Transformative Public Health Corps for NYC Neighborhoods and Residents

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SUMMARY

QUESTION: ***How can New York City build and sustain a transformative Public Health Corps to measurably improve health equity across neighborhoods?***

WHY IMPORTANT:

1. The COVID-19 pandemic exposed major weaknesses in New York City's health care delivery system and public health infrastructure.

2. Longstanding structural racism and unjust systems of access and power left many communities disproportionately vulnerable to infection, illness, and unemployment during acute and post-acute COVID-19 pandemic periods.

3. The best solution to improve equitable access to needed services, improve trustworthiness of medical and public health institutions, and provide needed jobs is to build credible, community-centered service delivery and communication systems.

4. New York City is **already** taking bold steps to address this. In 2021, the City announced the creation of a Public Health Corps workforce to build neighborhood-level public health capacity and infrastructure.

RECOMMENDATIONS:

To improve equitable access to health and social services, rebuild trust and reduce health inequities, we recommend that the Public Health Corps:

1. Establish clear health and social equity goals.

2. Design a plan to sustain and adequately resource the program.

3. Develop supportive supervision structures and career growth opportunities for Corps workers.

4. Improve effective communication and referral process between community organizations and the health sector.

CONSTRAINTS:

1. The proposal requires significant coordination across city agencies, namely Health+Hospitals and the Department of Health and Mental Hygiene.

2. As noted, long-term funding strategies for current Public Health Corps initiatives remain unclear. Given the ongoing fiscal challenges wrought by the pandemic, it could be challenging to devote the necessary municipal resources to build out these programs into the future.

SUMMARY

The COVID-19 pandemic exposed major weaknesses in New York City's health care delivery system, public health infrastructure, and economy. Longstanding structural racism and unjust systems of access and power left many low-income racial and ethnic minority and limited English proficient (LEP) communities disproportionately vulnerable to infection, illness, and unemployment during the acute and post-acute pandemic periods. Recovery has been further challenged by historical and contemporary examples of overt mistreatment and institutionalized racism within medical and public health systems, resulting in deep distrust of these systems from the same communities disproportionately impacted by the pandemic. One current glaring result is that racial and ethnic minorities have lagged in rates of COVID-19 vaccination compared to their White counterparts across most New York City neighborhoods for much of 2021, leaving them vulnerable to more pandemic-associated harms. The best solution to improve equitable access to needed services and enhance the trustworthiness of medical and public health institutions — while simultaneously addressing economic recovery through jobs creation — is to build credible and community-centered service delivery and communication systems. This needs to be centered within the neighborhoods where people live, with members of the communities themselves hired and trained as front-line community health workers (CHWs) who are closely attuned to the language and access barriers that the different communities face.

In 2021, New York City (NYC) and New York State (NYS) officials took initial and independent steps to create Public Health Corps workforces, designed to build neighborhood-level emergency response public health capacity and infrastructure to last beyond the COVID-19 pandemic. Within NYC, the Public Health Corps will be composed of CHWs, many potentially hired from the Test & Trace initiative. The current framework of the Public Health Corps includes two arms, one to be coordinated by NYC Health+Hospitals (NYC H+H), placing CHWs within primary care systems, and the other to be led by the NYC Department of Health and Mental Hygiene (DOHMH), placing CHWs with community-based organizations (CBOs), known as the Neighborhood Health Corps. On September 29, NYC City Hall announced the hiring of 500 CHWs to serve 20 priority neighborhoods across H+H and DOHMH.[1]

While public details of these efforts are scant at this early stage, and the extent to which city agencies and the state are coordinating efforts is unclear, we applaud the vision and direction of these proposed programs, especially given the strong body of evidence that supports the impact of CHW programs on improving health outcomes among vulnerable communities. In particular, we support the plan to place CHWs in local front-line community organizations, thus shoring up the very organizations that served heavily-impacted communities most directly during the pandemic.

Critically important, the Public Health Corps also provides a large number of jobs to residents from lower-income communities, including potentially many NYCHA residents. With starting salaries of approximately $45,000, plus benefits, and limited advanced education requirements, the Corps strategically links public health to jobs and economic recovery in population groups with highest rates of unemployment.

[1] Office of the Mayor, 'Mayor de Blasio Launches the NYC Public Health Corps," The City of New York, September 29, 2021, https://www1.nyc.gov/office-of-the-mayor/news/658-21/mayor-de-blasio-launches-nyc-public-health-corps#/0.

However, we believe that, in order to improve equitable access to health and social services, rebuild trust and reduce health inequities, such a Corps model requires: (1) clear health and social equity goals, (2) sustained adequate resources, (3) supportive supervision structures and opportunities to build capacity among Corps workers, and (4) improved communication between community organizations and the health sector.

THE PROPOSAL

1. Clear health and social equity goals

The launch of the NYC Public Health Corps program has been squarely framed as an effort to promote health equity, with priority neighborhood targets. This is to be lauded and clearly a bold step in the right direction. Such a Corps, by necessity, should draw its members from the same neighborhoods and ethnic groups. Because of their shared life experiences with the communities they serve, CHWs, as trusted members of those communities, can help transform the public health infrastructure in NYC to be more responsive to the health and social needs of diverse and underserved communities during non-emergency times — and to respond more quickly during emergencies. Operationalizing this vision can be challenging. The following tenets can perhaps be helpful as the Neighborhood Health Corps develops concrete objectives and targets:

1. Fundamental to the goals of achieving health equity is the overt recognition that a person's own life context — often referred to as one's social determinants of health — directly affect health through many channels. At the individual-level, CHWs should be trained and resourced to identify economic and social barriers, provide referrals to meet the everyday needs of residents, and help residents build self-efficacy to address them over time, whether at the individual, family, or neighborhood level. At the program level, however, these individual social and economic barriers should be routinely summarized, analyzed, and made public, to build awareness and foster inter-agency and cross-sector commitment to identify system-based solutions to address them.

2. Equity-based programs often take asset-based approaches. To infuse this into the Public Health Corps, CHWs can be trained on how to assist residents in identifying their local assets and social supports, and then building upon them. CHWs can also support activities aimed at building community capacity.

2. Sustained, adequate resources

At the moment, long-term funding strategies for these respective Public Health Corps initiatives remain unclear. Municipal commitments remain short term (less than 2 years), and a variety of grants are supporting initial efforts to launch the DOHMH-led Neighborhood Health Corps.

These initial commitments are an impressive start. In reality, however, such programs will need a minimum of 3-5 years to develop strong infrastructures and begin to demonstrate impact. Focusing here on the financing of community-based CHWs (as CHWs hired within H+H likely have more financing and reimbursement options available), we propose exploring two possible options. These include either securing Medicaid reimbursement options in New York State, or establishing a subsidized CHW 'reservist' model:

1. New York State currently does not have a uniform payment or reimbursement model for CHW services, but longer-term funding solutions might require innovative city-state partnerships to allow for Medicaid reimbursement for CHW services, including those operating out of CBOs. There are precedent models around the country. For example, in Minnesota, home-based services provided by CHWs can be reimbursed under Medicaid, and some accountable care organizations in Utah are covering costs of home-based preventive services through administrative payments.[2] [3] In New York, the now-completed Delivery System Reform Incentive Payment (DSRIP) program provided model mechanisms to reimburse for CHW home visits. Building on these initiatives, there are now a few health insurance payers and hospital community benefit plans supporting CHW reimbursement in NYC. Ultimately, by working to transform New York State's Medicaid systems to reimburse community-based CHW programs, New York City can achieve a long-term sustainable model for the provision of equity-oriented in-home services to connect patients to needed health and social services.

2. In addition to direct Medicaid reimbursement to CBOs for CHW services, an alternate, more distributed model could develop, where ultimately CHWs within the Corps are sustained within CBOs working in medically underserved and under-resourced communities, but subsidized by the municipal public sector as a sustained public health investment in reducing disparities. This model would require a smaller backbone of full-time CHW supervisors (housed either in larger CBOs or in the DOHMH), supporting a larger reserve of CHWs (possibly 500-1,000) housed in CBOs, modeled loosely on the U.S. National Guard. This Corps would help transform the public health infrastructure in NYC to be more responsive to the health and social needs of diverse and underserved community members. CHWs could work in full-time roles in community-serving institutions (e.g., CBOs, schools, libraries, pharmacies) throughout the City and engage in work reducing health disparities in those roles. During public health emergencies, some or all of the Corps members could be rapidly deployed for tasks such as contact tracing, mental health first aid, education, vaccine distribution, and field 'pulse' survey data collection. Corps members could undergo an initial in-depth training and then be called up for additional periodic training (monthly or quarterly) that could also include community service. Investing in CHWs and CBOs would support local economic recovery while also helping address social determinants of poor health disproportionately affecting low-income, minority populations. In addition, it provides an important prevention and disaster preparedness mechanism for the City to tackle ongoing and emerging crises.

[2] "Community Health Worker," *Minnesota State Department of Human Services*, July 29, 2020, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357.

[3] Tessa Acker et al., "Medicaid Reimbursement for Community Health Workers (CHWs) in Utah," *State of Utah*, June 2019, https://www.utah.gov/pmn/files/512933.pdf.

In either model, CHWs from communities experiencing social/health disparities can work on a variety of initiatives to significantly improve the impact of prevention (smoking cessation, physical activity, healthful diet, immunization) and treatment (access, adherence) services. At the same time, CHWs can also provide social support, build trust, and improve digital and health literacy, particularly among older adults, socially isolated individuals, homeless individuals, and people recently released from jail or prison.

3. Supervision and opportunities to build CHW capacity

For either model, we propose that New York City build out its Public Health Corps with a very careful eye towards supportive supervision. Ideally, an experienced and well-trained, always-ready group of senior community health worker (CHW) supervisors could serve as the true backbone of the Corps. Key elements of a strong supervision system include:

1. Articulated hiring criteria for CHW supervisors that include minimum prior experience working with CHWs or patient navigators, empathy for and clear understanding of the CHW role, and preferred backgrounds in social work or public health.

2. Clear, unambiguous roles and reporting structures between CHWs, their supervisors, and the managers of the program. This is particularly important when working across city agencies and community organizations.

3. Training and peer support opportunities that provide supervisors with tools to foster collaborative team-based problem solving, build effective communication, manage CHW burnout, and establish and share common goals between CHW team members and the CBO staff with whom they work. Several organizations around NYC (e.g., NYU Langone and the CHW Network of New York City) have established supervisory trainings for CHWs.

4. Access to transportation as needed to visit CHWs, bring supplies, and participate in field activities. Strong relationships between supervisors and CHWs can motivate CHWs and improve their performance.

5. To ensure retention, supervisors also require adequate compensation and opportunities for growth.

We encourage strong ties between supervisors in the H+H and DOHMH arms of the Corps to facilitate effective cross-agency referral pathways for health and social services, build functional communication channels, and expand career growth opportunities. Supervision of CHW programs is a challenging and rewarding position, and the quality of supervision often portends program effectiveness.

Finally, it will be important to also include opportunities for growth within the CHW workforce itself, including professional development trainings and tangible career pathways. For example, along the lines of the historically successful education programs for members of the armed services or Peace Corps, all Corps members could potentially receive discounts at CUNY programs to further their education.

4. Effective communication and referral processes between community organizations and the health sector

The vision for the Public Health Corps is for CHWs to be able to secure the right resources for NYC residents at the right time, and for clinical teams to identify social needs of patients during a clinical visit and make effective social service referrals, including to community-based CHWs. These will include, on the one hand, referrals for assistance with housing, employment, criminal justice, non-emergency transportation, and other needs. On the other hand, it will also include streamlined entry and navigation into the healthcare system. The Public Health Corps initiative provides an opportunity to design and test innovative referral systems and bi-directional communication between community organizations and clinical settings, including, and perhaps most immediately, between the two arms of the Public Health Corps (H+H and DOHMH). Technology platforms to connect healthcare and community providers exist and may indeed be part of the solution. But, perhaps most important, is the leadership and governance around designing such workflows, developing robust networks of contributing organizations, and building trust among partners to test and ultimately use shared processes.

HELP FROM BEYOND GOVERNMENT AGENCIES

Operation and maintenance of the Public Health Corps will appropriately be maintained by NYC government agencies. Yet, nongovernmental entities and academic partners can be engaged to support the mission. First, there are clear opportunities to amplify the work of the Public Health Corps through strategic alignments with other CHW programs. For example, Bronx Lebanon, NYU Langone Health, and several other hospitals have supported CHWs as part of their Community Service Plans. This is a model that could be more widely encouraged. FQHCs across the City also have reserves of CHWs and navigator staff. Promoting alignment on select goals can extend the impact of the City's core program. Second, partners can support critical launch efforts such as curriculum development and training. At least one CHW resource center already exists at NYU Langone Health, which maintains a living library of templates and resources for organizations to access as they launch or refine CHW programs. Third, a network of select larger CBOs from across the City could potentially help identify and support subsequent job placement of potential trainees. Finally, all major initiatives benefit from external evaluation, especially when evaluations are designed to inform and improve ongoing operations.

The Public Health Corps is a bold new initiative. With the mayor's full support, it has potential to make transformative and lasting effects on improving health equity across NYC neighborhoods, serving as a model for the rest of the country.