ESTABLISHING BEST PRACTICES FOR COMMUNITY HEALTH WORKER PROGRAMS ON LONG ISLAND

Recommendations to strengthen and sustain Community Health Worker (CHW) Programs across Long Island in preparation of the New York State 1115 Medicaid Waiver Amendment

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INTRODUCTION

Health and Welfare Council of Long Island (HWCLI) and the Health Equity Alliance of Long Island (HEALI) Coalition

HWCLI's Mission
Established in 1947, the Health & Welfare Council of Long Island (HWCLI) is a regional, nonprofit umbrella organization for health and human service providers. We are dedicated to improving the lives of Long Island's most vulnerable residents by responding to their needs through the promotion and development of public policies and direct services.

HWCLI serves the interests of poor and vulnerable people on Long Island by convening, representing, and supporting the organizations that serve them; and through:

- Illuminating the issues that critically impact them
- Organizing community and regional responses to their needs
- Advocacy, research, and policy analysis
- Providing services, information, and education

HWCLI's Approach
At HWCLI, we operate a series of programs that address the day-to-day challenges of suburban poverty, including nutritional security, economic stability, access to healthcare, and access to affordable health insurance. Together with our network of nonprofits, we provide a unique, crucial safety net for our neighbors who fall into an under-recognized category of suburban poverty – those who earn too much to qualify for federal assistance programs, but not enough to sustain the high cost of living on Long Island.

Simultaneously, we engage with local, state, and federal government to advocate for strong policy agendas that prioritize Long Islanders and the systems and services that impact those who are most in need. We partner with agencies across Long Island to unite our region's nonprofit community because we understand that together, our sector is more resilient, and our voices are more powerful. We believe grassroots community engagement is essential.

Our direct service programs inform our policy, advocacy, and convening work and vice versa. Each branch of our work is strengthened by the insights and understanding provided by the others.

The Health Equity Alliance of Long Island (HEALI) Coalition
One of HWCLI's coalitions is the Health Equity Alliance of Long Island, which formed under the NYS Medicaid 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) Program. The coalition convened

community-based providers focused on the wide variety of social care needs and continued beyond the DSRIP funding period with in-kind support from HWCLI. HEALI's focus is to engage health and human service agencies, community members, and other stakeholders to ensure equitable health and life outcomes for all Long Islanders through cross-sector partnerships, innovative funding strategies, and improvements in the health & human service delivery system. Under the leadership of the HEALI Steering Committee, the coalition uses our collective power to influence public policy and investment decisions by funders.

In response to the COVID-19 pandemic, HWCLI convened the sector across Long Island and determined that emerging and exacerbating health disparities and healthcare workforce shortages were among many concerns consistently stressed over the course of the organization's COVID response work - concerns that aligned with the existing focus areas of HEALI.

At the same time, NYS Department of Health also identified the health inequities that intensified over the course of the pandemic and made the healthcare delivery issues and disparities the key pillars of their 1115 Medicaid Waiver application to the Centers for Medicare and Medicaid Services (CMS).

1115 Medicaid Waiver Background

Health disparities have been a public health concern in the United States long before the COVID-19 pandemic. However, as the pandemic evolves, we continue to learn that racial minority groups such as Black, Hispanic, as well as low-income populations are facing disproportionate effects of COVID-19.[1] These groups had higher risk of COVID-19 cases and deaths and an increased prevalence of co-morbidities such as diabetes and cardiovascular disease that exacerbated the negative effects of the virus.[2] In addition, Social Determinants of Health such as financial status, environment, healthcare access and cultural factors have contributed to negative health outcomes related to COVID-19 for these populations. For example, having limited access to health care and health insurance, facing higher rates of food and housing insecurity due to financial instability, and immigration status concerns all play a critical role in terms of the quality of health care received and overall health outcomes.[3]

On Long Island in particular, these disparities were pronounced even before the pandemic, as Long Island is one of the most segregated regions in the nation. Predatory real estate practices, restrictive covenants and other forms of de jure segregation set into place patterns of segregation that have persisted for decades. Deeds on Levittown's initial 17,400 homes prohibited their ownership or occupancy by "anyone other than a member of the Caucasian race." In 2019, Newsday conducted an undercover investigation of ongoing predatory real estate practices that perpetuate segregation on Long Island. For these and several other reasons, disparity of household incomes and rates of child poverty fall along the same lines of racial segregation.

Not surprisingly, significant health disparities such as disproportionate prevalence of cancer, diabetes, heart disease, asthma, behavioral health, addiction, and maternal mortality are experienced in Long Island's low income and segregated communities of color. These health disparities were further evident during COVID with the number of cases, hospitalization, and death devastating communities of color on Long Island. Though the makeup of Long Island is sometimes generalized based on pockets of wealth across the region, Long Island is home to 768,476 Medicaid beneficiaries, or 10% of the State's total Medicaid population, showing ample opportunity for the 1115 Medicaid waiver to have a significant impact on the lives of hundreds of thousands of individuals.

It is evident that significant changes must be made to address health disparities that have amplified the negative effects of the pandemic among vulnerable groups. Since health disparities are based on a multitude of factors, a more person-centered and adaptable approach will be key when making equity-based advancements to improve overall health outcomes. New York State has planned a multi-year renewal of a Section 1115 Medicaid Waiver Amendment that improves integration of the health and human service delivery system across the State. The waiver aims to create equity-focused opportunities to serve populations in need and advance the healthcare delivery system to most appropriately and effectively address health disparities emphasized by COVID-19 across the state of New York.[4]

1. *"Building a more resilient, flexible and integrated delivery system that reduces racial disparities, promotes health equity, and supports the delivery of social care."*

2. *"Developing supportive housing and alternatives to institutions for the long-term care population."*

3. *"Redesigning and strengthening health and behavioral health system capabilities to provide optimal response to future pandemics and natural disasters; and*

4. *"Creating statewide digital health and telehealth infrastructure."*

As a result of the pandemic, there has been an undeniable amount of strain on the healthcare system and professionals. Hospitals and nursing homes serving populations in need across the state have faced many concerns that were prevalent even before the pandemic. Specifically, health care workers have worked in stressful conditions for an extended period that have led to negative impacts on mental health and staffing shortages, affecting workforce sustainability in the short and long term. New York State has identified Community Health Workers (CHWs) as a critical member of health and social care teams to mitigate the current issues facing the health care systems and the burden on patients and physicians. The waiver aims to address these deeply rooted concerns by reconstructing the health care system and workforce to effectively serve New York's Medicaid population, focusing on health equity to reduce health disparities, and implementing sustainable mechanisms to support the workforce to better serve under-resourced populations. The State proposes to do this by building a sustainable CHW workforce that will prioritize: [5]

- Providing training for the workforce to bolster CHW skillsets to adapt and manage pandemic-focused responsibilities and changing patient and community needs

- Improving workforce sustainability with the provision of career advancement opportunities such as training and continuing education

- Increasing CHW training, funding, and integration in alignment with the goals of the waiver to effectively address health inequities and workforce shortages across NY exacerbated by COVID-19

Investing in these key areas will play in integral role not only in the advancement of the health care delivery system, but also in the development and sustainability of the CHW workforce that will strengthen and adapt to serve communities in need.

As New York State plans a multi-year renewal of an 1115 Medicaid Waiver that improves integration of the health and human service delivery system across the State, HWCLI and the HEALI coalition are working to ensure the readiness of CBOs and CHW programs in the region to utilize these resources effectively.

ABOUT THIS MANUAL

To prepare the region for the 1115 Medicaid Waiver, HWCLI has taken steps to understand the community health worker workforce on Long Island. New York does not have uniform standards of the definition, implementation, and sustainable funding of the Community Health Worker (CHW) role and CHW programs. This manual provides stakeholders with key recommendations and action steps to strengthen CHW programs across LI and increase integration of CHWs within health care delivery systems.

Long Island Community Health Worker Survey

HWCLI created a Community Health Worker Survey that was sent to Community Based Organizations (CBOs) across Long Island with current or previous CHW programs. There was a total of **38** responses from **25** organizations across Long Island. The survey assessed which organizations employ CHWs and asked additional questions related to funding, roles, titles, and education. The results of the survey guided the framework of the follow up key informant interviews with CBOs to further gauge the needs of CHW workforce development.

Key Informant Interviews with Long Island CBOs

HWCLI conducted Community Health Worker Key Informant Interviews with eight Long Island organizations to gain a deeper understanding of the infrastructure, implementation, needs, and goals of CHW programs among CBOs on Long Island.

The interviews focused on four key areas:

1. *Hiring, recruitment and professional development process*: Identified key strategies to enhance CHW recruitment and retention practices and challenges.
2. *Funding streams*: Identified potential for expansion and challenges associated with funding sustainability and growth.
3. *Populations served by CHWs*: Identified gaps filled by CHWs in the community and ongoing population needs.
4. *The vision and goals for the program*: Gauged the scope of CBOs' short-term and long-term vision in the context of CHW workforce development and sustainability.

A discussion guide with questions under each target area that were utilized to guide interviews can be found in **Appendix 1.**

The development of this CHW Workforce Development Manual was based on the outputs of these activities coupled with collaborative work with Public Health Solutions (PHS), the largest public health nonprofit serving New York City to improve health outcomes and help communities thrive. PHS has vast experience in developing and managing a CHW workforce and provided examples from the state of New York and across the United States.

Key Recommendations

This Manual includes recommendations and key action steps for HEALI and other stakeholders in the context of implementing, strengthening, and sustaining a CHW Workforce on Long Island.

I.ESTABLISHING YOUR CHW WORKFORCE

The Centers for Disease Control and Prevention (CDC) defines the Community Health Worker (CHW) role as an individual who "serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery." [6] CHWs play a unique role in healthcare and social service delivery by engaging and working with patients and families by meeting them where they are based on their needs, priorities, and preferences. CHWs provide services in various roles and titles that make the role extremely versatile and an integral part of the overall healthcare system. **See Figure 1.**

Figure 1: Various CHW Roles

A CHW may play all or some of the roles shown above due to the complexity and overlap of services that CHWs provide under each role designation. As a case manager, CHWs conduct need assessments to refer clients to the appropriate services they require. As a community educator, CHWs provide pertinent information on health-related topics and behaviors to individuals with the intention of encouraging wellness and health. As a Peer Specialist, CHWs often have lived experience like that of the client and is able to relate to challenges clients are facing and offer a unique perspective. As a Health Liaison, CHWs serve as a bridge between medical professionals and clients.

As an advocate, CHWs listen closely to the needs of a client to properly assess and articulate what services are required if a client may not be able to. As a Patient Navigator, CHWs provide clients with support, advocacy, and assistance in benefits enrollment such as insurance. As Community Outreach Workers, CHWs

engage in targeted outreach to populations in need through the provision of education and resource support. Finally, as a Community Care Coordinator, a CHW is actively engaged with professionals from various disciplines in the health care system.

In addition to a wide variety of roles, CHWs provide key services in the following professional and community settings:

Figure 2: List of CHW Workplaces

In hospitals, nursing homes, clinics, and health centers, CHWs are assigned to individuals or groups of patients to provide support with disease self-management. Other responsibilities include assisting patients

> *"Some of the core skills are around not just having lived experience, but strategically supportively using it in support of the people that they're seeing and knowing when to disclose in a way that is helpful."*
>
> - *Chief Operations Officer, peer-led Long Island based CBO, during key informant interviews*

with general administrative procedures such as filling out medical forms. CHWs conduct home visits for clients that have impairments that impact daily activities, such as in aging and disabled communities. Community-based organizations employ CHWs to engage in outreach to key populations to provide education, screenings, and peer-based services. At schools, CHWs may be involved in health education programs and connecting students and families to essential services.

CHWs serve a broad range of populations including, but not limited to:

- People experiencing homelessness
- Racial/ethnic minorities
- Pregnant and newly parenting families
- Individuals with chronic health conditions
- Seniors

- Immigrant and undocumented populations
- Youth and their families
- Individuals living with mental illness or substance use
- Currently or formerly incarcerated individuals
- Other members of the public

CHWs engage with various populations to bridge community needs and the healthcare system at the local, state, and national level, and also empower clients by building trust that translates into improved health and well-being. Likewise, CHWs on Long Island have breadth of skillsets ranging from empathy to shared lived experience and deep knowledge of the communities they serve. **See Figure 3 below.**

Figure 3: LI CBOs Preferred CHW Skillset

During the key informant interview discussions about recruitment and hiring practices for CHWs, overall, the CBOs valued previous work and field experience over formal education or training programs. In fact, most of the CBOs interviewed have not recruited CHWs from related training and/or certification programs. Some of the CBOs recruited CHWs from training programs through Nassau Community College and Hofstra University.

It is important to note that in the state of New York, there are currently **no** certification or education requirements for CHWs. CHW training and certification programs and core competencies create pathways

for professional development and potential for growth in the field while keeping workers equipped with the pertinent skills to serve populations in a continually changing social and health landscape.

Recommendation: Due to the diversity of community needs and changing funding landscape, HEALI should elevate existing experience of CHWs. CHWs' professional and lived experience should be augmented with training to enable CHWs to remain adaptive and flexible as community and organization priorities evolve, with adequate funding to fully support continuing education opportunities.

Action Steps:

In the development of CHW programs on Long Island, HEALI should implement/require the following:

- Implementation of the Core Competencies listed below under Case Studies.
- Training opportunities that are accessible in terms of geography and time of day, given existing work schedules and cost.
- Training opportunities provided by CHW employers for CHW skillset growth and cultural competency.
- Prioritize Motivational Interviewing as a required course for hired CHWs.
- Candidate experience in related community health work including volunteer or paid experience working at a social service site.
- Candidate shared lived experience working with low-income populations, and/or people living with chronic conditions.
  Note: *Roles requiring complex systems navigators may require an associate degree or 3 years of related community health experience*

The following case studies showcase CHW competencies and trainings that have been established for the CHW Workforce in New York and across the United States. These examples provide Long Island with a foundational blueprint for CHW programs that will strengthen and advance their workforce.

CASE STUDIES:

Core Competencies

Community Health Worker Core Consensus Project

Implementing a set of core competencies that define the CHW role can be utilized as an effective measure to determine CHW eligibility on Long Island. The preferred core competencies established by the Community Health Worker Core Consensus Project (C3 Project) include Communication Skills, Interpersonal Skills, Service Coordination and Navigation Skills, Capacity Building Skills, Advocacy Skills, Education and Facilitation Skills, Individual and Community Assessment Skills, Outreach Skills, Personal Skills and Conduct, Evaluation and Research Skills, and Knowledge Base. These recommended core competencies established by the C3 Project have been supported by 15 National Public Health Organizations and acknowledgement/use by 20 state policy initiatives. This broad national support strengthens the case for local adoption on Long Island to bring uniformity to the Long Island CHW workforce to best serve communities in need. [7]

CHW Trainings

The Academy for Community Behavioral Health (Free)

The Academy for Community Behavioral Health "is dedicated to strengthening the role social service providers play in behavioral health. We invest in the knowledge, skills, and wellbeing of these providers so they can address related social, economic, and behavioral health inequalities with communities. Together, we aim to transform access to compassionate and culturally responsive care where it is needed most." This program offers courses for free in a variety of areas which teach CHWs to tailor their approach to each individual client/patient to effectively build trust and provide services. Additionally, these courses are also a great way to support the workforce as well as there are opportunities for CHWs to prevent and manage work related burnout and prioritize mental health. Key themes covered in the courses for social service providers include:

- Engaging in compassionate conversations with clients
- Building Emotional Intelligence skills
- Understanding Mental Health related topics such as grief and posttraumatic stress
- Education on the impacts of racism on healthcare delivery
- Motivational Interviewing

The Motivational Interviewing course offered at The Academy for Community Behavioral Health is focused on educating and training social service providers such as CHWs with the key skills on guiding patients and clients to encourage them to make positive behavior changes such as getting vaccinated, managing substance use and addiction, and managing health related conditions. Participants of this training series will learn how to implement skills such as compassion, empathy, and active listening to encourage clients to make decisions that will benefit them. [8] Furthermore, evidence shows that Motivational Interviewing focuses on the "ambivalence" that a client may have when making a behavior change decision and aims to dig deeper into the uncertainty to discover personal motivations to engage in a positive behavior change. [9] This is extremely important as Motivational Interviewing focuses on emphasizing an individual's autonomy and allowing them to work towards making positive changes with the guidance of a service provider.

During the Key Informant Interview discussion, almost all the CBOs were interested in implementing Motivational Interviewing training as part of their organizational strategy to strengthen their CHW workforce. Motivational Interviewing trains CHWs to communicate effectively when interacting with clients to learn about their needs and gaps in care. The skills may be used when making appropriate referrals to ensure the client receives the proper resources and support. Motivational Interviewing is a critical training that must be offered and required for CHWs to participate on Long Island. Though New York City-based, The Academy's offering is something to mirror on Long Island.

New York University (NYU) Langone Health: **Community Health Worker Research & Resource Center**

The Community Health Worker Research & Resource Center is focused on strengthening the NYU CHW Workforce through the provision of professional developmental opportunities. Since 2018, this active

committee has been engaged in [10]

- *Technical Assistance and Evaluation*
    - Based on the valuable experience of NYU Langone Health's CHW programs, the committee provides CHW programs with expertise on focusing on key areas when implementing a program.
    - Having programs that are culturally framed to appropriately address the needs of communities.
    - Establishing CHW programs in various communities to expand reach.
    - Implementing evaluation plans- utilizing research methods such as data analysis, surveys, reports**.**

- *Community Health Worker Think Tank and Annual Summit*

    - CHW programs and initiatives all over New York City and even the U.S. all convene together to discuss methodologies for establishing and sustaining a successful CHW programs/workforce as well as identifying unanswered questions and needs of communities that are being served.

The Community Health Worker Network of New York City (Paid)

The Community Health Worker Network of New York City, an organization primarily focused on strengthening the CHW workforce in the contexts of research, education, and advocacy, emphasizes the importance of having CHW trainings to strengthen the unique skillsets of CHWs. For example, in addition to being equipped with the pertinent knowledge of various healthcare disciplines, CHWs play a significant role in communities through empowerment and building trust. Furthermore, CHWs must consistently adapt to cultural, racial, and social settings to effectively connect and communicate with individuals and families. The Community Health Worker Network of New York City has created trainings that are focused on the complex role of CHWs while incorporating other disciplines such as Humanistic Psychology, Compassionate Communication, and Behavior Change Theory. CHW programs on Long Island should consider implementing these trainings to strengthen their role and increase integration in the healthcare system. [11]

II.CHW RECRUITMENT

Once an organization has determined the core competencies for a CHW role, the next step is to identify the right candidates. Below are questions to consider when creating a job description or reviewing resumes for the CHW program:

- Do eligible candidates have lived experience and/or experience working with the communities being served by your organization?
- Are language needs of existing and new client populations being met by CHWs?
- Will CHWs require a Bachelor's or Associate's Degree to meet documentation or other technical requirements?
- What is the organization's capacity to provide CHWs on staff with educational opportunities during their employment to strengthen and support their role in the short and long term?

*Please see **Appendix 2** for sample CHW Job Descriptions*

During the interviews, the CBOs shared that "soft" skills such as lived experience, communication skills, and workplace skills are highly preferred when hiring CHWs. Soft skills are an integral part of the CHW work as the ability to be compassionate and communicate effectively are vital to providing services to build relationships with clients, assess ongoing needs and connect clients to additional services and supports. These skills allow CHWs to understand the overall needs of a community and look for longer-term connections and solutions.

It is important to take into consideration the significant role that continuing education opportunities can play in further developing the role that a CHW plays in the health care system in the long term. "Hard" skills provide significant growth opportunities when training CHWs. Continuing education opportunities promote career development and job growth, which is not only integral as community needs continue to evolve, but also at a personal level for workers themselves who are seeking job growth and security. For example, the Florida Community Health Worker Coalition supports Community Health Workers through the promotion of collaboration, training, advocacy, and leadership development. The coalition offers CHWs with opportunities for National Certification, training catalogs covering various health care topics such as Cardiovascular and Diabetic care, and resources such as a provider toolkit that aims to increase and strengthen integration of CHWs in the Florida Healthcare Delivery System.[12]

In addition, financial security for CHWs is extremely important to consider in the conversation of funding. Salaries for CHWs fell between a range of $30-60k annually based on the funding source stipulations for each program or project. One organization shared that they were unable to hire a CHW intern due to funding constraints that prevented eventual employment. Critical to CHW sustainability is a diversity of funding sources to sustain the CHW workforce beyond individual grants. CHWs are critical to the health care system and play an integral role in connecting with communities in need. Additionally, we saw a wide range of salaries. With the overarching goal in mind to standardize the CHW role, it is vital to prioritize structure in the context of salary as well for increased workforce sustainability and clarity. Establishing a standard salary for CHWs appropriate for a Long Island CBO workforce would provide financial security for CHWs and opportunities for career growth.

RECOMMENDATION:
Through multiple funding streams for CHW workforce development, HEALI should establish a minimum standard for a yearly CHW salary. This is key to maintain financially secured employment for CHWs and encourage extended time in the workforce.

Action Step:

- Considering the CHW base starting salary average nationally of $45,000, Long Island should advocate for an appropriate base salary for CHWs based on local cost of living and requirements of the position. This will help to increase uniformity of the CHW title to not only standardize the CHW role, but to create clearer expectations among potential CHW applicants which then ultimately helps to keep the workforce strong and adaptable.

These mechanisms can create opportunities for CHWs to bolster their skillsets as community needs evolve, and to provide career advancement opportunities.

III.CHW FUNDING STREAMS

CHW programs are most often funded with project related grants or contracts that are either private or public. These funds may be awarded from the federal, state, or local level. For example, the CDC and The National Institutes of Health have funded CHW programs that were focused on disease prevention and management of health conditions such as diabetes and cardiovascular disease. Further, funding for a specific CHW program may come from multiple sources as with blended and braided funding. During the interviews, the CBOs reported that their CHW programs are mostly funded through government grants.

In 2020, the National Association of Community Health Workers released a brief focused on sustainable financing for CHWs. The key findings detailed the challenges associated with single grant or contract funding, including short time frames for project and program funding and funder-led programmatic decision-making, such as determining financial compensations and limiting scope of practice. The challenges discussed during the Key Informant interviews aligned with the findings of the NACHW brief regarding the limited opportunities for CHWs in terms of career advancement.

RECOMMENDATION:
HEALI should encourage collaboration among various stakeholders such as healthcare experts, government entities, and local organizations to create multiple funding streams. It is important to gain a clear understanding of current funding structure such as the length of funding, the type of contract (direct contracts or subcontracts), opportunities for billable services, opportunities for expansion, and any potential limitations to keep in mind.

Action Step:

- Institute a "Blended & Braided" model with multiple funding sources for increased workforce sustainability for program and CHWs. As Medicaid dollars alone are not sufficient to sustain this work indefinitely, other consistent funding streams (from, for example, the Department of Labor or Department of Education) should be integrated into sustainability plans.

A Blended and Braided model of funding involves the combination of two or more funding sources needed to establish, implement, and sustain an initiative. Advantages of this model include: [13]

- *Expands access to comprehensive services because of diversity of sectors involved in the funding, broadening the scope of services and benefits to populations being served*
- *Creates sustainability for the workforce in terms of hiring and retaining CHWs, reducing dependence on a single source of funding*
- *By combining blended fee-for-service revenue with grants funding, helps address the "Wrong Pocket" Problem, ensuring the entities that bear the cost of the practice receive commensurate benefits.*[14]

Long Island should advocate for a Blended and Braided model to effectively manage and maintain sustainable financing models to best serve populations in need across Long Island programs. Key considerations include:

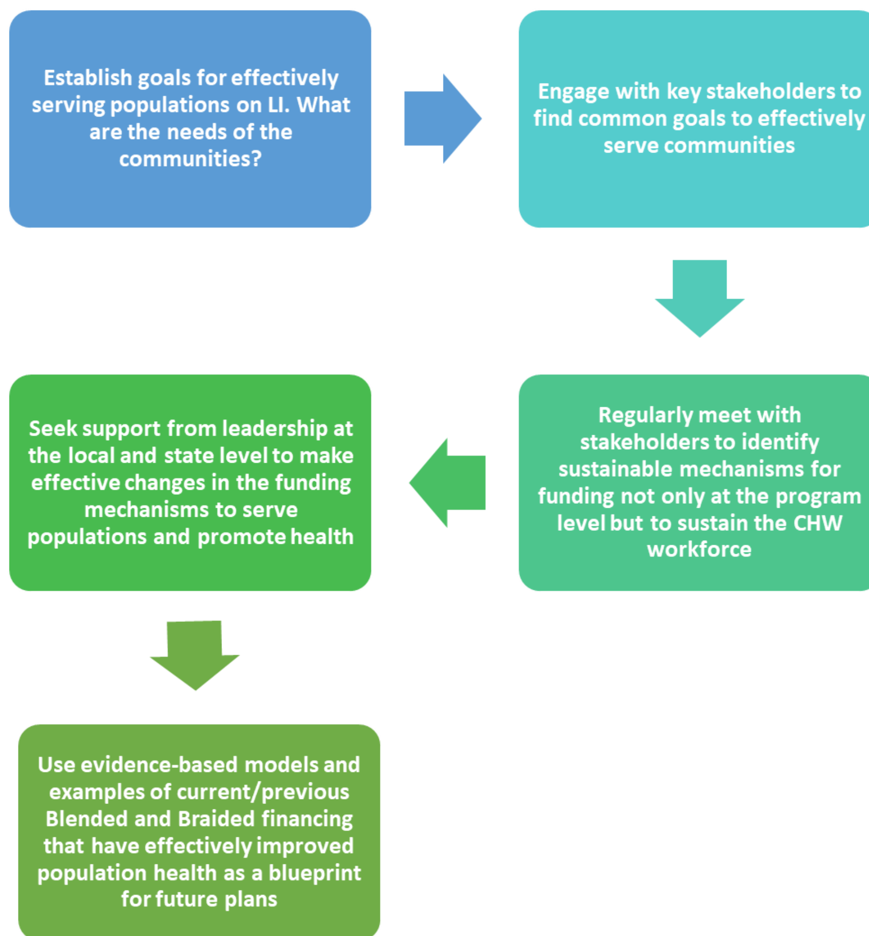

Figure 4: Blended and Braided Model Considerations

A comprehensive blended and braided funding model for CHWs requires organizations to consider CHWs as a fundamental and essential component to their programs and services, and could include a combination of the following sources of funding:

Government Support

- Potential Federal support for CHWs can be sought from the Administration for Children and Families (including MIECHV), Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, Administration for Community Living, United States Department of Agriculture (for rural areas), Office of Minority Health, and the Substance Abuse and Mental Health Services Administration.

- Potential State support for CHWs can be sought from the Department of Health, Office for the Aging, Office of Children & Family Services, Office of Health Insurance Programs, and Office of Mental Health.

Medicaid Program Support

- Section 1115 Demonstration Waiver – New York's proposed waiver amendment proposal offers multiple opportunities to support CHWs, both in the context of the proposed social determinants of health networks, and through Value-Based Payment contracts. CHWs play a critical role in supporting efforts including, but not limited to, connecting historically marginalized groups to sensitive and appropriate healthcare and social services, supporting transitions from hospital to home, connecting primary care patients to needed community resources, supporting pregnant and newly parenting families, facilitating successful transitions from prison and jail back to community, helping the homeless, unstably housed, and persons residing in public housing successfully manage chronic conditions, and supporting the aging, blind and disabled access healthcare and social services, to name a few.

- **Dual Eligible Programs (individuals eligible for both Medicare and Medicaid).** In New York, both the State and plans have invested in integrated care plans for dually eligible individuals requiring Long Term Services and Supports (LTSS) including Medicare Advantage Plus, the Program for All-inclusive Care for the Elderly (PACE) as well as integrated plans for those who do not require LTSS. CHWs are integral to helping individuals navigate these programs and services, ensuring they are optimizing the resources available to them.

- **Medicaid State Plan Amendments (SPA).** While New York has taken a narrow approach to the role of CHWs in the Medicaid program, blending Medicaid funding with state agency dollars to support targeted initiatives like health home care management and maternal and infant health home visiting, several states have moved towards a more general approach that allows CHWs to bill for services for a broader Medicaid population. Advocacy would be required for New York to take this approach.

- **Medicaid Managed Care Organizations (MCO) voluntary support or future contract requirements.** Some MCOs have recognized community-based organizations are better at reaching members, particularly those who have reasons to distrust institutions because they belong to historically marginalized groups. While they are not required to fund CHWs through their contracts, most do currently to a limited extent to close gaps in care, support care transitions, or improve quality outcomes related to chronic conditions. Plans may also support CHWs as part of Medicare Advantage supplemental benefits. Additionally, the state showed some interest in rebidding MCO contracts, and this openness creates an opportunity for contracts to require MCOs to support CHW-delivered services.

Internal financing by healthcare systems in anticipation of reduced costs or enhanced revenue, including internal Return on Investment (ROI)

- In New York, many healthcare systems are now subcontracting to community-based organizations to provide CHW services, as they can get a better ROI on those services because of reduced administrative overhead costs. Generally, healthcare systems are using grant funds and/or internal resources to test an intervention that includes CHWs. Once the net cost savings and other valued outcomes have been documented in relation to the intervention, CHW positions can be included in an ongoing operating budget without a designated source of payment.

Federally Qualified Health Centers (FQHCs): Prospective Payment Systems

- Technically, FQHCs may incorporate the cost of employing CHWs into the total cost proposal on which they negotiate per visit rates with Medicaid. Few do so currently.
- CHW expenses may also be treated as part of FQHC “enabling services” under HRSA 330 grant funding, along with transportation and language services.

Case Study:
Trust for America’s Health released a brief in 2018 which showcases relevant and valuable examples of the Blended & Braided Model that can be applied to Long Island approach to finding sustainable financing mechanisms for CHW programs.

Collaboration across multiple sectors can pave the way for a more thoughtful approach to address the needs of vulnerable communities across Long Island that not only expand the range and ability for CHWs to effectively serve populations in need while finding sustainable solutions to securing CHW employment for the long term.

IV.CHW WORKFORCE SUSTAINABILITY

Sharing best practices among diverse health and social service organizations can play an essential role in promoting recruitment, training, supervision, career development for CHWs, and funding strategies, with the goal of achieving sustainability. These are all integral components of a CHW workforce that will pave the way to best serve communities while supporting CHWs. To do so, implementation of best practices models is key to ensure that the value of a CHW program is being maintained and strengthened.

RECOMMENDATION:
HEALI should promote and implement a model that focuses on evidence-based practices for sustaining CHW workforce in the long term.

Action Steps:

- Involve CHWs in key decision-making across all levels of organizational hierarchy
- Ensure sufficient and diverse funds for permanent CHW positions
- Evaluate the skill level of current CBO workforce and areas to focus on for recruitment
- Assess the evolving demographic, cultural and linguistic needs of communities served by CBOs

Evidence-based practices such as The Indiana CHW Development Recommendations below detail evidence-based practices necessary to sustain the CHW workforce. The recommendations align with the action steps mentioned previously to achieve long-term sustainability of the CHW workforce.[15]

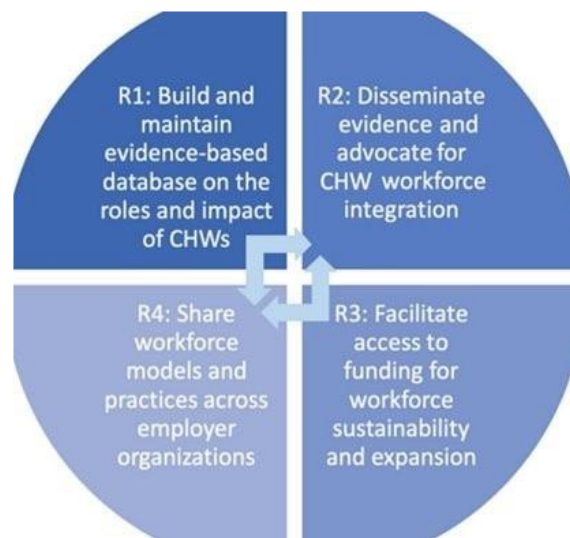

Figure 5: Indiana CHW Development Recommendations

The findings of the Key Informant interviews showed that CBOs would like to broaden the scope of the CHW practice in each respective program. For example, integrating CHWs into key decision-making, the patient referral process, and outreach are ways that CBOs are interested in utilizing their CHW Workforce. In a similar fashion, The Nebraska CHW Workforce Development State Assessment found the integration of CHWs into professional interdisciplinary teams is still necessary, which mirrors the gaps that Long Island CBOs we interviewed must address in order to increase CHW program sustainability.[16]

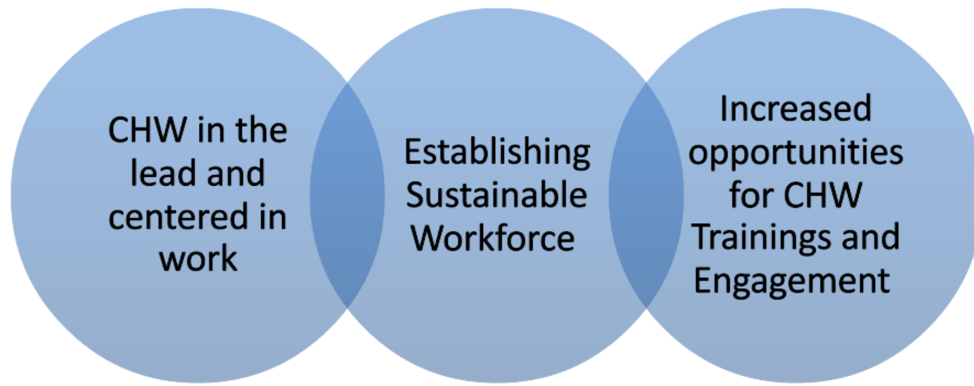

Figure 6: CHW Integration in Organizational Workflow

CLOSING

Community Health Workers play a critical role in connecting community members to critical social care services as well as connecting clients to behavioral healthcare and medical services. They fill a significant gap for individuals in navigating between the social care system and healthcare systems and within each system. The development of a robust and well-funded CHW workforce could fill critical gaps in both service delivery systems and promote health equity.

According to the World Health Organization, by 2030 there will be a shortage of about 18 million health workers. Health care staffing shortages will widen the devastating gap in the health care delivery system process, affecting those that are most in need.[17] Advancing the CHW workforce is integral to the effectiveness of the health care delivery system due to the unique skillset that they bring to the table in conjunction with other health care professionals such as doctors and nurses. See Figure 7 for how CHWs can effectively strengthen the mechanisms by which patients and clients are being served.[18]

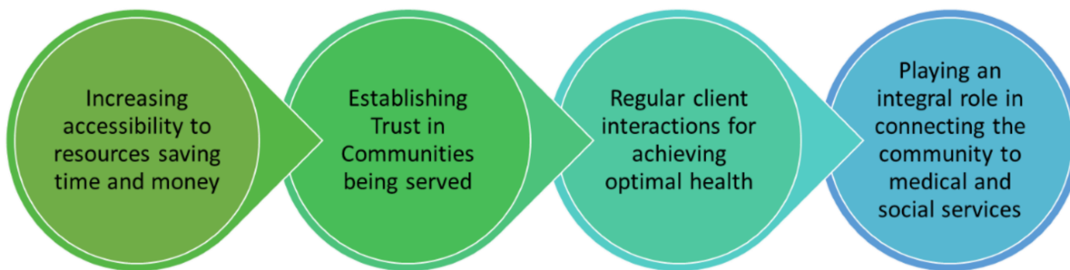

Figure 7: CHW Impact on Healthcare Delivery

The evolution and elevation of CHWs is a critical priority to effectively fill the gap in medical and social care delivery to vulnerable communities based on the recommendations provided in this manual amid growing inequities and the opportunity of the 1115 Medicaid Waiver.

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APPENDIX

1. **CHW Key Informant Interviews Discussion Guide**

Introductions and Framing the Interview/Setting the Stage (5 min*)*
Name/Title/Role

New York State's most-recent Medicaid 1115 Waiver has outlined a Federal-State partnership plan to reduce health disparities, **including interest in funding community health worker programs across the state.** To position Long Island strongly to support a greater CHW workforce, we need your input to help us determine the current and potential future state of the region in terms of CHW current utilization and future readiness. Even if you have not employed or do not currently plan to employ Community Health Workers, your input is valuable.
Given your organization's mission and experience working with CHWs, we'd like to spend approximately [45 minutes] discussing four key topic areas:

- CHW Hiring and Recruitment Process
- CHW Funding Streams
- Populations Served by CHWs
- Professional Development and Additional Support for CHWs

This conversation will be recorded. Do you have any questions or concerns before we proceed?

Starter questions:

1. Does your organization currently host a CHW program?
   a. What is the size of the CHW program?
2. If yes, do the staff in this interview work directly with the CHW program?
3. What is the size of your CHW program and are they part of one program or spread across multiple programs?

Key Informant Discussion Topics & Questions (10 min per topic)

A. **CHW Recruitment**

- Determine key strategies for enhancing CHW recruitment as well as addressing gaps leading to recruiting challenges
- Understanding demographic, cultural, and linguistic needs of communities served by HEALI CBOs
- Understanding skill level of current CBO workforce and areas to focus for recruitment

1. From your perspective, what are necessary or core skills for CHWs to have?
2. Do you require specific training or certifications for CHWs at your organization?
   i. If yes, what are some examples?
   ii. If yes, are those in-house CHW training or external training? Free or is there an expense?
   iii. Are there general skills lacking in your CHW workforce that you would like to see as part of training?

3. What CHW training programs have you recruited from, if any?
    i. For those CHWs who have completed a CHW training program, where was those training completed?
    ii. Was it Long Island-based?
4. Do you offer any additional professional development opportunities for CHWs at your organization or with an external partner (e.g., free training, webinars, etc.)?
5. What core competencies do you feel are critical for a CHW training program?
6. What have been the challenges related to hiring and recruiting CHWs?
7. What are the key factors resulting in CHW attrition?

B. **Funding**

- Gain a clearer understanding of current CBO funding structures such as length of funding, contract type, potential program expansion and challenges associated with funding.
- Advocating for a "Blended & Braided" model with multiple funding sources for increased workforce sustainability.

1. Are CHW salaries funded by one source or multiple sources?
    i. If so, how are outcomes and deliverables managed?
2. Do you bill Medicaid for any services provided by CHWs?
3. What is your primary funding source? Private? Public? If public, – county, state, federal?
4. What are your CHW salary/hourly ranges?
    i. How was that determined?
5. If additional funding was allotted, what areas would your organization prioritize for CHW workforce development?
6. Do program eligibility requirements, CHW caseload, etc. vary based on your funding streams?

C. **Populations Served**

- Assessing if the populations currently served by CHWs address the community needs
- Identifying need for specific services (Ex. Gender specific, undocumented, etc.)

1. What current needs in your community are not met or are under-addressed?
2. What are the eligibility requirements of your CHW program(s)?
    i. Are there primary communities that your program serves (top 3)?
    ii. What are the demographics primarily served by CHWs?
3. How many participants have been served by CHWs to date in your organization?
4. What is the approximate caseload of each CHW?
5. What organizational settings do your CHWs work in? (Ex. Community Based Organizations, clinics, community health center, etc)
6. What, if any, limitations do your CHWs have on addressing the needs of clients they work with?
7. How do CHW adapt to changing community needs?
8. If new needs emerge, are CHWs able to address those or do they refer to other providers? (Assessing flexibility of funding)

D. **Vision and Additional Support for CHWs**

- Developing a short- and long-term vision for a CHW Training and Development program

1. Are there ongoing and/or refresher training requirements for on board CHWs (I.e., specific to their role or part of your organization's annual all-staff requirements)?
2. What are some personal challenges encountered by CHWs?
3. What are some goals you have for your CHWs in the next few years?
4. What key workforce development aspects would you recommend being included in a training program scaled across Long Island?

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Appendix 2:

2.0 Community Network Specialist
Food and Nutrition Services Bundle/WholeYouNYC

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POSITION:

Job Title:	Community Resource Network Specialist	**Position Number:**	
Project/Unit:	**Healthcare Community Partnership**	**Location:**	Hybrid
Reports To (title):	Project Manager	**Effective/Rev. Date:**	
FTE:	Full Time 1.0 FTE		

POSITION SUMMARY:

(brief overview of basic role within the organization):

PHS is looking to hire a Community Resource Network (CRN) Specialist position to join a growing team of CRN Specialists. The CRN Specialist will be responsible for meaningfully connecting vulnerable New Yorkers to clinical and community support services across New York City using an online referral technology platform and tracking the process through various technological tools. The CRN Specialist will be responsible for connecting with clients over the phone, identifying needs and encouraging clients to utilize appropriate resources, primarily food and nutrition resources at the start. With the client consent, the the CRN Specialist will refer to appropriate organizations and programs and may be required to follow up with individuals at various points to ensure access to effective care and community resources.

The CRN Specialist works independently with clients to do outreach and follow up, as well as closely with the CRN team and supervisor to share experience, identify unresolved issues, share best practices, and participate in problem-solving.

The CRN Specialist will work under the supervision of the Community Resource Network Project Manager in the Healthcare-Community Partnerships and work closely with other members of the Healthcare Community Partnerships team, with interaction with other teams within PHS' Neighborhood Health Division as needed.

LEADERSHIP RESPONSIBILITIES:

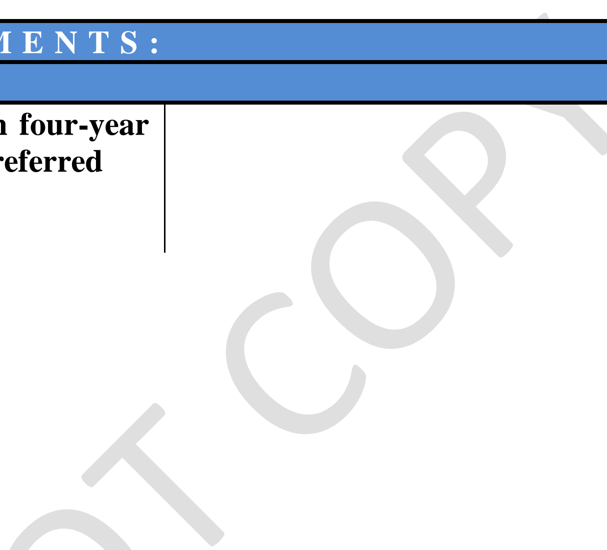
None

SUPERVISION REQUIRED:

Requires general supervision. Work is occasionally supervised during progress and reviewed upon completion.

MINIMUM REQUIREMENTS:

Education:	**Bachelor's degree from four-year college or equivalent preferred**
Experience:	3-4 years



Additional Requirements: 1 Education, Experience and Skills:

- B.A. or B.S. degree with coursework in community health or related field, preferred
- Bilingual preferred.
- Ability to work remotely, over the phone as needed
- Eager to learn about new projects, services, and resources
- Enthusiasm for supporting vulnerable New Yorkers of diverse background
- Excellent communication and listening skills, patience, non-judgmental attitude and ability to show empathy
- High degree of self-organization and ability to work independently
- Ability to rapidly navigate between different technological platform and systems
- Ability to work effectively with a diverse work team; possess cultural competency skills
- Demonstrated experience in identifying and solving problems in a constructive way
- High level of professionalism (such as timeliness, excellent communication with team members and supervisors, rigorous documentation)
- Knowledge and experience working with vulnerable populations strongly preferred
- Knowledge of motivational interviewing and/or other coaching techniques preferred
- Ability to communicate effectively in-person and over email and phone with clinical staff, patients/participants, and Community-Based Organization (CBOs) partners as needed
- Remain flexible to work on various HCP projects that utilize the CRN
- Comfortable providing brief presentations and trainings to clinical teams and CBOs on the CRN resources and ways to refer patients/participants to services as needed

JOB DUTIES and RESPONSIBILITIES:

	Essential	Non-Essential	
1	☐	☐	**In addition to below, performs all other duties as assigned.**
2	☐	☐	

- Become familiar with the range of services typically included in the Community Resource Network
- Become familiar with the technological platforms used by PHS, including Unite NYC

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- Conduct outreach to a range of different clients in NYC to identify and prioritize their needs
- Screen clients for eligibility for a range of services, then refer to appropriate social support and clinical services across a portfolio of programs
- Carefully document the outreach, screening, and referrals in the appropriate technological platform, following the Community Resource Network protocol
- Identify additional resources based on gaps in meeting needs within the referral platform
- Provide support and follow-up to enrolled clients
- Provide feedback on workflows and assist with troubleshooting to improve processes
- Participate in all meetings as requested.

Job Description Approval/Signoff:

Employee:		
	Signature	***Date***
Manager:		
	Signature	***Date***

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2.1 COVID Free West Queens
COVID Resource and Outreach Specialist

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COVID 19 Resource and Outreach Specialist – Job Description

Company Overview:
Health disparities among New Yorkers are large, persistent, and increasing. Public Health Solutions (PHS) exists to change that trajectory and support vulnerable New York City families in achieving optimal health and building pathways to reach their potential.

As the largest public health nonprofit serving New York City, we improve health outcomes and help communities thrive by providing services directly to vulnerable low-income families, supporting community-based organizations through our long-standing public-private partnerships, and bridging the gap between healthcare and community services. We focus on wide range of public health issues including food and nutrition, health insurance, maternal and child health, sexual and reproductive health, tobacco control, and HIV/AIDS. To learn more about our work, please visit healthsolutions.org.

Position Summary:

As part of continued efforts to ensure that New York City's response to citywide recovery from COVID-19 is achieved through an equitable and place-based approach, the Fund for Public Health in New York City (FPHNYC) has partnered with Public Health Solutions and two community-based partnering organizations to implement a community health worker model that engages communities, address social needs, support health interventions and conduct social service navigation in communities most affected by the COVID-19 pandemic.

PHS seeks a Community Resource Coordinator (CRC) to work closely with community members, PHS staff and partner community-based and clinical organizations throughout this project. The CRC reports to the Project Manager, with a focus on engaging community members, collecting and providing COVID-19 education, information and connection to other resources in targeted communities of Western Queens. The CRC will also assist in coordinating outreach and engagement events and participate in community meetings and stakeholder briefings. The Coordinator position is full time, 35 hours per week.

This project is grant funded with an anticipated end date of 05/31/2023.

Minimum Requirements:

- Minimum of 1 year experience in public health, community development and health issues in urban, underserved neighborhoods.
- Knowledge of social services navigation and community-based organization landscape in NYC preferred.
- Comfort working with Microsoft Office, including Excel for data entry.
- Dedicated to helping improve the lives of disenfranchised and marginalized communities and working together toward achieving health equity.
- Ability to thrive in a work environment that is respectful, goal-oriented, and focused; yet is fun and dedicated to achieving a work-life balance.
- Ability to balance and manage a hybrid work environment that includes a combination of in-office, remote work, and field work.
- Excellent team player with the ability to be flexible, work collaboratively both internally and externally, and also complete tasks independently.
- Ability to embrace diversity and establish trusting relationships with individuals of differing identities.
- Must be willing to be outside for up to 3 hours or more at a time, walking and engaging the public, even in cold temperatures.
- Open to working evening hours and weekends when necessary.
- Strong communication and cultural competency skills.
- Bilingual candidate, preferred.
- Resident of Queens with familiarity of West Queens area is preferred.

Job Duties and Responsibilities:

- Coordinate and facilitate community outreach around COVID-19 vaccination.

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- Conduct screenings and referrals to community resources for community members in diverse settings using motivational interviewing techniques.
- Provide participant-centered support, screening and referrals to services that meet the specific needs of the individuals.
- Manage a caseload and provide consistent follow-up to ensure participants have been connected to services.
- Provide up-to-date information on public health guidance and COVID-19 vaccines, serve as a point person to guide community members to COVID-19 resources.
- Coordinate and lead regular community outreach and educational sessions focused on ways to prevent the spread of COVID-19 and increase knowledge of community services.
- Provide input on the project's marketing and promotional materials as needed.
- Provide monthly updates to a neighborhood-based asset map and resource inventory.
- Perform other related duties as assigned.

NOTE: All applicants must comply with PHS' vaccination policy. Effective October 1, 2021, employees will be required to provide verification that they are fully vaccinated against COVID-19 (with an FDA-authorized vaccine).
PHS is proud to be an equal opportunity employer and encourages applications from women, people of color, persons with disabilities, lesbian, gay, bisexual and transgender individuals, and veterans.

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2.2 Managed Care Organization Partner Program
Complex Care Coach

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Job Title: **Complex Care Coach (CCC)**
Department: **Healthcare-Community Partnerships**
Location: **New York, NY**

Company Overview:
Health disparities among New Yorkers are large, persistent and increasing. Public Health Solutions (PHS) exists to change that trajectory and support vulnerable New York City families in achieving optimal health and building pathways to reach their potential.

As the largest public health nonprofit serving New York City, we improve health outcomes and help communities thrive by providing services directly to vulnerable low-income families, supporting community-based organizations through our long-standing public-private partnerships, and bridging the gap between healthcare and community services. We focus on a wide range of public health issues including food and nutrition, health insurance, maternal and child health, sexual and reproductive health, tobacco control, and HIV/AIDS. To learn more about our work, please visit healthsolutions.org.

Position Summary:
PHS is hiring a **Complex Care Coach** (CCC) to support exciting programs within the Healthcare-Community Partnerships team. The main program of focus for this role is in partnership with a local managed care organization. The program involves engaging and connecting members with chronic conditions to social and clinical care. The Complex Care Coach may contribute to the work of the "Community Resource Network," a closed-loop referral system where staff identify culturally and linguistically competent resources for community members.

The Complex Care Coach will be responsible for meaningfully connecting high-need people living with HIV and AIDS (PLWHA) and/or other chronic conditions to clinical and community support services across New York City using an online referral technology platform. The CCC will be responsible for screening and assessing high-risk managed-care members to identify appropriate resources and follow up with ensure access to effective care and community resources. The Coach may also assist the PHS program team with data collection to understand the persons screened, referred, and engaged in services throughout the program.

This work will be done over the phone.

The CCC will work under the supervision of the Program Manager, Healthcare-Community Partnerships and work closely with other members of the Healthcare Community Partnerships team and possible interaction with other teams within PHS' Neighborhood Health Division as needed.

Specifically, the Complex Care Coach (CCC) will:

- Screen, refer, and assist PLWHA and/or other chronic conditions to access priority clinical services and social support services.
- Identify additional resources for members' social needs such as housing, emergency food, SNAP (food stamps), immigration support available on the Unite NYC platform and refer appropriately.
- Provide support and follow-up to members to determine if services are received.
- Become familiar with the online referral platform, UniteNYC, and a case management system required by the funder, with adaptability to use additional platforms as needed. CCC will be expected to learn the functions of each, including workflow for most efficient use of each platform, and reporting.
- Provide feedback on workflows and assist with troubleshooting to improve processes.
- Develop and maintain thorough knowledge of the community-based organizations and providers in the funder network and PHS' Community Resource Network.
- Provide assistance and support around PHS' Community Resource Network as needed.
- Present on member cases to funders and attend partner meetings.
- Perform other related duties as assigned.

Qualifications:

- Bilingual in Spanish, required

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- 2-3 years of work focused on community engagement, community health work, supporting enrollment in services, and working with vulnerable New Yorkers to increase access to services
- Strong enthusiasm for conducting outreach, helping people identify their goals, and connecting them to services
- Training and experience in using Motivational Interviewing tools and Goal Setting techniques, preferred
- B.A. or B.S. degree with coursework in community health/related field or equivalent experience, preferred
- Ability to work remotely as needed
- Impeccable phone manners
- Ability to track and document tasks precisely in multiple software tools
- Strong interpersonal and listening skills and outgoing personality
- Non-judgmental attitude and ability to show empathy
- High-degree of self-organization and ability to work independently
- Excellent verbal and written communications skills
- Interest in, and commitment to, serving and advocating for people of diverse backgrounds
- Ability to relate positively to a wide variety of people and work effectively with a diverse work team; possess cultural competency skills
- Knowledge and experience working with vulnerable populations strongly preferred
- Knowledge and experience of Community Based Organizations and Social Services available to New Yorkers

NOTE: All applicants must comply with PHS' vaccination policy. Effective October 1, 2021, employees will be required to provide verification that they are fully vaccinated against COVID-19 (with an FDA-authorized vaccine).

PHS is proud to be an equal opportunity employer and encourages applications from women, people of color, persons with disabilities, lesbian, gay, bisexual and transgender individuals, and veterans.

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