Circle of Security (COS) is a group-based model that focuses on helping caregivers reflect upon children's attachment needs to promote secure attachment with a child.

Practical Resources for Effective Postpartum Parenting (PREPP) is a dyadically-oriented protocol for the prevention of postpartum depression. It uses targeted psychotherapy and infant behavior interventions in a brief, accessible model along with routine perinatal medical visits.

ChildParent Psychotherapy

IPT INSTITUTE

Circle of Security INTERNATIONAL
Early Intervention Program for Parents & Children

PERINATAL PATHWAYS

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TTAC's Trainings

TTAC offers trainings on a range of essential topics in early childhood mental health as well as cutting edge issues

Recordings and PPTs available through ttacny.org or through hyperlink on this slide.

- Trauma and Resilience
- Sensory Processing Disorders
- Perinatal Mood and Anxiety Disorders
- Early Childhood Mental Health Consultation
- Reflective Practice
- Diagnosis and Assessment

Samples of Archived Webinars and Events

- TTAC Annual Spring Conference: Supporting Families with Substance Use Disorders in the Perinatal Period: Synthesizing Clinical, Research & Policy Perspectives
- TTAC Podcast: In-Depth with Experts: Two-Generational Health During the Perinatal Period
- Grief in Early Childhood: Healing the Present, Protecting the Future Paternal Mental Health: Supporting Fathers and Non-Birthing Parents in the Perinatal Period
- The Central Role of Human Relationships in Infant Mental Health

Upcoming Webinars

- Perinatal Mental Health: A Continuum of Care
- Introduction to Pregnancy And Infant Loss
- Tiny Voices, Big Messages: What No at Mealtime Really Means

TTAC IECMH Learning Modules

Two Learning Modules:

- The first module in the series is **the Impact of Early Childhood Adversity (An Overview of the Topic)**
- The second module in the series is **Nurturing Resilience: Supporting Infant and Early Childhood Mental Health**
- CEUs Available upon completion!

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A Collaboration Between
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NYC Health

Welcome!

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NYC DOHMH New Family Home Visits Initiative, Citywide Doula Initiative, & Family Wellness Suites

TTAC Resource Fair
October 28, 2025

NYC Health

Part 1: New Family Home Visits Initiative (NFHV)

Sherllay Castro, CLC

October 28, 2025

NYC Health

NFHV Goals

The NFHV Initiative aims to:

- Improve access to high-quality care and supportive services among pregnant and parenting families by expanding existing partnerships and cultivating new ones with clinical and community-based providers
- Prioritize and serve an estimated 22,000 pregnant and parenting families who live in Taskforce on Racial Inclusion and Equity (TRIE) neighborhoods known to have the highest racial and social inequities exacerbated by the COVID-19 pandemic
- Focus acutely on maternal mental health, chronic disease and early childhood development
- Operate the efficient Coordinated Intake and Referral (CI&R) system to manage referrals for families

NYC Health

Coordinated Intake and Referral System (CI&R)

- Multifaceted, HIPAA-compliant technology (**Unite Us**) used to support the management of client referrals
- Provides a fast and efficient way for NYC health and social service providers to refer pregnant and parenting families to home visiting programs, doula services, and other community services they may need
- Includes foster and adoptive parents of young children (newborn-4 years old)
- Funded and operated by the NYC Department of Health and Mental Hygiene as part of the NHFV Initiative

NYC Health

CI&R Eligibility

- First-time parents residing in Taskforce on Racial Inclusion & Equity (TRIE) neighborhoods
- All families with an infant 0 – 3 months old residing in New York City Housing Authority (NYCHA) housing in TRIE neighborhoods
- All families with an infant 0 – 3 months old engaged with the Administration for Children's Services (ACS) or Department of Homeless Services (DHS) citywide
- Families who are eligible for home visiting programs DOHMH has formal referral partnerships with

Programs/Resouces Available Through the CI&R System

Newborn Home Visiting Program	Nurse-Family Partnership	Healthy Families NY	Power of Two/ABC	Citywide Doula Initiative	Community Resources
Offers home visits for families with infants aged 0-3 months to provide feeding support, health and safety guidance.	Provides nurse home visits to 1st time, low-income mothers before 28 weeks of pregnancy and continuing until child is 2 years old.	Offers home-based support to expectant families from pregnancy or shortly after birth until child enters school or Head Start.	Provides support to caregivers of children ages 3-48 months to develop the responsive parenting for healthy development.	Offers free non-medical support before, during and after childbirth for Medicaid-eligible families in TRIE zip codes, shelters and foster care.	DV/IPV services, Early Intervention, shelter and housing assistance, health insurance, food, infant items, and more!

NYC Health

CI&R Benefits

Both providers and families benefit from the system:

- It simplifies the referral process, improves access to care, and reduces the duplication of services.
- It connects families to vital services to complement your care and improves their health and wellbeing.
- It is fast and free. All services are provided at no cost to referral partners, providers, and families.

Interested in becoming a CI&R partner? Email bkhub@health.nyc.gov

Newborn Home Visiting Program (NHVP)

Thelmina Locke-Morgan

October 28, 2025

NYC Health

Newborn Home Visiting Program

The Newborn Home Visiting Program (NHVP) operates under the umbrella of the NFHV Initiative to provide free post-discharge support to families with a new infant.

Staffing Model:

- Public Health Advisors (primary home visitor)
- Specialists (nurses, social workers, lactation consultants)

Eligible Families Include:

- First-time parents residing in Taskforce on Racial Inclusion & Equity (TRIE) neighborhoods
- All families with an infant 0 – 3 months old residing in New York City Housing Authority (NYCHA) housing in TRIE neighborhoods
- All families with an infant 0 – 3 months old engaged with the Administration for Children's Services (ACS)or Department of Homeless Services (DHS) citywide

NHVP Key Messages

- Maternal and infant health education
- Infant feeding; including breastfeeding education and practical support
- Safe sleep and injury prevention
- Home environmental hazards
- Early childhood development
- Maternal depression education and screening
- Chronic illness education
- Community resource connection

Nurse-Family Partnership (NFP)

Angelina Kim Li, LCSW, PMH-C

October 28, 2025

NYC Health

NYC Nurse-Family Partnership

Unparalleled support for first-time mothers

Nurse-Family Partnership® is an evidence-based, nurse home visiting program with over 40 years of data showing significant improvements in the health and lives of first-time, low-income parents and their families.

Key Goals:

- Improve Pregnancy Outcomes
- Improve Child Health and Development
- Improve Economic Self-Sufficiency of the Family

NYC Health

TRIAL OUTCOMES

The following outcomes have been observed among participants in at least one of the trials of the program:

48% reduction in child abuse and neglect

56% reduction in ER visits for accidents and poisonings

50% reduction in language delays of child age 21 months

67% less behavioral/intellectual problems at age 6

79% reduction in preterm delivery for women who smoke

32% fewer subsequent pregnancies

82% increase in months employed

NYC Health

NFP Eligibility

NYC NFP is provided at **no cost** to the client and **regardless of age**, **immigration status** and **gender identity**. The program serves anyone who:

- Is having their first baby
- Is low-income (Medicaid- and/or WIC-eligible)
- Is 28 weeks pregnant or less
- Lives in one of NYC's five boroughs (all ZIP codes)

- Program is also available in NJ and Nassau

NYC NFP's Targeted Citywide Initiative (TCI) was created in 2007 to engage NYC's **most at-risk, hardest-to-reach** first-time mothers. TCI serves clients who:

- Live in foster care
- Are homeless / live in shelters
- Are or recently were incarcerated or involved in the criminal or juvenile justice system

NYC Health

NFP Mental Health Support

- For Clients:
  - NYC NFP offers in-home therapy to NFP clients who are experiencing barriers to receiving mental health services in the community.
  - Social workers can also provide evidence-based modalities when appropriate

- For Nurse Home Visitors:
  - SW supports nurses through case conferencing and individual consultation and reflective support.
  - SW can also provide joint visits and other client support as needed.

NFP Expansion

- Exciting News!

- Starting January 2026
- Will enroll multiparous birthing individuals
- Not limited to gestational age before 28 weeks

Part 2: Citywide Doula Initiative (CDI)

Cara Saunders, MPH, CD

October 28, 2025

NYC Health

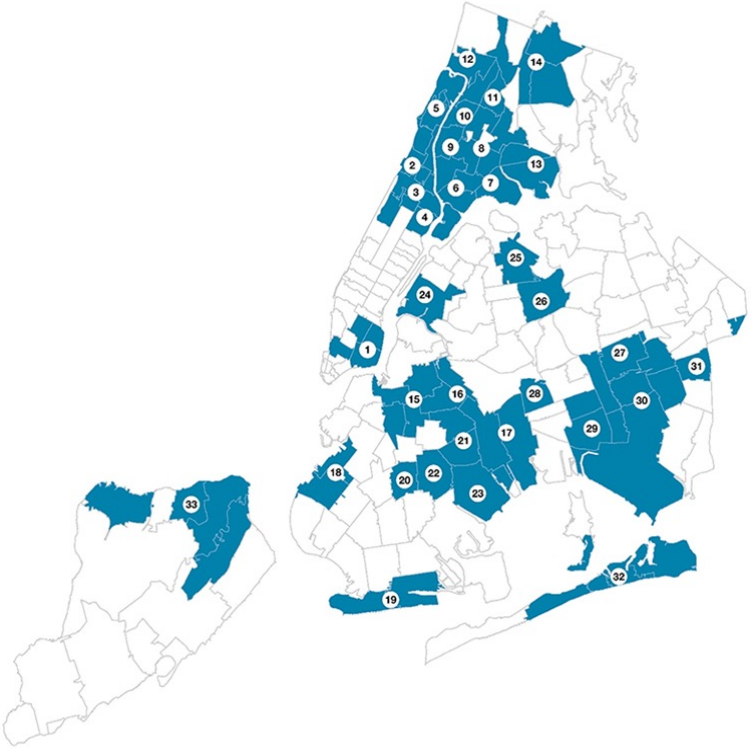
What is a Doula?

A professional trained to provide non-clinical support – emotional, physical, and informational – to people during:

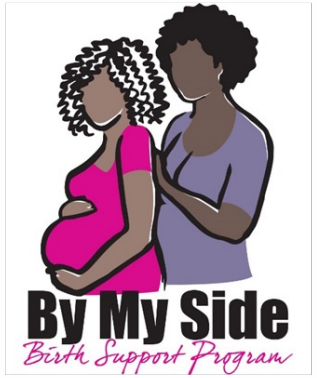
- Pregnancy
- Birth
- Postpartum

The Citywide Doula Initiative

- Providing no-cost doula care in underserved neighborhoods citywide
- Expanding and strengthening the doula workforce
- Supporting hospitals in becoming more doula-friendly



Community Based Partners



NYC Health

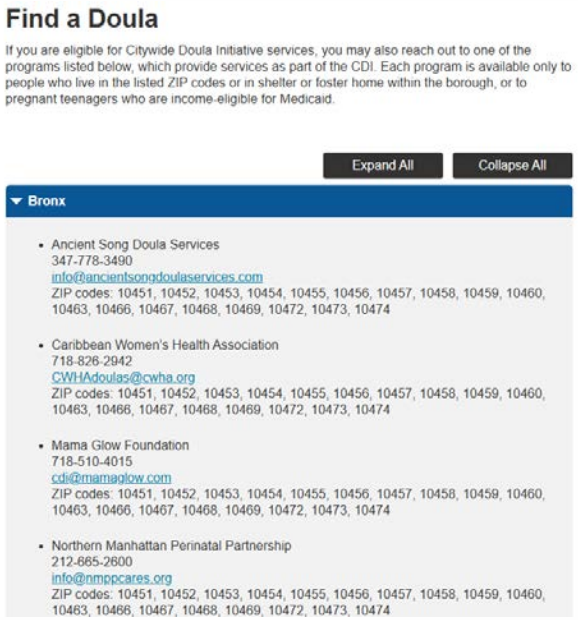
Client Eligibility and Referrals

Clients must:

- Be income eligible for Medicaid AND

- Live in one of the TRIE neighborhoods, a foster home, a shelter, or be a teen parent

Referral Pathways:



Find a Doula

If you are eligible for Citywide Doula Initiative services, you may also reach out to one of the programs listed below, which provide services as part of the CDI. Each program is available only to people who live in the listed ZIP codes or in shelter or foster home within the borough, or to pregnant teenagers who are income-eligible for Medicaid.

Expand All | Collapse All

Bronx

- Ancient Song Doula Services
  347-778-3490
  info@ancientsongdoulaservices.com
  ZIP codes: 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10463, 10466, 10467, 10468, 10469, 10472, 10473, 10474
- Caribbean Women's Health Association
  718-826-2942
  CWHAdoulas@cwha.org
  ZIP codes: 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10463, 10466, 10467, 10468, 10469, 10472, 10473, 10474
- Mama Glow Foundation
  718-510-4015
  cdi@mamaglow.com
  ZIP codes: 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10463, 10466, 10467, 10468, 10469, 10472, 10473, 10474
- Northern Manhattan Perinatal Partnership
  212-665-2600
  info@nmppcares.org
  ZIP codes: 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10463, 10466, 10467, 10468, 10469, 10472, 10473, 10474

- 1-800-OK-DOULA
- CDI@Health.nyc.gov
- Unite Us
- Reach out to individual programs

Part 3: Family Wellness Suites (FWS)

*Vivian Cort*és, PhD, MPH, MCHES

October 28, 2025

What is a Family Wellness Suite?

Family Wellness Suites are safe, welcoming, and supportive spaces for family members to receive services, health education, and linkages to community resources.

Suites meet **pre-natal**, **post-partum**, and other **social service needs** of families to:

- **Improve** maternal and infant health outcomes
- **Reduce** racial inequities in perinatal birth

Brownsville Family Wellness Suite
259 Bristol St, Brooklyn, NY 11212

Email: BrooklynFWS@health.nyc.gov
Phone: (718) 312-6136

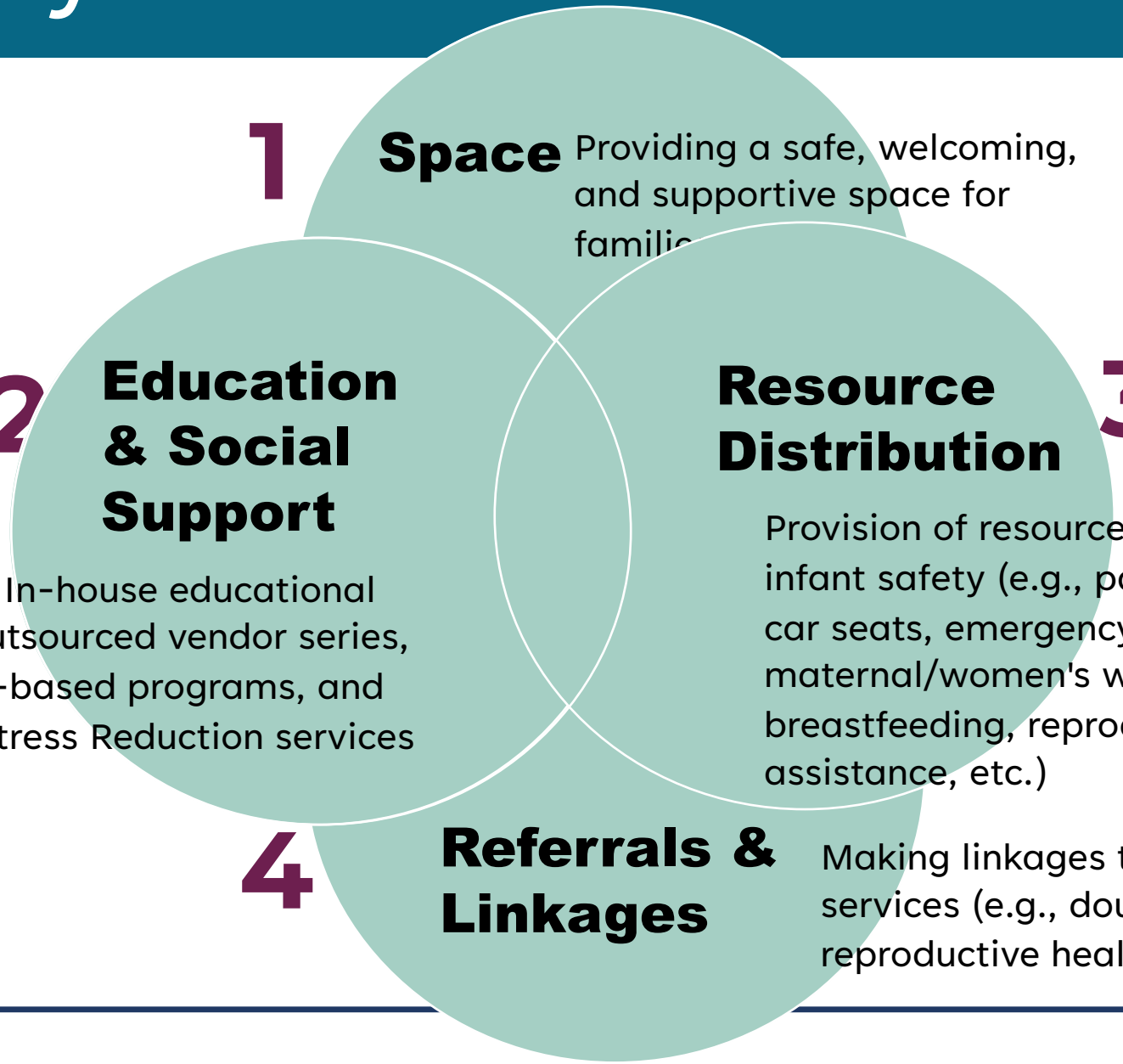
Bronx Family Wellness Suite
1826 Arthur Ave, Bronx, NY 10457

Email:
BronxActionCenter@health.nyc.gov
Phone: (718) 508-0741

Harlem Family Wellness Suite
158 E 115th St, New York, NY 10029

Email: HarlemFWS@health.nyc.gov
Phone: (646) 682-3437

Family Wellness Suite Focus Areas



1 Space

Providing a safe, welcoming, and supportive space for familie

2 Education & Social Support

Includes: In-house educational series, Outsourced vendor series, Evidence-based programs, and Fitness/Stress Reduction services

3 Resource Distribution

Provision of resources to encourage infant safety (e.g., pack 'n' play cribs, car seats, emergency diapers) and to maternal/women's wellness (e.g., breastfeeding, reproductive assistance, etc.)

4 Referrals & Linkages

Making linkages to both on-site and off-site services (e.g., doula, mental health, and/or reproductive health services)

Family Wellness Suite Programming

In-House Educational Track

- Lactation 101
- What is a Doula? (v)
- Postpartum Mental Health
- Hypertension & Gestational Diabetes Overview (v)
- Nutrition 101
- Healthy Relationships
- Birth Control Options
- Safer Sex & STIs (v)
- Reproductive Concerns: PCOS, Fibroids, & Endometriosis (v)
- **Physical/Stress Reduction Activities (Yoga, Walking, Massages, etc.**
- **Infant & Maternal Safety**

External Vendors

- **Perinatal Yoga Classes**
- **Perinatal Massages**
- **Childbirth Now**
  - Childbirth Education & Breastfeeding Support (4-class series)
  - Labor comfort & Partner support (I)
  - 4th Trimester (I)
  - Newborn 1st Ped visit (I)
  - Postpartum Care & Recovery

Evidence Based Interventions

- Lactation Support
- Infant & Adult CPR
- Parenting Courses
- Mental Wellness

NYC Health

How can you refer clients to the suites?

Sending a Referral to the Bronx?	Sending a Referral to Brooklyn?	Sending a Referral to Harlem?
Please complete the electronic referral form.	Please complete the electronic referral form.	Please complete the electronic referral form.
https://forms.office.com/g/MvKgC5uPzK	https://forms.office.com/g/WW1SN9yt9N	https://forms.office.com/g/PVDjWAshnE

Please allow **up to 2 weeks** for the program to contact families.

Suites make **2 outreach attempts** before having to move on to the next referral.

Thank You!

Q&A

ProjectTEACH

How Project TEACH Can Help Clinicians Meet the Mental Health Care Needs of Pediatric and Perinatal Patients

TTAC Resource Fair

October 28, 2025

NEW YORK STATE | Office of Mental Health

ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

It's So Nice to Meet You!

Michele Phillips

Senior Project Director
Project TEACH, University at Buffalo

MP246@Buffalo.edu

ProjectTEACH

FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Project TEACH is New York State's Child/Adolescent & Perinatal Psychiatry Access Program.

All Project TEACH services are funded by

NEW YORK STATE | Office of Mental Health

ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

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

POSTPARTUM RESOURCE CENTER OF NEW YORK

NYS Conference of Local Mental Hygiene Directors, Inc.

ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

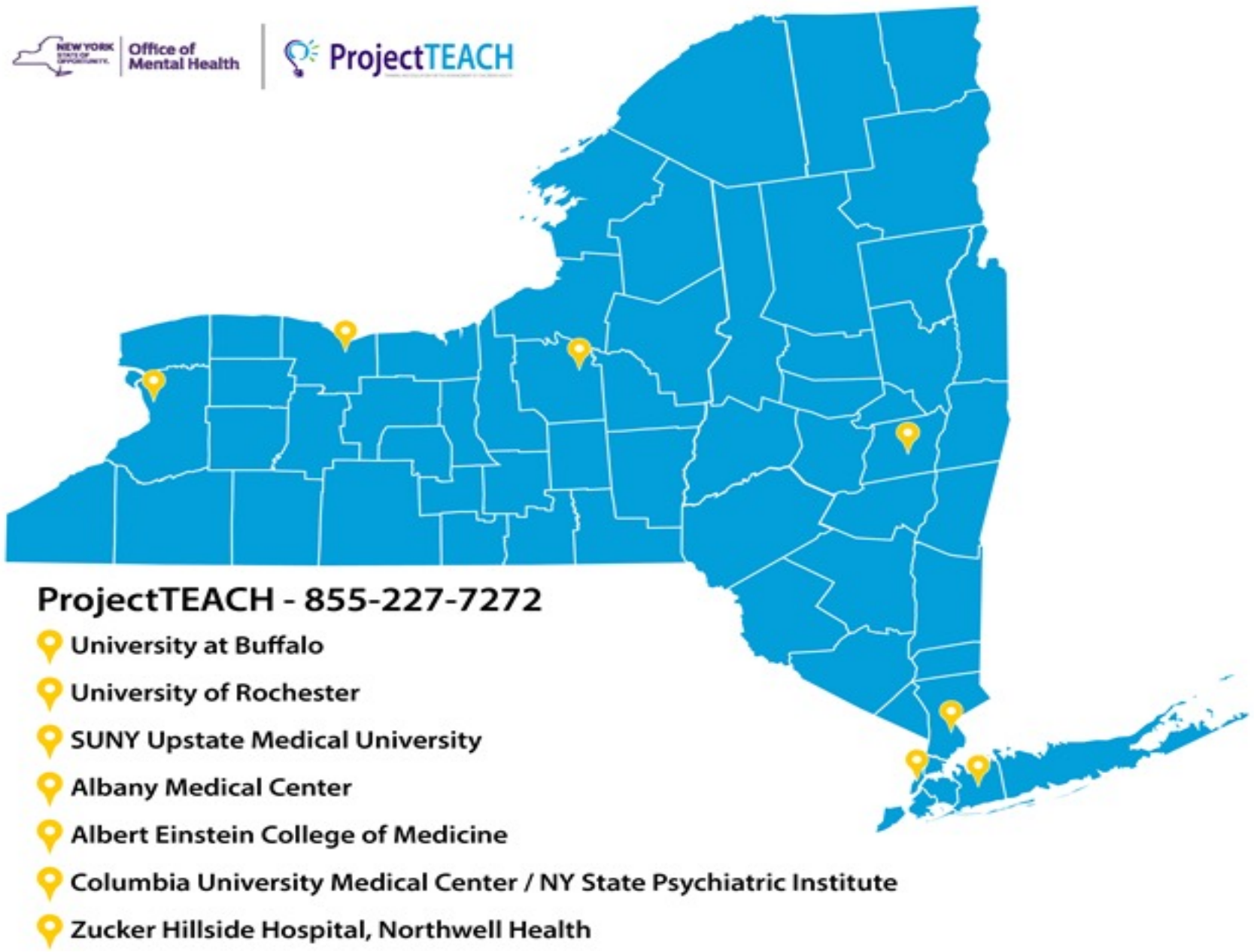
History of Project TEACH

- **2010:** Founded and funded from the beginning by NYS OMH
  Previously 2 programs: CAPES & CAP-PC. Focused on child/adol. mental health
- **2015:** Became “Project TEACH” across the state. Regional access, but shared mission & deliverables.
- **2018:** Project TEACH added a limited Maternal Mental Health Initiative (MMHI).
- **2022:** Project TEACH is one, state-wide program with centralized access, integrated teams of child/adolescent and maternal mental health providers.
- **2025:** Expansion of MMH services.

All Project TEACH services are free, fast and friendly!

ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

No matter where you are in New York State, our team is here to help!



ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Child & Adolescent Psychiatry (CAP) Team

University at Buffalo
- David Kaye, MD*
- Sourav Sengupta, MD
- Beth Smith, MD

University of Rochester
- Michael Scharf, MD**
- Jim Wallace, MD
- Vicki Katsetos, MD

SUNY Upstate Medical University
- Wanda Freemont, MD*
- Eric McMaster, MD
- Nayla Khoury, MD

Columbia University/NYSPI
- Rachel Zuckerbrot, MD*

Zucker Hillside Hospital/Northwell Health
- Victor Fornari, MD*
- Carmel Foley, MD
- Zoya Popivker, DO

Albany Medical Center
- Suzanne Sumida, MD
- Naema Qureshi, MD

Albert Einstein College of Medicine
- Jay Herrick MD*

* Medical Director
** Executive Medical Director

ProjectTEACH
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Perinatal Psychiatry/Psychology Team

University at Buffalo
- Joshna Singh, M.D.

University of Rochester
- George Nasra, M.D., MBA
- Jeffrey Iler, M.D.
- Ellen Poleshuck, Ph.D.

SUNY Upstate Medical University
- Nevena Radonjic, M.D., Ph.D.

Columbia University / NYSPI
- Elizabeth Fitelson, M.D.
- Catherine Monk, Ph.D.
- Nicole Tchalim, M.D.

Zucker Hillside Hospital / Northwell Health
- Kristina Deligiannidis, M.D.*
- Yardana Kaufman, M.D.
- Khatiya Moon, M.D.

Albert Einstein College of Medicine
- Rubiahna Vaughn, M.D.
- Julia Vileisis, M.D.

Project TEACH Perinatal Psychologist
- Vanessa Tirone, Ph.D.

* Medical Director

ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Liaison Coordinators (LCs) & Administration

Liaison Coordinators (LCs)

- Maureen Ryan, Psy.D – Syracuse (Mon)
- Leslie Cummins, LCSW – Northwell (Tues)
- Sasha Miller, LCSW – Northwell
- Katherine Carnicelli, LCSW – Columbia (Wed)
- Kristin McGinley, LCSW – Buffalo (Thur)
- Amy Lyons, LCAT – Rochester (Fri)
- Kayla Tombank, LMHC – Albany
- Abigail Bailey, LMHC – Montefiore

Project Administration

- Michael Scharf, MD - Executive Director
- Michele Phillips - Sr. Project Director
- Ira Bhatia, M.Ed. - Sr. Project Administrator

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Services Available to NYS Professionals

All services are at no-cost due to funding from NYS OMH.

- **Telephone Consultations** (with potential for patient evaluation)

  Consult with Child/Adolescent Psychiatrists, Reproductive Psychiatrist and Perinatal Psychologist and Child and MMH Sub-Specialty Experts.

- **Education Events** (including CME and CEUs)

  Intensive Trainings, Webinars and Onsite/Virtual Trainings: 18 “Core” Mental Health Topics

- **Referral and Resource Support**

Warm Line: 1-855-227-7272
(Open to clinicians Monday-Friday, 9 am – 5 pm)

www.ProjectTEACHny.org

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Warmline 1-855-227-7272

- Call our toll-free warmline (M-F, 9a-5p) to start an intake with a Liaison Coordinator (LC)
- **Child/Adolescent Services -** Open to pediatric healthcare clinicians.
- **MMH Services:** Warmline is open to any professional who works with perinatal individuals, including:
  - Prescribing (physicians, NP, PA, CMN, etc.) and non-prescribing practitioners (therapists, social workers, nurses, etc.)
  - Other practitioners who might interact with individuals in the perinatal period in a professional capacity, i.e.,
    - Lactation counselor, Home health aide, Community mental health worker, LPN, Nurse aide, Peer counselor, Social service staff (WIC, CPS/ACS, etc.), Family educators, Service coordinators/ or case managers, CASACs, State and local residential or in-patient facilities and Hospital staff, especially labor and delivery or ED teams.

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Referral, Resource & Linkage Support

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

- Clinical treatment
- Care management
- Patient and family support

Project TEACH provides referrals to:

- Any professional who supports perinatal patients.
- Healthcare clinicians that treat children and adolescents (up to age 22)

Any professional in the state can call the Project TEACH warmline for MMH referral support: 855-227-7272

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Telephone Consultations

Project TEACH provides pediatric, family medicine and maternal health prescribers the opportunity to consult with child and adolescent psychiatrists and reproductive psychiatrists.

Consultation with a perinatal psychologist is open to mental health or physical health clinicians.

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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What happens when you call?

- Prescriber, or other staff, can start the intake:**1-855-227-7272**
- Liaison coordinator answers the call and takes down clinician info and summary of patient case or general question.
- A psychiatrist or perinatal psychologist calls back the prescriber or clinician at their preferred time (within 30 minutes or at convenience of the caller).

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Who can consult with the Psychiatrists?

- Prescribers: Physician, NP, PA, Resident, Fellow
- Practicing in: Pediatrics, Med/Peds, Family Medicine, Ob/Gyn, MFM,Internal Medicine, Neurology, Psychiatry, etc.
- Location: Inpatient, Outpatient, ER, Private practice, etc.

Who can consult with the Perinatal Psychologist?

- Mental health and physical health clinicians
- Allied health professionals working with perinatal patients

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Patient Evaluations

with a Child/Adolescent or Reproductive Psychiatrist

During a telephone consultation, a request or recommendation may be made for one of our child/adolescent or reproductive psychiatrists to provide a face-to-face evaluation of your patient.

- Offered virtually*, these face-to-face patient evaluations occur **within two weeks of request.**
- The prescriber will receive an evaluation report within 2 business days.

*MMH evaluations are all virtual. Some child/adolescent evaluations are offered in-person.

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Specialty Consultation with a Content Expert

Specialty Consults are provided at the recommendation of the CAP/RP or at the request of a PCC.

0-5 Years
- Evelyn Berger-Jenkins, MD, MPH (Columbia)
- Kenya Malcolm, Ph.D. (U of Rochester)

Autism Spectrum Disorder
- Michael Cummings, MD (Buffalo)
- Pankurhee Vandana, MD (Columbia)

LGBTQ
- Richard Pleak, MD (Northwell)

Problem Sexual Behaviors
- Barbara Libov, Ph.D. (Northwell)
- Jamie Gaglianese, MS, LMHC (Syracuse)

Substance Use – Child/Adolescent
- Scott Krakower, DO (Northwell)

Substance Use - MMH
- Seetha Ramanathan, MD (Syracuse)

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Training

- **Intensive Trainings**
  Spring and Fall (1 virtual and 1 live) for Child/Adolescent (15.0 CME) & MMH (6.0 CME)
- **Core Topic Trainings**
  Offered onsite or virtually to practices or agencies seeking in-house education.
- **Webinar Wednesday Series**
  5 Child/Adolescent and 5 MMH topics (Noon – 1 pm on Wednesdays)
- **Archived Events Online at www.ProjectTEACHny.org**
- **Educational Resources**
  Clinical (rating scales, toolkits, videos and links) and Patient-Facing (fact sheets, videos and links)

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Intensive Training Programs – Fall, 2025

Child and Adolescent Intensive Training • Live, Virtual Event • 15.0 CME Credits

Sunday, October 27th and Sunday, November 2nd • Noon – 4 pm
Monday, October 28th and Monday, November 3rd • 8 am – Noon

"Child and Adolescent Mental Health for Primary Care Clinicians"

Presented by Project TEACH's team of Child/Adolescent Psychiatrists, along with clinicians from pediatrics & family medicine.

Maternal Mental Health Intensive Training • In-Person Event • 6.0 CME/CEU Credits

Monday, November 17th • 8:30 am – 4 pm • Albany Hilton, Albany, NY

"Foundations in Perinatal Mental Health: Your Role in Support, Screening and Treatment"

Presented by Project TEACH's team of Perinatal Psychiatrists, Psychologists and clinicians from family medicine and ob/gyn.

www.ProjectTEACHny.org/events

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Child/Adolescent Core Topic Trainings

- Offered directly to pediatric practices & scheduled at your convenience
- 1.25 CME/topic
- Trainings are specific to how each topic presents and can be managed in a primary care setting.

Core 1.0 Topics

- ADHD
- Anxiety
- Depression
- Aggression
- Trauma Informed Care

Core 2.0 Topics

- Suicide Assessment and Management
- Eating Disorders
- Self-Injurious Behavior
- Role of PCC in Management of ASD/IDD
- School Refusal

To Schedule: Call the warmline 855-227-7272

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MMH Core Topic Trainings

- 1-hour courses offered directly to your agency or practice.
- Trainings are designed to meet the needs of the audience.

Now Presenting

- Recognizing & Assessing Mental Health Concerns: Next Steps in Care
- Suicide Risk Assessment & Management
- Non-Prescriber's Guide to Psychiatric Medications
- Treating Depression & Anxiety: Psychopharmacological Approaches
- Trauma Bipolar Disorder: Psychopharmacological Approaches

Coming Soon

- Trauma-Informed Care
- Substance Use Treatment Approaches
- Supporting BIPOC Individuals
- Health Transitions to Parenthood

To Schedule: Call the warmline 855-227-7272

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Webinar Wednesday Series

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

March 26th	"Will You Write a Letter for Home Instruction? Setting Limits with Patients & Families"
May 28th	"How to Reach That 16-page Neuropsychological Evaluations: What is Important?"
July 16th	"Could This Be Autism? Supporting Tweens & Teens w/Social Communication Differences"
September 17th	"OCD: Anxiety's Sneaky Cousin"
November 19th	"Prenatal Exposure to Alcohol: Neurodevelopmental Effects"

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

February 26th	"Clinical Use of Zuranolone for Postpartum Depression"
April 30th	"Marijuana Use in the Perinatal Period"
June 18th	"Patient-Centered Care: How to Talk About Weight During the Perinatal Period"
October 15th	"Passion and Parenthood: Bridging the Gap in Perinatal Sexual Health"
December 17th	"Infant Mental Health: What it is and how to promote it in your work with families"

www.ProjectTEACHny.org/events

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Scholarships to support MMH Certification

- Project TEACH provides scholarship and mentorship opportunities with the following professional programs:
  - National Curriculum in Reproductive Psychiatry (NCRP)
  - Perinatal Mental Health Certification Program (PMHC) through Postpartum Support International
  - The ROSE (Reach Out, Stay Strong, Essentials) Program Annual Training

- Application information will be posted on our website.
  (Launching October 2025)

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Archived Training Events

Many past webinars from our faculty are available to participants on a range of maternal mental health topics. Stored in our Learning Management System (LMS), these trainings are available with CME+/CEU credit—at no cost.

Create an account and view our catalogue by clicking “Earn CME” on our website: www.ProjectTEACHny.org

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Educational Resources

On our website and in our emails, you can find:

- Physician Resources
  - Rating scales, prevention education, journals and guides
  - MMH and child/adolescent psychiatry tool kit for non-psychiatric practitioners
- Patient and Family Resources
  - Videos and PDFs on mental health topics
  - 4 child/adolescent and 2 maternal resources added each year
    - Available in 7 languages.

https://projectteachny.org/resources/mmh-resources/

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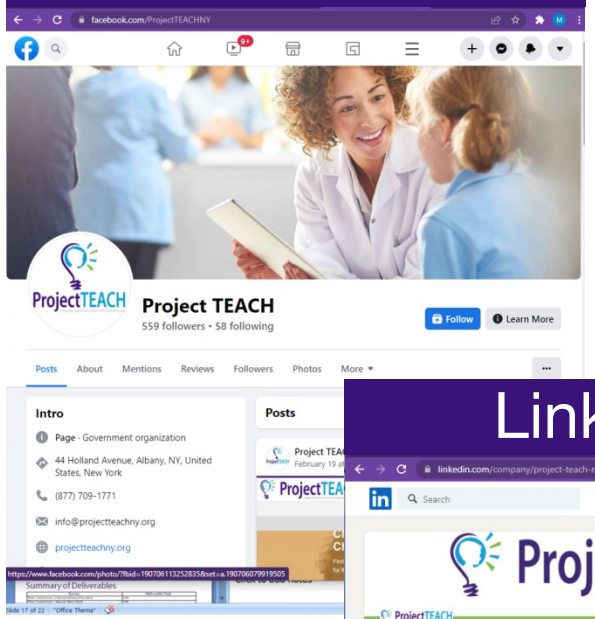
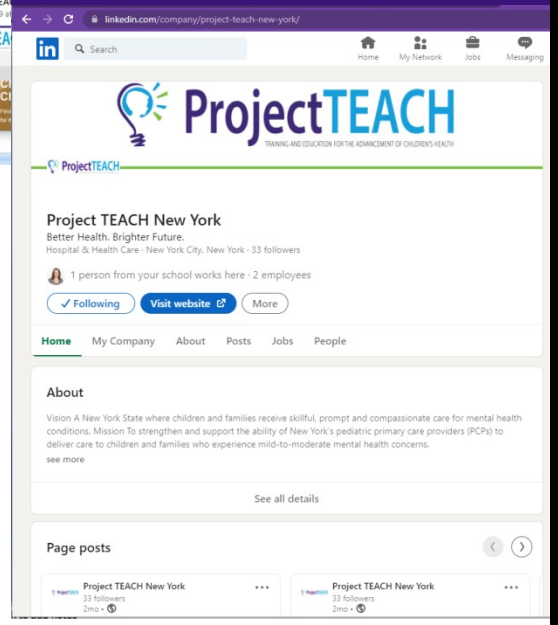
Stay in touch with us, access resources and register for no-cost CME

Facebook



LinkedIn



Website - www.ProjectTEACHny.org

Let's Work Together!

- Call our warmline for consultation and/or referral support: **1-855-227-7272**
- Attend an education event
- Tell a colleague about Project TEACH services
- Be social with us. Like our Facebook and/or LinkedIn pages or fill out a Stay In Touch form on our website.

Questions?

NEW YORK STATE'S CHILD/ADOLESCENT & PERINATAL PSYCHIATRY ACCESS PROGRAM

ProjectTEACH

FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Supporting Pediatric and Maternal Health Clinicians to Deliver Quality Mental Health in NYS.

Telephone Consultations

Linkage & Referral Support

CME Education Programs

1.855.227.7272

Monday - Friday • 9 am - 5 pm

Services are at no-cost to clinicians in New York State.

NEW YORK STATE | Office of Mental Health

HealthySteps

Marcia E. Rice, R.N., M.S.
Mental Health Program Specialist
Office of Prevention and Health Initiatives

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Poll: How Familiar Are You With HealthySteps?

Please select the option that best describes your familiarity with the HealthySteps program:

- I've never heard of it
- I've heard of it, but don't know much
- I'm somewhat familiar
- I'm very familiar
- I work directly in a HealthySteps site

HealthySteps Overview

HealthySteps "provides early childhood development support to families where they are most likely to access it – the pediatric primary care office."

HealthySteps is a program of Zero To Three

Source: https://www.healthysteps.org/

Source: https://www.healthysteps.org/our-impact/
https://youtu.be/gI2fMA5STpE

HealthySteps Overview:

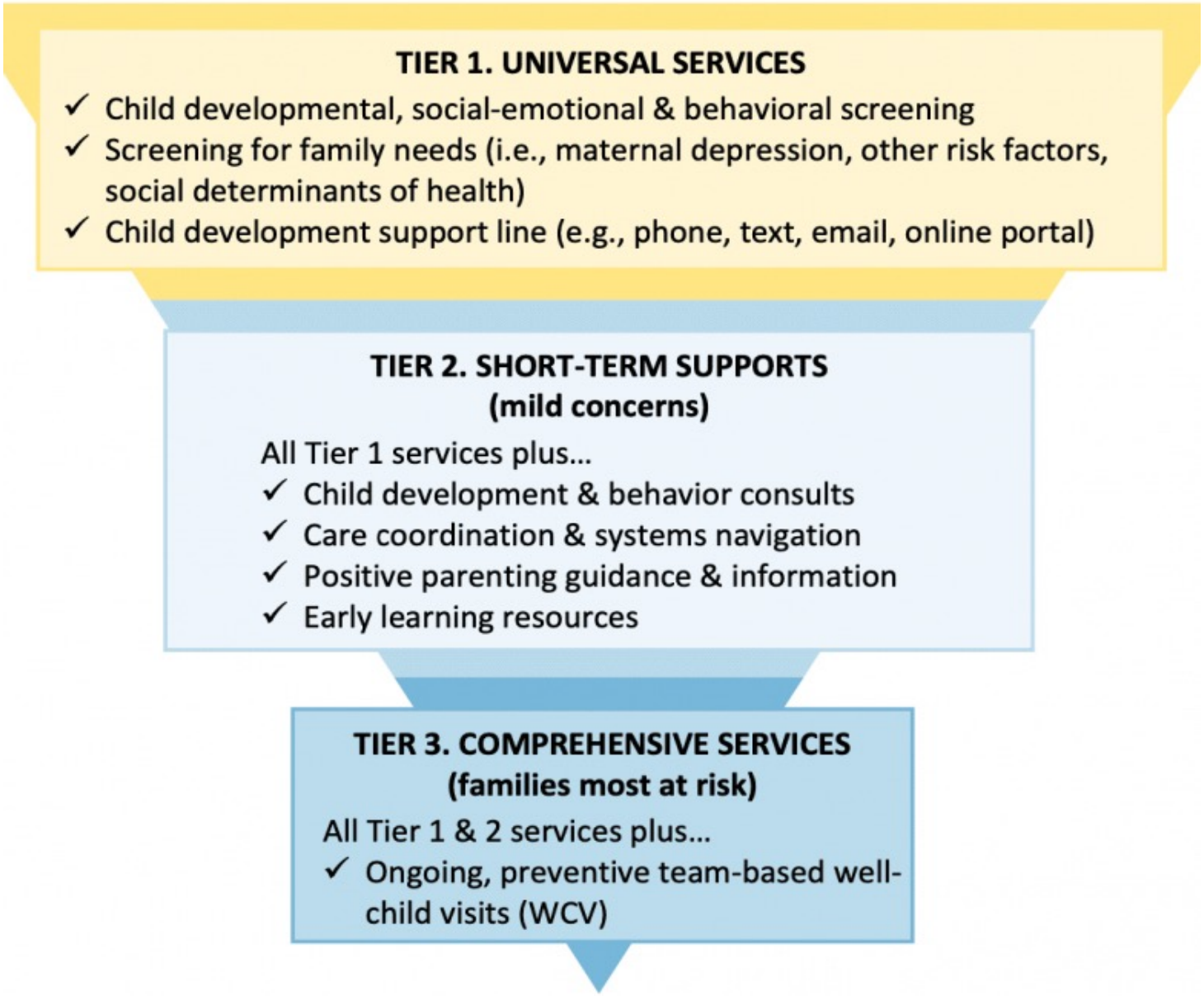
- A key component of the program is the addition of a

HealthySteps Specialist

- The specialist is a professional with expertise in child and family development who becomes a part of the pediatric care team

Source:
https://www.healthysteps.org/what-we-do/

CORE COMPONENTS (SERVICES)



Source: https://www.healthysteps.org/what-we-do/our-model/tiers-and-core-components/

Reach Out and Read: https://reachoutandread.org/

HealthySteps Evidence

The HealthySteps model shows desirable impact in many areas including the following domains:

- Child safety
- Early literacy and school readiness
- Parenting skills and engagement
- Family health and wellbeing
- Quality of care and connections
- Well child visits, vaccines, and screenings
- Breastfeeding and early nutrition
- Maternal depression

Source: https://www.healthysteps.org/our-impact/the-evidence-base/

HealthySteps Equity

"When we remove barriers and promote greater access to opportunity, flourishing is possible for everyone."

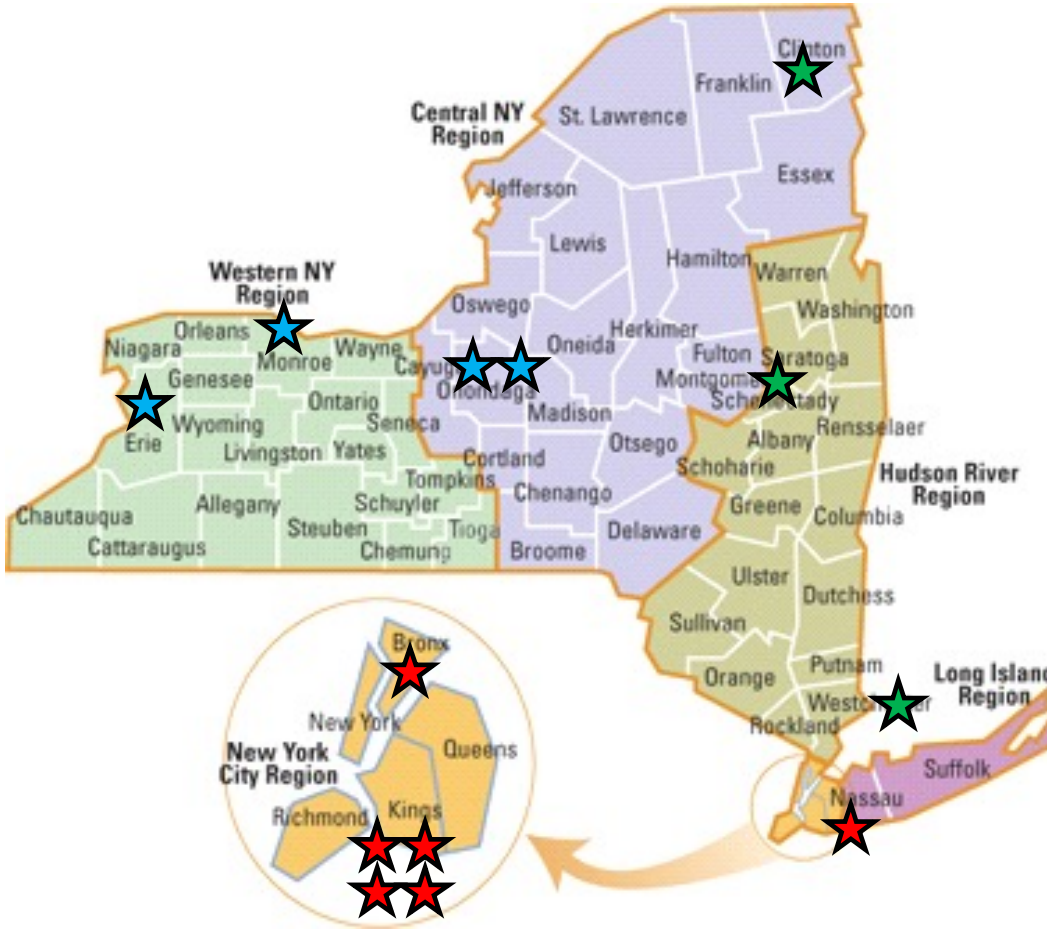
Sources: https://www.healthysteps.org/our-impact/health-equity/

https://www.healthysteps.org/wp-content/uploads/2021/07/HealthySteps_Advances_Health_Equity.pdf

OMH Legacy HealthySteps Sites

- In 2016, the NYS Office of Mental Health issued an RFP for the implementation of HealthySteps in pediatric primary care practices throughout the state.

- There are currently 13 OMH funded legacy sites from 2016



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OMH HealthySteps 2022 Sites

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OMH HealthySteps 2023 Expansion Sites

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OMH HealthySteps 2024 Expansion Sites

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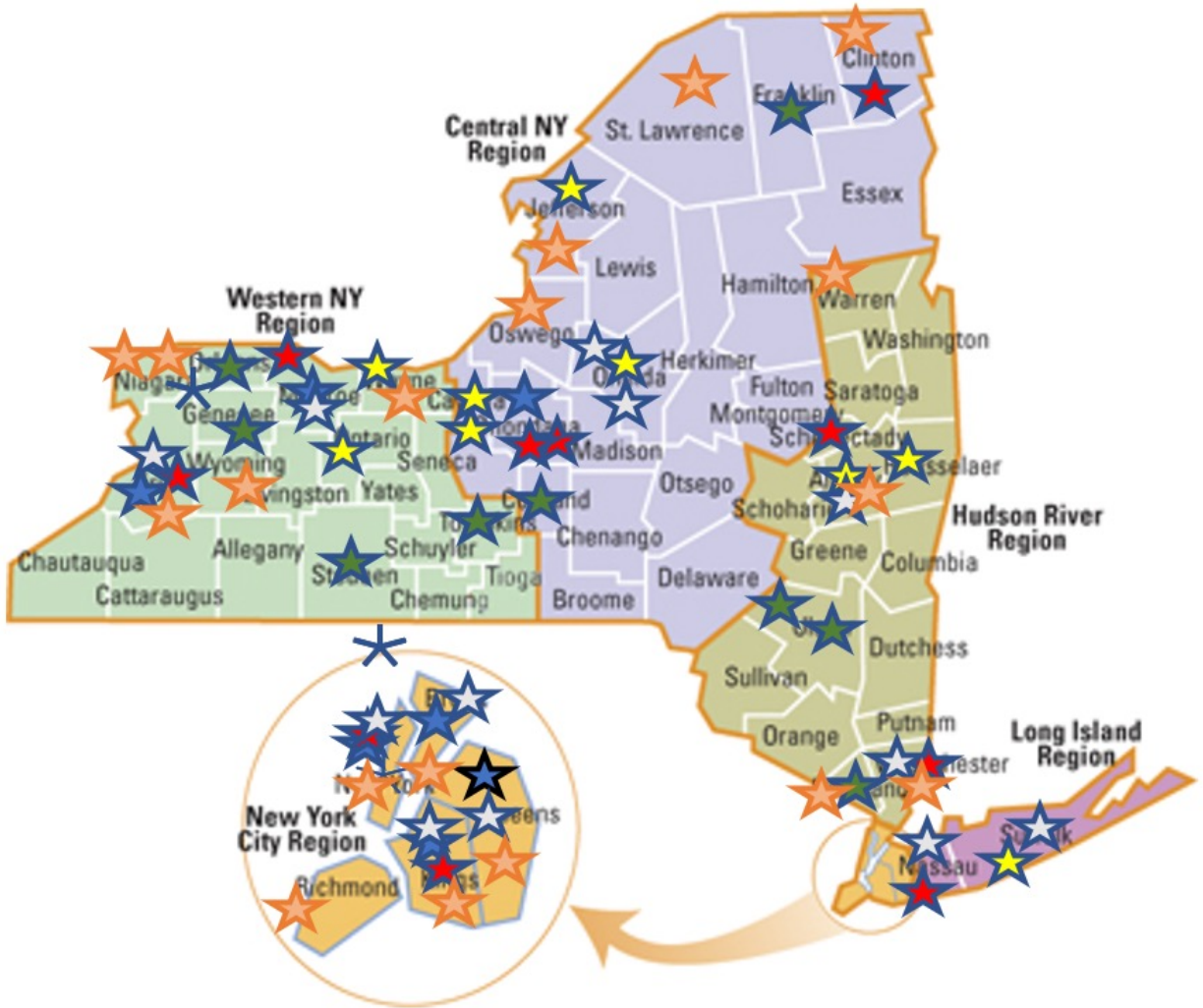
OMH HealthySteps Awards made as of 2024 (125)



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HealthySteps Continued Expansion Efforts

- Goal of 224 awards by 2027
- OMH Procurement Opportunities https://omh.ny.gov/omhweb/rfp/

OMH HealthySteps Sites Impact (updated as of 6/30/2025)*

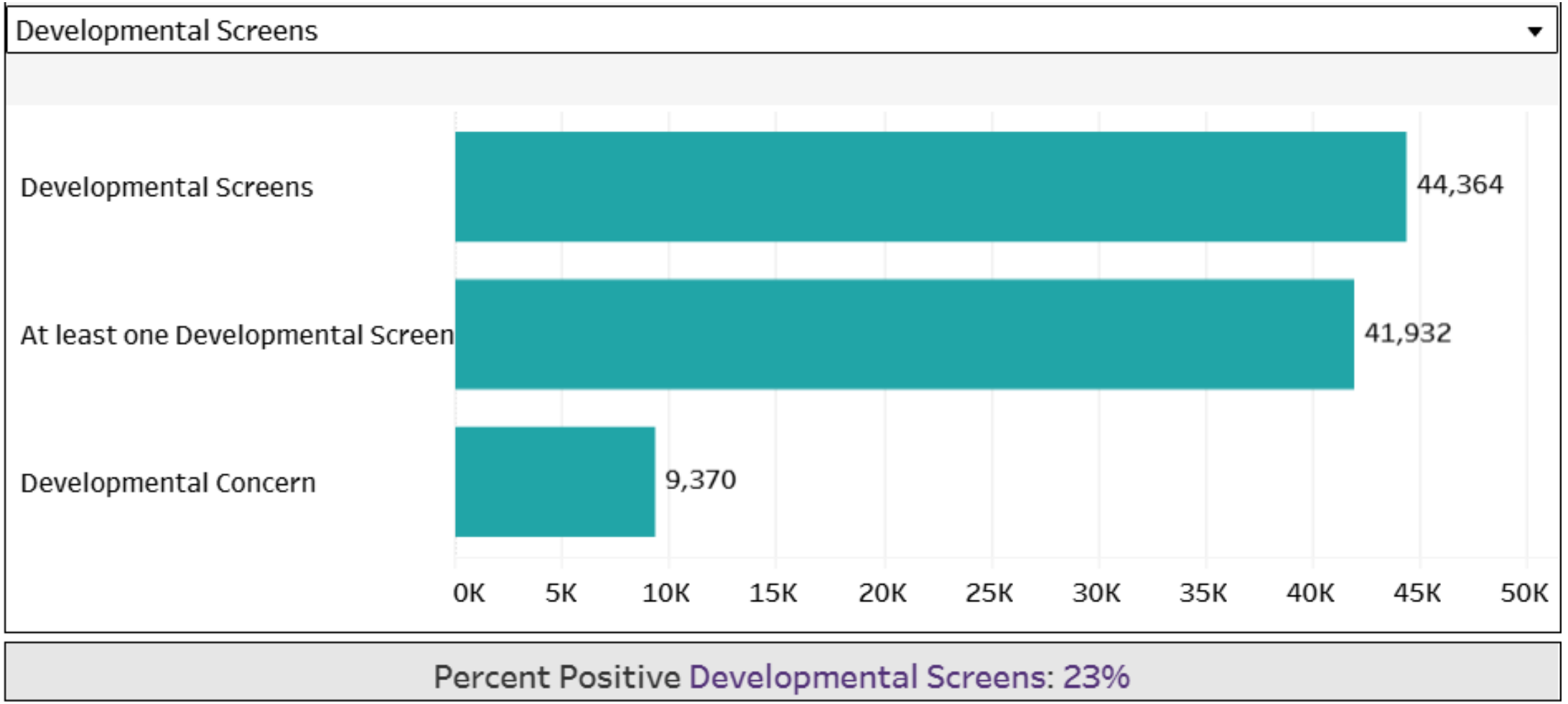
Number of Children who received Tier 1 Services* in 2024 = **52,936**
Number of Children who received Tier 1 Services Q1 2025 = **47,680** (1/2025-3/2025)
Number of Children who received Tier 1 Services Q2 2025 = **45,703** (4/2025-/2025)

Select Cumulative Data

- **Number of Developmental Screens = 85,973**
- **Number of Autism Screens = 41,682**
- **Number of Social-Emotional Screens = 59,146**
- **Number of Maternal Depression Screens = 76,851**

- Data includes Legacy sites and June 2022 and November 2022 cohorts who started providing data on 1/1/2024. Total 47 sites
- Tier one services include all children ages 0-3 in each practice plus 4 and 5 years old in sites who choose to serve those ages.

OMH HealthySteps Sites Impact: Child Development: 2024



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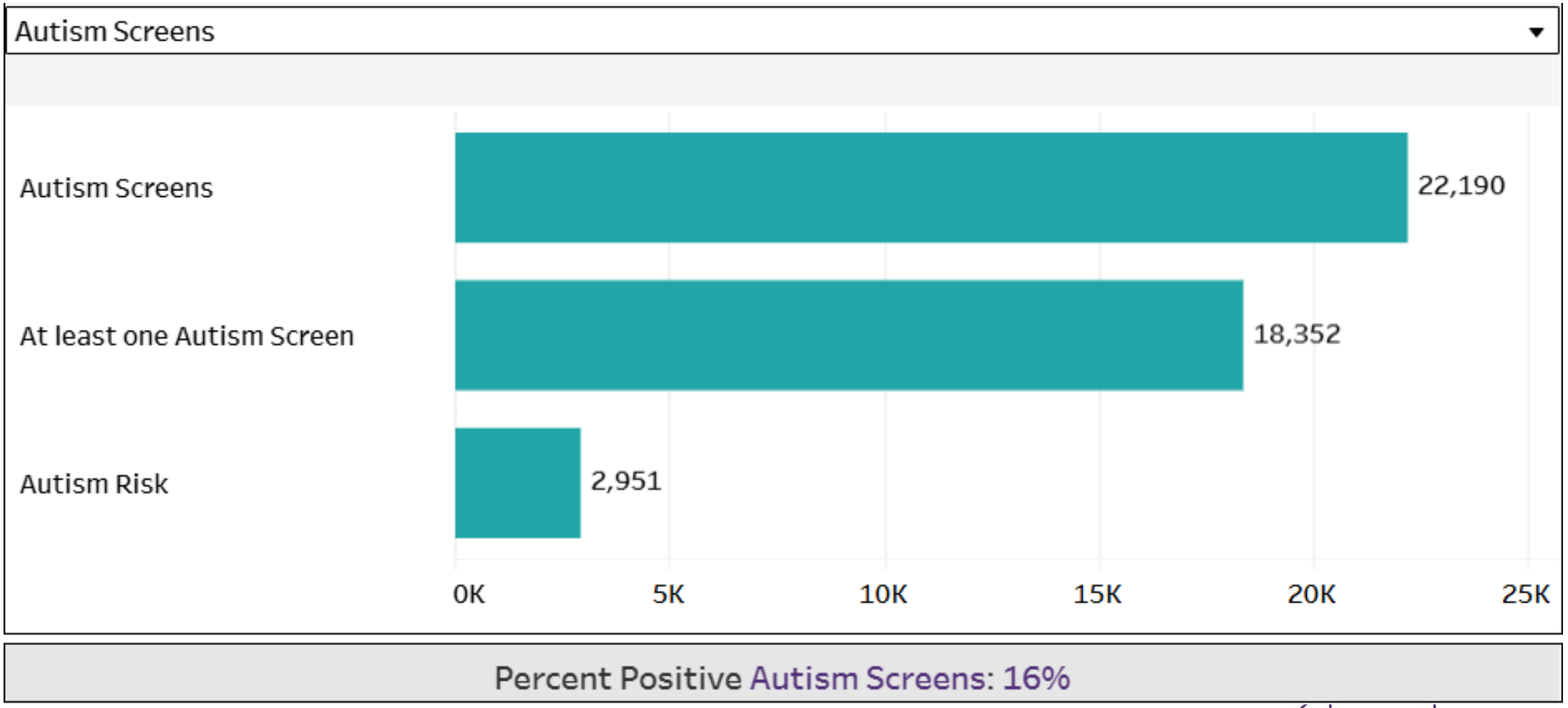
OMH HealthySteps Sites Impact: Child Development: 2024



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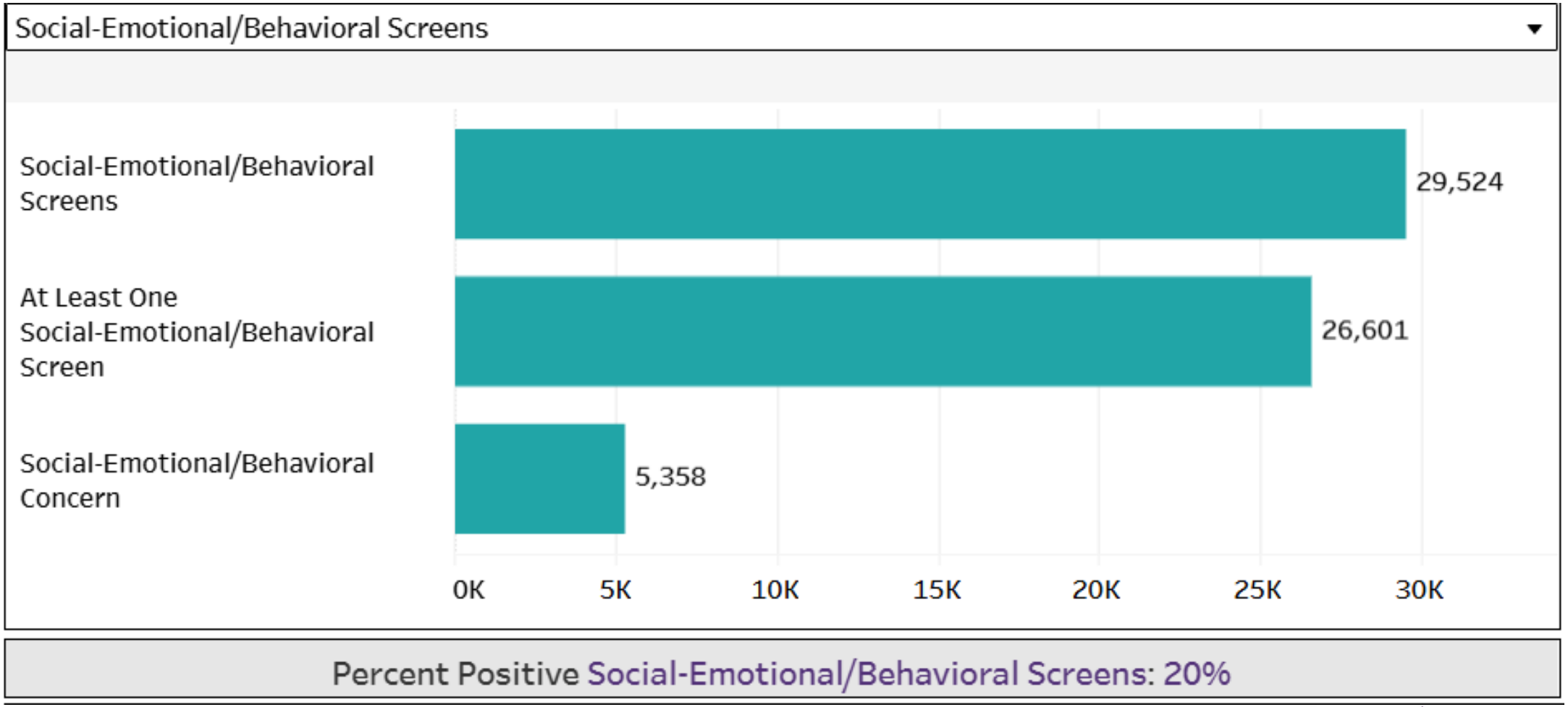
OMH HealthySteps Sites Impact: Child Development: 2024



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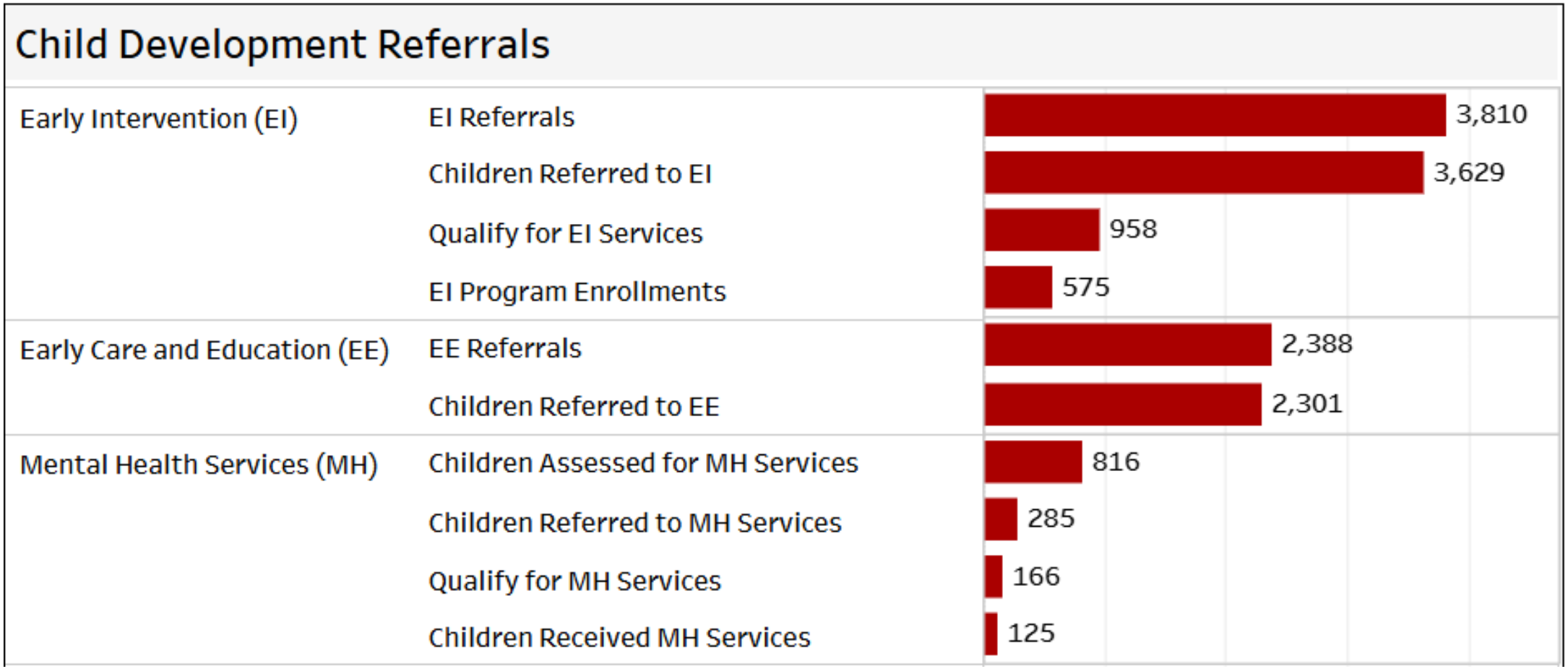
* Data includes Legacy sites and June 2022 and November 2022 cohorts who started providing data on 1/1/2024. Total 47 sites.

OMH HealthySteps Sites Impact: Child Development: 2024



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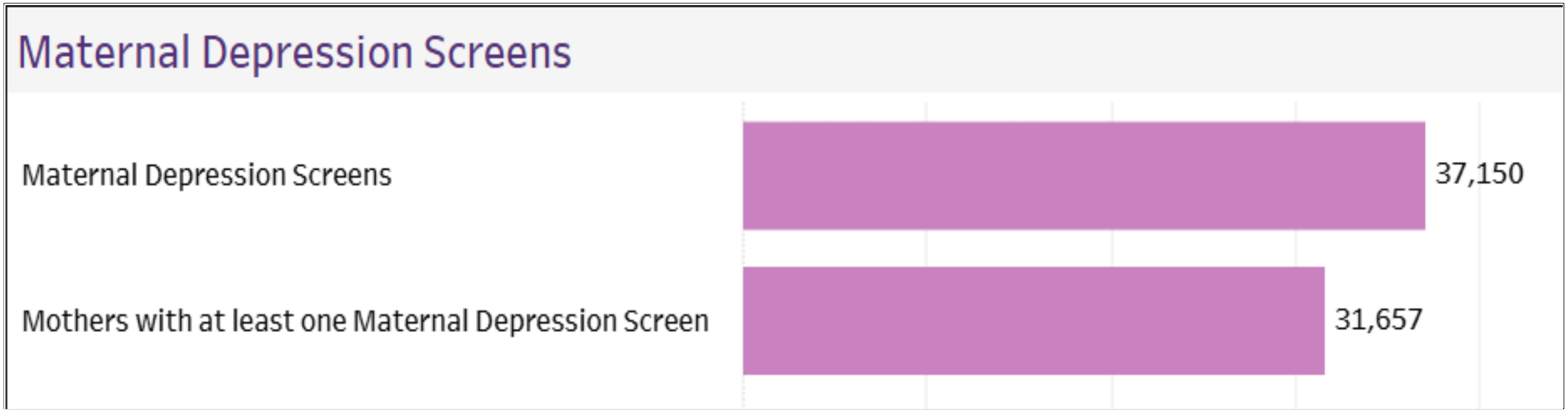
* Data includes Legacy sites and June 2022 and November 2022 cohorts who started providing data on 1/1/2024. Total 47 sites.

OMH HealthySteps Sites Impact: Maternal Depression 2024



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Data includes Legacy sites and June 2022 and November 2022 cohorts who started providing data on 1/1/2024. Total 47 sites.

OMH HealthySteps Sites Impact: Family Needs 2024

Family Needs Screens completed in 2024

- 40,618 Food Insecurity
- 32,217 Housing Instability/homelessness
- 32,267 Interpersonal Safety
- 20,410 Substance Misuse
- 29,355 Tobacco Use
- 33,486 Transportation needs
- 32,339 Utility needs

- 2282 ACEs Questionnaires

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Data includes Legacy sites and June 2022 and November 2022 cohorts who started providing data on 1/1/2024. Total 47 sites.

HealthySteps Resources

HealthySteps Website:
http://healthysteps.org/

HealthySteps Model:
https://www.healthysteps.org/what-we-do/our-model/

HealthySteps Evidence:
https://www.healthysteps.org/our-impact/the-evidence-base/

Find a HealthySteps site near you:
https://www.healthysteps.org/who-we-are/the-healthysteps-network/healthysteps-practice-directory/

Zero To Three:
https://www.zerotothree.org/

Contact Information

Marcia E. Rice, R.N., M.S.
Office of Mental Health
Mental Health Program Specialist
Office of Prevention and Health Initiatives
marcia.rice@omh.ny.gov

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Social Care Networks

Dr. Donna Demetri Friedman - Mosaic Mental Health

Introduction to Social Care Networks (SCNs): Bridging the healthcare gap

- **What are SCNs?** Regional groups of local organizations, primarily nonprofits, that address the health-related social needs (HRSNs) of Medicaid members.
- **Background:** The SCN program was established as part of the New York Health Equity Reform (NYHER) to improve overall health outcomes by focusing on social factors in addition to medical care.

Why are SCNs important?

Factors like housing instability, food insecurity, and lack of transportation can impact a person's health as much as clinical care.

Addressing Social Determinants of Health

Social Determinants of Health (SDoH) are the conditions in which people are born, grow, live, work, and age.

The "Why" Behind Social Care Networks

- **Key SDoH categories addressed by SCNs:**
  - **Economic Stability:** Employment, poverty, and financial security.
  - **Neighborhood and Environment:** Housing stability, home safety, and accessible public spaces.
  - **Social and Community Context:** Social support and safety.
  - **Food:** Food security and nutrition.
  - **Healthcare Access:** Connecting members to services like transportation for appointments.

How the SCN System Works: A Coordinated Approach to Care

- **Screening:** Identifying a Medicaid member's unmet social needs through standardized tools.
- **Navigation:** Connecting members to appropriate community services and resources.
- **Service Delivery:** Providing tangible services related to food, housing, and transportation.
- **Collaboration:** Working with a diverse network of healthcare providers, community-based organizations (CBOs), and health plans.
- **Technology:** Using a shared platform to facilitate referrals, track a member's journey, and ensure data privacy.

Social Care Networks in NYC

- New York City is divided into three SCN regions, each with a designated Lead Entity.
  - **Manhattan, Brooklyn, and Queens:**
    - **Lead Entity:** Public Health Solutions (WholeYouNYC). (646) 619-6400
    - **Coverage:** Serves over three million Medicaid members.
    - **Mission:** Works with a network of over 300 CBOs to screen members and connect them to resources.
  - **Bronx:**
    - **Lead Entity:** SOMOS Healthcare Providers, Inc. (833) 766-6769
    - **Screening:** Provides an online self-screening tool to identify needs.
  - **Staten Island (Richmond County):**
    - **Lead Entity:** Staten Island Performing Provider System (PPS). (917) 830-1140
    - **Services:** Connects residents to the SCN via their website.

Services Offered through NYC SCNs: A Comprehensive Approach to Support

- **Housing Services:** Assistance with housing applications, finding temporary housing, rental assistance, and minor home modifications.
- **Food and Nutrition:** Referrals to food pantries, home-delivered meals, and cooking supplies.
- **Transportation:** Non-emergency transportation services for medical appointments and other essential social service visits.
- **Care Management:** Navigators help members understand their options and get connected to the right services.

How Medicaid Members Can Get Help

- **Initial Step:** Medicaid members can contact the SCN for their borough.
- **Screening:** A Social Care Network can help members identify needs related to their living situation, access to healthy food or transportation, employment, education, and personal safety.
- **Navigation:** A navigator will help locate services in the community and assist in getting connected.
- **Additional Services:** For those with certain qualifying health conditions, temporary services may also be available.

Measuring Success and Impact: A Focus on Outcomes

- **Health Equity:** The SCN program is designed to reduce health disparities by addressing systemic social issues.
- **Improved Outcomes:** Measuring the impact on members' health, including potential reductions in emergency room visits and hospital readmissions.
- **Cost Reduction:** By addressing underlying social needs, the program aims to reduce overall healthcare costs.
- **Community Engagement:** SCNs empower community-based organizations and foster collaboration among local partners.

The Future of SCNs: Integration and Expansion

- **Sustainability:** Ensuring that SCNs and their provider networks are financially sustainable.
- **Data Integration:** Further integrating data between healthcare and social service providers to improve care coordination.
- **Equitable Access:** Continual efforts to ensure all eligible Medicaid members can easily access the resources they need.