# New York State Employment First Commission

Report and Recommendations
March 1, 2015

## Executive Summary

Everyone has the right to work. It is this underlying premise that is the driving force behind the development of an Employment First policy in New York State. On September 17, 2014 Governor Andrew M. Cuomo signed Executive Order 136 to create a commission to establish an Employment First policy for New York State. The state seeks to build on important economic development investments the governor has made to ensure that individuals with disabilities equally benefit from the improving economy and have sustained opportunities to engage in the competitive labor market. Specifically, the state aims to increase the employment rate of individuals with disabilities by 5%; decrease the poverty rate of individuals with disabilities by a comparable 5%; and engage 100 businesses in adopting policies and practices that support the integrated employment of individuals with disabilities.

This report outlines the recommendations of the Employment First Commission, which held two statewide public listening sessions and received verbal and written input from more than 30 advocacy, trade, and provider organizations, as well as several individuals. Based on this input, the commission has developed the following recommendations:

1. **Cultural Modeling**: New York State agencies can model the integrated employment of individuals with disabilities. Whether through enhancements to the governor's programs to hire persons/veterans with disabilities (sections 55-b and -c of New York State Civil Service Law), or through community-based organizations directly hiring individuals, a strong culture of employment first must be established (page 13).
2. **Energizing the "Demand-Side" of the Equation**: Redesign and reinvigorate the New York Business Leadership Network to pursue the aggressive goal of engaging 100 business partners. A business first platform can be established through promoting existing tax credits, supporting businesses to pursue federal contracts, and harnessing the power of New York's regional economic development efforts (page 13).
3. **New York Employment Services System (NYESS):** The NYESS system has already distinguished New York as the leader in moving individuals with disabilities into the world of employment as the largest Social Security Administration Ticket to Work (TTW) network in the nation. Ensuring the full adoption of the system across community providers and state agencies will utilize the power of New York's integrated employment case management system to comprehensively monitor and support employment outcomes in New York State (page 14).
4. **Benefits Advisement:** Benefits systems are complex and only limited resources are available to help individuals accurately understand eligibility requirements and the impact of employment on benefits. New York State can utilize emerging tools like Disability Benefits 101 (DB101) and a network of "life coaches" to expand benefits advisement (page 15).
5. **Medicaid Buy-In for Working People with Disabilities (MBI-WPD):** New York can integrate the MBI-WPD program into the online New York State of Health application portal, automating and standardizing eligibility determinations and referring applicants who require additional assistance (page 15).
6. **Transportation:** Transportation to work is a key element for employment success. A cross-agency taskforce can examine barriers to integrated transportation; identify potential solutions, such as a

rural transportation tax credit; and build on initiatives like the proposed mobility transportation project (page 16).

7. **Education:** New York State will continue to support schools in embracing approaches that increase the integration of students in their communities. The Promoting the Readiness of Minors in Supplemental Security Income (PROMISE) grant will guide ongoing policy and practice around early employment supports for individuals with disabilities and offer coaching for their families. Options for local school districts include implementation of a "school of choice" for students, and revisiting the array of available credentials/diplomas. Local schools districts should be supported with best practices that would give them the ability to place a greater emphasis on career planning and counseling for all students, resulting in better long-term outcomes (page 16).
8. **Creating an Employment First Service Culture:** Training is recommended for direct support professionals, with an emphasis on the skills needed to deliver employment support services focused on achieving individualized goals (page 17).
9. **Self-Employment and Entrepreneurship:** Expanding upon the New York State Education Department's Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR) model of engaging New York State entrepreneurial assistance programs and/or small business development centers will facilitate the development of small businesses operated by individuals with disabilities (page 17).
10. **Expanded Access to Assistive Technology:** Increasing access to assistive technologies through a strategic partnership with the Office for Children and Family Services (OTDA), ACCES-VR, and the Justice Center administered Technology-Related Assistance for Individuals with Disabilities (TRAID), the inventory of employment-related devices can be expanded and training increased on the use of such devices (page 17).
11. **Outcome Measures:** Progress toward these goals can be measured using NYESS to compare Medicaid data to New York wage data, enabling the detection of changes in the employment and poverty rates. Timeframes associated with attainment of these rigorous goals should be established in conjunction with a strategy for implementation. An independent academic body should be engaged to review the ongoing progress toward attainment of the projected goals (page 18).

While New York State has made significant progress in developing an Employment First framework, through a variety of collaborations across federal, state, private, and public partners, New York State's full potential has yet to be realized. The Employment First Commission believes that New York State can accomplish the goals of Employment First by engaging in a statewide comprehensive, cross-disability, cross-sector approach to removing employment barriers and by establishing clear policies to promote the hiring of individuals with disabilities. The commission believes that the recommendations, when adopted, will prove to be the catalyst for realizing the Employment First vision in New York State.

# *Employment First*

*Policy Briefing and Recommendations*

**Why *Employment First*?**

Everyone has the right to work. It is this underlying premise that is the driving force behind the development of an Employment First policy in New York State. On September 17, 2014 Governor Andrew M. Cuomo signed Executive Order 136 to create a commission to establish an Employment First policy in New York State. This policy seeks to make competitive, integrated employment the first option when considering supports and services for people with disabilities and is expected to increase the employment rate and decrease the poverty rate of individuals with disabilities as well as increase business practices that promote the hiring of people with disabilities. New York State seeks to build on important economic development investments the governor has made to ensure that individuals with disabilities equally benefit from the improving economy and have long-lasting improved employment opportunities.

The employment and earnings gap between New Yorkers with disabilities and those without, as in the rest of the United States, continues to grow exponentially. According to the 2013 American Community Survey, there are nearly 1.1 million working age adults with disabilities in New York State (8.7% prevalence rate).[1] The employment rate of working-age people with disabilities (ages 21-64) was 32.6% compared to 67.5% for people without disabilities, a gap of 34.9%. For working-age individuals with disabilities who are employed, the median annual labor earnings equaled $23,217 compared to $34,484 for those without disabilities, a gap of $11,267. Moreover, more than 31% of individuals with disabilities are living in poverty versus only 18% of their peers without a disability. Add to that picture the fact that one out of two (425,000) working age adults with disabilities in New York are recipients of supplemental security income (SSI). The composite picture of a working age adult with a disability in New York is an individual who is more likely unemployed, with no more than a high school education, living in poverty, and dependent on government benefits.

While New York State has made significant progress in developing an Employment First framework through a variety of collaborations across federal, state, private, and public partners, the state's full potential has yet to be realized. New York can accomplish this goal by engaging in a statewide comprehensive, cross-disability, cross-sector approach to removing employment barriers and establishing clear policies to promote the hiring of individuals with disabilities. Comprehensive systemic and programmatic change, including a significant shift in attitudes and beliefs about the employability or entrepreneurial nature of people with disabilities, requires that work be done not only at the policy and agency level, but also by reshaping the cultural expectations in our communities. Even the core beliefs of those responsible for supporting, assessing, and enrolling job-seekers with disabilities into employment programs need to be aggressively challenged. This "top-down" and "bottom-up" cross-sector strategy is a unique approach to promoting employment for people with disabilities that will increase the employment rate of these individuals.

Moreover, despite research from Cornell University that built on Mathematica Policy Research, which demonstrates that recipients of Medicaid who are working and enrolled in the Medicaid Buy-in Program for Working People with Disabilities (MBI-WPD) show a 43% decrease in Medicaid expenditures as a result of

[1] http://www.census.gov/acs/www/

employment, New Yorkers with disabilities continue to have limited knowledge of, and access to, comprehensive work incentives planning; asset development tools; evidence-based employment services and supports; self-employment and entrepreneurial development; and access to and participation in key employment initiatives like the Social Security Administration's (SSA's) Ticket to Work Program (TTW). Their challenges are further complicated by traditional employment program assessment and eligibility processes that focus on reduction of perceived deficits rather than person-centered criteria that identify individual capacity. Family members, while actively engaged in ensuring access to services, have limited knowledge of new innovations leading to full employment and labor market participation, and often seek to protect their family member from the challenges of the workplace rather than empower them to embrace the risks and rewards of employment.

In addition, access to adequate transportation continues to be a significant barrier to individuals with disabilities obtaining and maintaining employment. In many rural and suburban areas of New York, there is no access to transportation, and what was at one time available in some rural areas is now retracting. While implementation of creative solutions has been attempted, the lack of sustainable options continues to exacerbate a growing issue.

While increasingly interested in managing the challenge posed by disability diversity in the workplace, employers need more access to effective human resource information practice in this area, business-to-business networking opportunities, and strategies for building partnerships with the supply side (i.e., service providers). Service providers continue to express strong interest in designing and implementing evidence-based practices that lead to successful integrated employment outcomes and working more effectively with business and industry to meet their respective needs, while at the same time transforming segregated work programs (e.g., sheltered workshops) into integrated opportunities. Policymakers and advocates in New York State need an understanding of the policy barriers that serve as obstacles to successful employment and a more robust picture of the employment, economic, and education outlook of New Yorkers with disabilities to inform new integrated employment policy.

**Environmental Scan of Current Employment First Initiatives**

There are myriad initiatives in New York State that help individuals with disabilities enter and retain employment from which a solid Employment First platform can be built. These include:

*Medicaid Reforms*

Under Governor Cuomo's Medicaid Redesign Team's (MRT) plan, the state prioritized Medicaid's role in the improvement of employment outcomes for people with disabilities. The following three broad-sweeping Medicaid reforms to two of the state's home and community-based services (HCBS) waiver programs identify employment services as important to habilitation, rehabilitation, and recovery of Medicaid recipients' health-related well-being and quality of life.

1. *Addressing Employment Services Needs of Medicaid Recipients with Intellectual and Developmental Disabilities*

Individuals receiving 1915c People First waiver services for intellectual and developmental disabilities will benefit from Employment First concept-driven reform addressing employment outcomes as part of its HCBS

habilitation model. The New York State Office for People with Developmental Disabilities' (OPWDD's) Health Systems Transformation for Individuals with Developmental Disabilities agreement is a blueprint for its 1915c People First HCBS waiver reform and service delivery transformation. It includes a comprehensive plan to increase competitive integrated employment opportunities for individuals with intellectual and developmental disabilities.

The 1915c People First waiver plan:

- Introduces a new waiver service, Pathway to Employment: a person-centered, comprehensive career/vocational employment planning and support service;
- Commits to addressing its sheltered workshop model with a transition plan for competitive, integrated employment options;
- Increases collaboration with the state's vocational rehabilitation agency and education department to maximize available workforce development and placement resources to transition youth with disabilities into competitive employment opportunities with appropriate supports;
- Outlines strategies for job retention including quality assurance of service delivery;
- Proposes the redesign of fee structures that incentivize employment services; and
- Recommends monitoring benchmark data with strategic goal setting and outcomes measurements.

*2. Addressing Employment Needs of Medicaid Recipients with Behavioral Health Needs*

Individuals receiving New York's 1115 Behavioral Health Partnership Plan waiver services will also benefit from Employment First reform. The New York State Department of Health's (DOH's) transformation plan draft includes reform to its behavioral health services, including health and recovery plans (HARPs). HARPs will provide individuals with significant mental illness and/or substance use disorders access to an enhanced HCBS benefit package. These enhanced benefits, including behavioral supports in-home and in community settings, are designed to enable recipients to live in the most integrated setting possible. These HCBS behavioral health waiver services specifically address employment outcomes as part of the recovery model.

The HARP program will include a menu of individual employment support services, including pre-vocational training, transitional employment support, intensive supported employment services, and ongoing supported employment services.

*3. Addressing Employment Disparities as a Social Determinant of Health*

The MRT further committed to addressing employment outcomes for people with disabilities by convening a workgroup to consider social determinants of health, with a focus on employment. The group was charged with providing guidance to DOH on how best to address social determinants of health and to decrease/eliminate disparities due to social determinants of health. The MRT issued a report in October 2014 that offered a series of 12 initiatives meant to expand overall employment opportunities for individuals with disabilities (see Appendix B for the detailed report highlighting the recommendations of the MRT workgroup).

*4. Medicaid Buy-In for Working People with Disabilities (MBI-WPD)*

The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) allows individuals with disabilities who are working to maintain their Medicaid eligibility beyond the maximum income and asset limit for Medicaid eligibility. Increased utilization of the MBI-WPD program is expected to result in a significant cost savings to government. A recent study performed by Cornell University's Employment and Disability Institute demonstrates that enrollment in the MBI-WPD program (and thereby, employment) resulted in a reduction in Medicaid expenditures of approximately 43% compared with "regular" Medicaid enrollment. Similarly, a national study conducted by Mathematica Policy and Research compared MBI-WPD participants with other working-age disabled Medicaid enrollees and found that buy-in participants in 2005 incurred lower annual Medicaid expenditures per enrollee than other adult disabled Medicaid enrollees.[2] This difference was observed in New York State, as well as in most states with a buy-in program. Mathematica's findings suggest that once enrolled, buy-in participants on average demonstrate a decrease in Medicaid expenditures, and participants who are working require fewer services, or a less expensive mix of services, than other Medicaid enrollees with disabilities.

*Providing a Single Point of Access for Employment Services and Supports: The New York Employment Service System (NYESS)*

NYESS is a comprehensive, single point of entry, job matching, employment supports coordination, and data warehouse system. It is also an employment network under the Social Security Administration's (SSA) Ticket to Work (TTW) program. NYESS was designed to support competitive employment opportunities and outcomes for all individuals with disabilities who desire services and supports, regardless of how or where they choose to access services.

NYESS has made groundbreaking strides in helping individuals with disabilities to achieve successful employment outcomes through SSA's TTW program. Through extensive work with SSA, NYESS has made key administrative changes to how the "ticket" of an individual is used in New York. Providers can work collaboratively with an individual to achieve an employment outcome financially beneficial to all parties. Services that do not achieve measurable outcomes are not rewarded. As a result, NYESS and its network of providers are now serving more SSA beneficiaries and creating more employment outcomes than any other employment network in the country. The NYESS administrative employment network brought over $3.2 million in revenue from the TTW initiative in 2014 to community provider organizations and local workforce investment areas.

*Respecting Employment as Fundamental to Community Integration: New York State's Olmstead Plan*

New York State's 2013 Olmstead Plan prioritized employment as a foundational component to community integration. The plan identified several implementation strategies in addition to the state's Medicaid redesign efforts, and made recommendations for improving employment outcomes for individuals with

[2] Gilbert Grimm et al. "Analysis of Medical Expenditures and Service Use of Medicaid Buy-In Participants, 2002-2005." http://www.mathematica-mpr.com/~/media/publications/PDFs/disability/buy-in_medex_rpt.pdf, page 22.

disabilities.[3] New York's Most Integrated Setting Coordinating Council (MISCC) is tasked with monitoring and providing public accountability for the implementation of the state's Olmstead Plan. Quarterly meetings address the progress on the comprehensive statewide plan to ensure that people of all ages with physical and mental disabilities receive care and services, including the opportunities for integrated competitive employment, in the most integrated settings appropriate to their individual needs.

New York's Olmstead Plan recommendations for employment include:

- Investing in programs that value competitive integrated employment as the preferred alternative to sheltered workshops;
- Ensuring that employment considerations are included in the development of health and human services common core needs assessment items and quality outcome measures;
- Continuing the state's commitment to NYESS;
- Aligning the state's various disability workforce strategies, including vocational rehabilitation services, with the state's traditional workforce resources; and
- Aligning the state's disability workforce strategies with its economic development strategies, identified through statewide and regional planning and priorities.

*Prioritizing School to Work Transition Planning and Work Experience Opportunities: New York State Education Department*

The New York State Education Department (NYSED) recently adopted two new high school exiting credentials for students with disabilities: the Career Development and Occupational Studies (CDOS) Commencement Credential and the Skills and Achievement Commencement Credential (SACC). All students with severe disabilities taking the New York State alternate assessment receive the SACC upon high school exit. These students receive instruction in the state's alternate academic and career learning standards and are provided opportunities, as appropriate, to engage in instructional and work preparation experiences, both in school and, whenever possible and appropriate, in the community. The SACC must be accompanied by documentation of the student's skills and strengths and levels of independence in academic, career development and foundation skills needed for post-school living, learning, and working.

The CDOS Commencement Credential, which recognizes a student's readiness for entry level employment, can be a supplement to a regular diploma or can be awarded as the student's exiting credential. To obtain the credential, the student must complete a career plan, satisfactorily complete at least 216 hours of career and technical education coursework and/or work-based learning experiences (including at least 54 hours of work-based learning), demonstrate attainment of the state's learning standards in the areas of career development, application of academic skills, and the universal foundation or soft skills necessary for employment, and have at least one "employability profile" documenting his/her work readiness skills. In lieu of these requirements, a student may also earn the CDOS Commencement Credential by passing the assessment for one of the national work readiness credentials. While both credentials focus on preparation for employment and recognize a student's employment skills, neither the SACC nor the CDOS Commencement Credential are high school diplomas.

[3] http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/olmstead-cabinet-report101013.pdf

NYSED's Office of Special Education has awarded new contracts through the regional special education technical assistance support centers for transition specialists located throughout the state to assist school districts to implement effective transition plans and activities. They facilitate regional interagency workgroups and conduct regional professional development for parents and school personnel on a variety of transition related topics. The Office of Special Education also funds a state technical assistance center on transition and will be issuing a request for proposals to school districts, boards of cooperative educational services, and other approved special education providers to develop career and technical education coursework and work-based learning opportunities for students with disabilities in their schools.

NYSED has made a further commitment to improving employment outcomes for youth with disabilities through the Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR). ACCES-VR is building the capacity to serve both in-school and out-of-school youth with disabilities to achieve quality employment outcomes. The ACCES-VR Transition and Youth Services initiative includes three key strategies:

- An ACCES-VR statewide transition and youth initiatives team to develop and coordinate new strategies for youth engagement within ACCES-VR;
- Core rehabilitation services youth employment services contracts with community rehabilitation providers to serve youth with vocational assessment, work readiness, and work experiences; and
- Regional vocational rehabilitation community employment specialists who work with ACCES-VR district offices in outreach to school districts on vocational rehabilitation and post-school employment options for youth with disabilities.

Collectively, these transition and youth services initiatives provide technical support to local school districts in implementing successful work experiences and school-to-work transitions. ACCES-VR has identified a commitment to also supporting out-of-school youth with disabilities to participate in career planning, work readiness preparation, and community work experiences with a range of supports that will result in employment.

*Improving Community Rehabilitation: New York State Commission for the Blind Vocational Rehabilitation Services*

New York State Commission for the Blind's (NYSCB's) strategies include a goal for establishing, developing or improving community rehabilitation programs and use of funding for innovation and expansion activities. NYSCB has been working closely with its providers to review current services and to encourage development of new vocational rehabilitation programs and services.

Recent innovative activities include:

- Contracts awarded to two agencies to provide four-week residential pre-college programs on two college campuses for approximately 40 students;
- Pre-vocational training curricula for 10-14 year old vocational rehabilitation individuals approved for a number of partner agencies. Programs include development of independent living skills and career exploration opportunities;

- Approval by NYSCB of a number of trained and certified benefits advisers, located at agencies, independent living centers, or who work independently. These advisers are equipped to provide information not only on social security benefits, but in all other benefits areas that can be used to allow individuals to become more economically self-sufficient as they return to work; and
- Formation of two joint NYSCB/provider workgroups, which met in 2013 to review the comprehensive services and placement/diagnostic vocational evaluation contracts and recommend enhancements to service provision through those contracts.

*Supporting Employment First Objectives: New York's Community of Practice*

New York State also benefits from the following work of leaders in policy development and service delivery who are committed to improving employment outcomes for individuals with disabilities:

- New York Makes Work Pay, a statewide initiative focused on improving the rate of employment among people with disabilities, funded by a grant from the Centers for Medicare & Medicaid Services (CMS), and administered through the New York State Office of Mental Health (OMH) and the Research Foundation for Mental Hygiene (RFMH), with their management partners Cornell University and Syracuse University, in conjunction with DOH.
- Disability-inclusive employment consortiums have emerged across the state to encourage service provider agencies and advocacy groups to combine resources, share innovative practices, and affect public policy.
- The Supported Employment Leadership Network (SELN), a cross-state cooperative venture of intellectual and developmental disability agencies committed to improving employment outcomes for adolescents and adults with developmental disabilities, is supporting OPWDD in establishing and meeting its new objectives for employment outcomes.
- NYS PROMISE grant to improve education and career outcomes for low-income children with disabilities will advance postsecondary education and employment outcomes for 14-16 year old students receiving SSI. PROMISE is a joint initiative of the US Department of Education (USDOE), SSA, the US Department of Health and Human Services (USDHHS), and the US Department of Labor (USDOL). Grant activities are being coordinated by OMH; the contract administered by RFMH; and research and outreach activities conducted by Cornell University's Employment and Disability Institute.
- The Institute for Innovative Transition is participating in two statewide grants on employment and education policy in New York State:
    - The New York State Partnerships in Employment Systems Change grant is a federal grant from the Administration on Intellectual and Developmental Disabilities that will lead to policy and implementation changes to significantly increase the numbers of young people with intellectual and developmental disabilities who are competitively employed in an integrated environment; and
    - A grant from the New York State Developmental Disabilities Planning Council (DDPC) is focused on increasing the number of students with intellectual and developmental disabilities who have access to higher education across the state.
- DDPC is granting funding to develop a New York specific Disability Benefits 101 (DB101) portal that will be fully integrated with NYESS, to assist all individuals with disabilities in making informed decisions about going to work.

- Think College NY is a network that strengthens post-secondary options and improves employment outcomes for students with developmental disabilities.

*Additional Disability Inclusive Employment Initiatives, Programs, and Partnerships*

New York State has committed to the implementing additional policies, programs, and partnerships to improve employment outcomes for people with disabilities.

- The Governor's Program to Hire Individuals and Veterans with Disabilities, an alternative hiring program for individuals with disabilities, includes a new recruitment resources center web portal that launched in 2014.
- New York's Service-Disabled Veteran-Owned Business Act, signed into law in 2014, allows eligible veteran business owners to become certified as a New York State Service-Disabled Veteran-Owned Business (SDVOB) in order to increase participation in New York State's contracting opportunities. SDVOBs will be able to join New York State's preferred source program, a state-mandated initiative to create and sustain employment opportunities for New Yorkers with disabilities by requiring state and local agencies to purchase products and services from preferred source providers that maintain disability inclusive workforces.
- New York State promotes tax credits as an incentive for hiring of individuals with disabilities, which include:
    - Work Opportunity Tax Credit (WOTC) is a federally funded program that provides up to $2,400 in tax credits for hiring low-income individuals who face barriers to employment, including individuals with a disability. The legislative authority for the WOTC program expired on December 31, 2014. In anticipation of possible retroactive reauthorization by Congress, hiring businesses and organizations are encouraged to submit WOTC applications for all eligible employees hired after December 31, 2014;
    - Workers with Disabilities Employment Tax Credit is a state-funded program that provides up to $2,100 in tax credits for hiring individuals with a disability in the second year following the first year of WOTC eligibility; and
    - Developmental Disabilities Tax Credit is a state-funded program that provides up to $5,000 tax credits for hiring individuals certified by NYSED and OPWDD as having a developmental disability.
- New York's Disability Employment Initiative (DEI), funded by the USDOL and administered by the New York State Department of Labor (NYSDOL), aims to improve coordination and collaboration among programs at state and local levels, including the TTW program, and builds effective community partnerships that leverage public and private resources to better serve individuals with disabilities and improve employment outcomes.
    - NYESS is continuing DEI-like services in six local workforce investment areas with more projects to be funded.
- The Justice Center for the Protection of People with Special Needs administers the Technology Related Assistance for Individuals with Disabilities (TRAID) program. Through its 12 regional TRAID Centers, the program provides assistive device loans, demonstrations, and training for individuals with disabilities to enable them to be successful in employment across New York State. An agreement between the NYSCB and TRAID provides loans to individuals in immediate need of devices for training or employment. Regional TRAID staff also provide technical assistance to staff

at the New York's career centers when providing employment services to persons with assistive technology needs.

- New York State's Office of Temporary and Disability Assistance (OTDA) and the AIDS Institute have implemented the HIV/AIDS Employment Services Initiative to offer intensive job placement and case management services to help individuals with HIV/AIDS retain employment while ensuring continued access to health insurance to ensure going to work does not compromise health outcomes.
- NYSCB's Business Enterprise Program (BEP) has identified a strategic plan to grow the program. The BEP offers opportunities for individuals who are blind to gain the training and skills necessary to manage one of many vending facilities/newsstands located in federal and state office buildings throughout the state. NYSCB's strategic plan includes establishing additional convenience stores, cafeterias, and vending machine routes across the state to increase management opportunities for blind individuals.
- USDOL Employment Resources Rebalancing Initiative (ERRI) was implemented in 2014 as a means to identify and better understand the variety of challenges facing states that want to improve integrated employment outcomes for their citizens with disabilities, and to determine specifically what is required of states to redirect public investments from segregated, facility-based programs (sheltered workshops) and segregated day service programs to services that support integrated employment. New York State was one of several states selected for this initiative.
- New York's 101 career centers provide a full range of employment services to job seekers, including occupational skills training, job match, and referral to approximately 100,000 state-based jobs via Jobs Express, as well as career counseling and planning. On an annual basis, New York's career centers serve approximately 460,000 individuals, with more than 20,000 self-identifying as having a disability. In addition, federal authorization places emphasis on helping individuals with disabilities access employment, education, job-driving training, and support services to help secure employment and advance careers.

  Recent federal requirements for New York's career centers benefit individuals with disabilities by mandating ACCES-VR's membership on both the state workforce investment board and all 33 local workforce investments boards; holding ACCES-VR and NYSDOL accountable to comprehensive performance measures; permitting local workforce investment boards to create a standing committee with a focus on the provision of services for individuals with disabilities; mandating annual assessments of physical and programmatic access of career centers; and creating a national advisory committee on strategies to increase competitive integrated employment for individuals with disabilities.

**Best Practices: Employment First – From Policy to Practice to Outcomes**

New York is not alone in its effort to develop an Employment First policy. There are 46 other states that have some type of Employment First activity, with at least 29 having formal policies in place. The bridge from policy to practice to fully realize an Employment First vision in New York is critical. Bold action is needed to produce change. Business as usual has not produced the change needed to increase employment rates for individuals with disabilities. Strong practices implemented in other states have made procedural changes to support an Employment First policy. In Ohio, people with disabilities must sign a waiver (giving

explicit reasons why employment is not a viable option) to enroll in adult day services.[4] Other states, like Virginia, are rolling out a comprehensive training curriculum regarding Employment First for all direct support professionals working in the system to systematically change the system's culture.[5] North Carolina, like many other states, has established a business to business network, the North Carolina Business Leadership Network (NCBLN), to support the business community with information and resources to source, hire, and promote people with disabilities; do business with organizations owned and operated by people with disabilities; and market their products and services in an accessible manner to people with disabilities across the state.[6] Other states, like Georgia, are forming a specified unit to drive the Employment First vision to ensure the statewide implementation of the movement.[7]

The State Employment Leadership Network (SELN), a joint program of the National Association of State Directors of Developmental Disabilities Services and the Institute for Community Inclusion at the University of Massachusetts Boston, in their review of all Employment First efforts notes:

> "*It is important to recognize that creation of documents, reports, and policies, in and of itself, will not result in increases in workforce participation, without a long-term commitment to action steps that make the Employment First vision a reality for all citizens with disabilities. Setting a vision and direction is a starting point—but it must be done in conjunction with comprehensive systems change that results in shifting of resources towards integrated employment, a service system that provides consistent and high quality employment assistance and supports, and measurement and accountability for achieving employment outcomes. Employment First is also about more than just simply changing how services and supports for people with disabilities are provided—it is a catalyst for and reflective of an ongoing fundamental cultural shift and view by policymakers, public officials, service systems, service providers, employers, and most importantly by individuals with disabilities themselves, that views people with disabilities as full participants in the economic mainstream, working side-by-side with their fellow citizen.*"[8]

New York has established real targets for measurable actions to demonstrate the effectiveness of the Employment First policy.

## What are New York's Goals?

Based on New York's existing employment services framework and infrastructure New York State is establishing three aggressive goals to measure the success of its Employment First policy:

1. **Increase the employment rate of individuals with disabilities by 5%.**
2. **Decrease the poverty rate of individuals with disabilities by 5%.**
3. **Register 100 businesses as having formal policies to hire people with disabilities as part of their workforce strategy.**

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[4] http://dodd.ohio.gov/medicaid/Documents/DODD%20Employment%20First%20Form1.pdf
[5] http://www.dbhds.virginia.gov/library/document-library/dbhdsstrategicplanforemploymentfirst_final.pdf
[6] http://www.ncdhhs.gov/mhddsas/services/employment/
[7] http://www.employmentfirstgeorgia.org/
[8] http://www.selnmembers.org/components/com_wordpress/wp-content/uploads/2014/10/seln_ef-resource-list_10-1-14.pdf

## Recommendations

*To accomplish these critical goals, based on the wealth of information gathered from key stakeholders across the state through listening sessions held by members of the Governor's Employment First Commission, the commission recommends the following:*[9]

### 1. Cultural Modeling

To truly create an Employment First culture in New York State, the state agencies and their respectively funded community-based organizations need to effectively model the employment of individuals with disabilities. Segregated approaches to vocational rehabilitation must be replaced by integrated opportunities. Some state agencies have taken the lead in hiring individuals they are supporting, but this can be enhanced by linking these efforts with existing programs and setting new expectations.

Existing state programs can be improved to increase opportunities for individuals with disabilities in state jobs. Section 55-b of the New York State Civil Service Law authorizes the New York State Civil Service Commission to designate up to 1,200 positions normally filled through competitive examination to be filled through the appointment of qualified people with disabilities.[10] No initial written or oral examinations are required for appointment. However, because no examination is required, these individuals are not being placed on canvas lists and made aware of available positions. The onus is placed on these individuals to seek out eligible positions. Including individuals in 55-b positions on canvassing lists will expand their opportunities for career advancement and free up entry level positions for other individuals with disabilities. To ensure successful adoption of these policy changes, the commission is recommending the reinstatement of the statewide 55-b coordinator, who will provide oversight to the process.

The NYSDOL Skills Matching and Referral Technology (SMART) technology uses artificial intelligence software to analyze résumés for skills and work experience, and identify matches with available employment opportunities. The software compares résumés with openings in New York's Job Bank and from Job Scout, a tool that synthesizes job postings in other Internet-based job posting and recommends job leads. Utilizing SMART and NYESS, which are already fully integrated, mechanisms can be developed to match individual's résumés and skills to available job opportunities in state and local government, including available 55-b and -c openings.

This concept of cultural modeling is particularly important in rural communities where some community-based organizations are the largest employers in their respective regions. As a result, it is increasingly important for the community based organizations to model the hiring of people with disabilities to other local businesses.

### 2. Energize the "Demand-Side" of the Equation

The concept of business-to-business modeling and mentoring related to employing individuals with disabilities is not new. The US Business Leadership Network (BLN) has been leading a national effort "to help business drive performance by leveraging disability inclusion in the workplace, supply chain, and marketplace."[11] While modeling of hiring of people with disabilities needs to begin with state and local government, and community based organizations, the overwhelming number of jobs in New York State are in the private business sector.

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[9] See Appendix C: Listening Sessions – Dates and Times

[10] http://www.cs.ny.gov/dpm/b55.cfm

[11] http://www.usbln.org/about-us_mission.html

To this end, New York needs to redesign and reinvigorate the New York BLN to pursue the aggressive goal of engaging 100 business partners in having formal policies to hire people with disabilities as part of their workforce strategy. A core network of employers can champion the "business first" platform, promote hiring individuals with disabilities, and advise other businesses on how to take advantage of underutilized incentives like WOTC, the Workers with Disabilities Employment Tax Credit, and the Developmental Disabilities Tax Credit. Additionally, expanding the Developmental Disabilities Tax Credit to include all disabilities will further incentivize business participation. NYESS will partner with NYSDOL, supporting NYSDOL's well-developed business services units with community organization job developers to support the BLN. Focused discussions with the BLN will be employed to identify methods of addressing complex needs while supporting business goals. Options will be explored to address supply-side strategies such as job carving (i.e., the development/selection of specific job duties within a business to design a job) to ensure that they meet the demand-side needs as a viable option, while creating meaningful employment for individuals.

New York State should also promote state and federal policy supporting hiring individuals with disabilities. Businesses should be encouraged and supported in pursuing federal contracting opportunities that require a 7% hiring rate for individuals with disabilities. New York can also build on Minority Women Owned Business Enterprise (MWBE) policies to include individuals with disabilities as a minority group.

New York can utilize the power of its current regional economic development efforts to infuse opportunities for individuals with disabilities to obtain work. Over the past three years, New York has invested more than $2 billion in job creation and community development. However, there has not been an emphasis placed on the employment of individuals with disabilities. The Employment First policy can be infused into the regional economic development councils by requiring businesses to employ people representative of the community in which they operate, including those with disabilities.

### 3. New York Employment Services System (NYESS)

Use of NYESS is a key step toward ending the fragmentation of the employment services system in New York State. Adoption of NYESS by all agencies that provide employment supports to people with disabilities will allow data collection and exchange among all state agencies supporting individuals with disabilities in employment.

Moreover, NYESS, which is now fully integrated with NYSDOL's One Stop Operating System, JobZone, and CareerZone, is also a key venue to integrate various components of other recommendations included in the Employment First initiative, such as life coaching, benefits advisement and education (DB101), and cultural change. Full adoption and integration, however, will be best facilitated through the development of significant system enhancements that will increase the functionality and usefulness of the system. NYESS has already begun initial discussions and planning around the redesign of the system, but with the availability of additional resources, this redesign process could be greatly enhanced; could occur on a more rigorous timeline; and as a result, create greater outcomes for individuals.

Mandated use of the system by all disability service providers that provide employment services would solidify New York's ability to track employment outcomes and likely generate more that $4 million annually through SSA's TTW program to fund many of the Employment First initiatives. State agencies not directly

entering data into the system could meet this mandate by exchanging data with NYESS. In addition, the state will continue to explore possible alternatives to a single employment case management system that may better address all state agencies' needs.

### 4. Benefits Advisement

People with disabilities may believe they are inhibited from working because they do not know or understand the impact of employment on their benefits. New York will build upon existing benefits screening tools to provide a comprehensive benefits advisement system. Over the next three years, NYESS, in partnership with DDPC, will be developing an interactive web-based platform, DB101. DB101 will provide accurate, up-to-date information and benefits calculators so individuals, including individuals with disabilities, can better assess how going to work will impact their access to publicly funded health insurance and income support programs such as SSI, SSDI, Supplemental Nutrition Assistance Program (SNAP), housing assistance, and other public benefits. DB101 will be integrated with NYESS, as well as NYSDOL's offerings like JobZone and CareerZone, and will allow people with disabilities, and anyone working with or caring for those individuals, to utilize an accessible tool to explore employment options and understand the impact of a specific job on an individual's benefits over time.

Benefits systems are complex and limited resources are available to help individuals accurately understand benefits that are available and how their eligibility to benefits will change if they work. NYS should enhance benefits advisement capacity and provide life coaching to all individuals with disabilities seeking economic self-sufficiency. The concept of life coaching is based in part upon the current Work Incentive Information Network (WIIN), an informed and educated network of professionals and peers throughout New York State who understand public benefits, various work incentives, and the interchange between these elements. The goal of the WIIN is to increase the number of individuals with disabilities who choose to work by helping them navigate the complex systems of public benefits by providing them with information to make an educated and informed choice about work, and by providing assistance to take the next step toward economic independence, self-sufficiency, and an exit from poverty.

Additionally, life coaches should be deployed at strategic times when assistance is most needed. This can be accomplished through developing tools in NYESS to determine users' needs, eligibilities, available work incentives, and entitlements, to assist them in moving toward self-sufficiency by preemptively prompting interventions at key decision points. By building triggers that are followed-up by certified benefits practitioners and/or members of WIIN to address the results and recommendations presented by the electronic systems, individuals' needs will be met in real time to produce real results.

As results and outcomes are generated, life coaches and/or community organizations could earn outcome based payments. The recommendation is that this should be explored and implemented, if possible, similar to the TTW program, but funded via Medicaid instead of through SSA. The expense to the Medicaid program is anticipated to be offset by savings related to the decrease in Medicaid usage.

### 5. Medicaid Buy-In for Working People with Disabilities

Enrollment in the MBI-WPD program has remained at approximately 10,000 people despite estimates that approximately 150,000 New Yorkers currently qualify for the benefit. Individuals report difficulties in completing the enrollment process in MBI-WPD through local departments of social services and New York City Human Resources Administration (HRA). The state is in the process of taking over administration of the

Medicaid program from local districts, which will centralize and create consistency in determinations. In the coming years, MBI-WPD program will be integrated into the online New York State of Health application portal, automating eligibility determinations and referring applicants who require additional assistance to the state enrollment assistance center.

### 6. Transportation

Transportation is a necessary support for individuals with disabilities to secure employment. A cross-agency taskforce is needed to explore options to address the transportation needs of individuals with disabilities. The commission recommends that the taskforce be comprised of members from key state agencies like the Office for People with Developmental Disabilities, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, the Office of Temporary and Disability Assistance, the Department of Labor, the State Office for the Aging, the State Education Department's Adult Career and Continuing Education Services-Vocational Rehabilitation, the Commission for the Blind, the Office of Children and Family Services, the Department of Health, the Department of Transportation, and other relevant agencies. This group will be tasked with compiling recommendations for review by commission to address this issue.

Beyond the potential recommendations of the joint taskforce, the commission recommends that New York State pursue a rural transportation tax credit for employers providing resources or direct transportation to employees.

The 2015-2016 executive budget proposes funding for a mobility transportation project jointly coordinated by the Department of Health and the Department of Transportation. Lessons from this study can be used to develop pilot projects that will test mobility strategies that can benefit communities, including individuals with disabilities.

### 7. Education

New York should continue to provide supports to schools to assist students in understanding their disability, accepting responsibility for their own success, accessing appropriate preparatory curriculum, and learning time management skills and computer skills; and offer students opportunities to get involved in the community life of educational institutions.[12]

Early access to employment experiences lead to improved long-term outcomes. New York is participating in the PROMISE research initiative. This research is testing the impact of early employment supports and coupled with services with significant family involvement. Results from this study will guide better post-secondary educational and employment policy and practice.

The commission recommends implementing a "school of choice" option for students with disabilities whereby students and their families can choose the schools that will best support them in achieving a degree recognized and valued by post-secondary educational institutions and employers. This would require two key policy changes to occur. First, financial resources would need to be available for use by the student to attend their school of choice. In other states where a school of choice model is used, school districts have the option to participate and the extent of that participation is determined at the local

[12] http://www2.ed.gov/about/offices/list/ocr/transitionguide.html

level. Second, the Commission recognizes that the array of available credentials/diplomas in New York State needs to be re-visited to include a recognized "portfolio-based" option for degree completion.

Schools also need to have adequate levels of school guidance counselors and/or transition coordinators who are trained to provide career planning supports to students with disabilities seeking higher education, employment, or job skills training. All students need guidance and models of success. As a result, it is recommended that a peer-modeling approach also be used in conjunction with this planning to provide real-life context to the planning process.

Local decision making, including planning for education, is at the forefront of this process. State agency partners will explore with local school districts various options that will meet their needs and advance the goals outlined in this report.

**8. Creating an Employment First Service Culture**

Any major change in employment policy must be accompanied with changes in the systemic attitudes about the employability of individuals with disabilities. The basic premise of Employment First must be embraced. Over the past several years agencies like OPWDD, SED's ACCES-VR, and OMH have been providing targeted training to employment services staff on the delivery of high quality evidence-based employment services to individuals with disabilities. The commission recommends building upon this robust foundation by extending the offering of these trainings focused on the delivery of high quality employment services to the full spectrum of direct support professionals who are tasked with supporting individuals with disabilities to achieve their individualized goals. This expanded training focus will increase the knowledge base of the entire system supporting individuals with disabilities, and will infuse the Employment First culture throughout the state.

**9. Self-Employment and Entrepreneurship**

Several advocacy organizations have identified the need to support self-employment opportunities. While there is recognition that self-employment is viable for a small portion of the population, the options to pursue self-employment are limited in the NYS system. ACCES-VR has policies that support two levels of self-employment initiatives, one requiring less than $5,000 of resources that does not require a business plan, and a second above $5,000, which requires more rigorous business planning and review by a team of professionals, including, but not limited to New York State entrepreneurial assistance programs and/or small business development centers. The commission therefore recommends that this model be expanded upon, and to consider including supporting a localized incubator model that will provide a safety net of success.

**10. Expand Access to Assistive Technologies**

Assistive technologies can often be the bridge to competitive, integrated employment for individuals with disabilities. Assistive technologies can support individuals to develop job skills, identify employment opportunities and maintain employment. However, there is limited public inventory available to individuals with disabilities, and further, students with disabilities who had their assistive technology needs met through the school districts often find that there is a gap in services once they graduate.

In New York State, TRAID, a federally funded program, is administered by the New York State Justice Center for the Protection of People with Special Needs. The TRAID program contracts with 12 community-based

organizations (regional TRAID centers) to provide access to assistive technology for individuals in all regions of the state. The regional TRAID centers are responsible for providing information and referral, device re-utilization, demonstrations, maintenance, loans, and training. Due to limited resources, in 2014, only 4% of device loans from TRAID centers were employment related. The commission recommends increasing access to assistive technologies through a strategic partnership with ACCES-VR, OTDA, and TRAID that will expand inventory of employment-related devices and increase training on the use of such devices.

**11. Outcome Measurement**

There are a number of potential tools to measure the success of New York's progress. One method would be to utilize data from the American Community Survey. While this database is accurate, delays associated with availability make it less responsive in nature. As a result, the Employment First Commission recommends using NYESS to compare Medicaid data to New York wage data to create a proxy to measure increases and respective decreases in the employment and poverty rates in New York. The commission is further recommending that timeframes associated with attainment of these rigorous goals should be only established after the final recommendations have been adopted, and a strategy for implementation has been developed. Finally, the commission suggests that a credible external academic body be engaged to review the ongoing progress towards attainment of the projected goals. Within six months an external partner for review will be identified with an initial metric of data measurements to establish a baseline and tracking system for reviewing progress towards the goals. It is recommended that the Most Integrated Setting Coordinating Council's (MISCC) employment sub-committee be tasked with overall performance tracking and coordinating implementation.

# Appendix A

Executive Summary – Recommendations

## What are New York's Goals?

1. Increase the employment rate of individuals with disabilities by 5%.
2. Decrease the poverty rate of individuals with disabilities by 5%.
3. Register 100 businesses as having formal policies to hire people with disabilities as part of their workforce strategy.

| Recommendation | Primary Agents | Potential Steps for Implementation | Timeframe |
|---|---|---|---|
| **MRT Recommendations**<br>Assist with the assessment and implementation of the MRT recommendations (Appendix B) | *DOH and all state agency partners* | Continue the work of the MRT committee to assess and implement committee's recommendations where possible | Establish timelines and potential implementation strategies: 1-9 months |
| **1. Cultural Modeling**<br>• Modeling of hiring of people with disabilities in state agencies & providers that receive funding<br>• Enhancement of 55-a, -b, -c programs: Inclusion on lists, reinstatement of statewide coordinator | *All state agency partners*<br><br>*NYS Civil Service*<br><br>*NYSDOL/OMH/NYESS* | A. Introduction of education and training on infusing cultural modeling into state agency operations. use state agency peer modeling to assist other agencies in embracing the model<br>B. Reinstatement of 55B statewide coordinator<br>C. Utilization of SMART to match candidates to openings in the state | Training/peer modeling: 18-24 months<br><br>Coordinator: 9-15 months<br>SMART: 12-15 months |
| **2. Energize the "Demand-Side" of the Equation**<br>• Re-invigoration of the NYS Business Leadership Network<br>• Recruitment of 100 business partners<br>• Inclusion of "disability" in the MWBE<br>• Utilization of regional economic development to promote disability employment<br>• Support for the federal goal of 7% employment of individuals with disabilities | *NYSDOL*<br><br>*ACCES-VR/NYSCB*<br><br>*OMH/NYESS* | A. Identification of an entity to lead/develop the Business Leadership Network<br>B. Introduction of new legislation on MWBE to include disability as a minority group<br>C. Explore automation of tax credit claiming for participating businesses<br>D. Introduction of policy for regional economic business councils to ensure all projects target initiatives that are representative of the full community population.<br>E. Development of NYESS and NYSDOL business service consortiums | BLN lead identified: 3 months<br><br>MWBE inclusion: 24 months<br><br>Tax credit claiming: 18 months<br><br>Regional economic business councils: 12 months<br><br>NYESS/NYSDOL: 12 months |

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|---|---|---|---|
| **3. New York Employment Services System (NYESS)**<br>• Mandated use of the system by all disability service providers<br>• Enhanced service delivery and cross systems integration and data reporting | *NYSDOL, OMH/NYESS*<br>*All state partners funding employment services* | All state agencies would need to implement policy to:<br><br>A. Require all provider organizations receiving funding for the provision of any employment service to fully utilize NYESS<br>B. State agencies not directly entering data, will exchange appropriate data | Policy: 3 months<br><br>Full adoption: 18 months<br><br>Data exchange: 18 months |
| **4. Benefits Advisement**<br>• Development of life coaching network<br>• Implementation of DB101 tool<br>• Availability of a Medicaid funded benefit advisement service | *ACCES-VR, NYSCB, OMH/NYESS, and OPWDD*<br>*DDPC, DOH* | A. Development of the DB101 portal, while integrating into NYESS to ensure that automated life coaching triggers can be sent to the network of life coaches/benefits advisors<br>B. Development of a new Medicaid service funded through DOH to support outcome-based benefit advisement | DB 101 developed: 24 months<br>Medicaid service designed: 6 months<br>Provider selection: 12 months |
| **5. Medicaid Buy-In for Working People with Disabilities** | *DOH* | A. Integration of MBI-WPD into the online application portal to increase utilization<br>B. Train benefits advisors, life coaches, and professionals on enrolling | 18 months |
| **6. Transportation**<br>• Development of a statewide transportation taskforce to develop cross systems solutions<br>• Introduction of a rural transportation tax credit<br>• Learn from the transportation mobility project and implement subsequent new policies | *DOT*<br><br>*DTF*<br><br>*NYSDOL* | A. Formation of the cross-agency taskforce, and develop recommended strategies (based on mobility project and other sources)<br>B. Introduction of legislation to create a rural transportation tax credit | Taskforce: 0-24 months<br><br>Tax credit: 12-18 months |
| **7. Education**<br>• Development of early preparatory models of education<br>• Learn from NYS PROMISE and take the principles to scale<br>• Implement a school of choice model<br>• Develop a "diploma" option portfolio based in comparison with CDOS<br>• Introduce more school counselors to provide career planning and prep | *NYSED*<br><br>*Board of Regents*<br><br>*All state agencies connected to PROMISE: OMH, ACCES-VR, NYSCB, OPWDD, DOH, OTDA* | A. Revisit CDOS credential and develop a portfolio-based diploma<br>B. Review findings of NYS PROMISE, and make appropriate policy and practice adjustments according to findings<br>C. Investigate the utilization of additional school counselors and appropriate funding | CDOS and diploma options: 18-24 months<br>NYS PROMISE: 36 months<br><br>School counselor: 24 months |

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|---|---|---|---|
| **8. Creating an Employment First Service Culture:**<br>• Offering cultural training on Employment First to ALL direct support professionals | *OPWDD, OMH, ACCES-VR, NYSCB, OASAS* | A. Identification of funding mechanism to deliver training<br>B. RFP Release to engage trainer<br>C. Development of a training curriculum to be utilized statewide | Funding identified: 3 months<br>RFP release: 9 months<br>Training initiated: 12-36 months |
| **9. Self-Employment and Entrepreneurship** | *ACCES-VR, NYSCB, and NYSDOL* | A. Develop a cross agency standard and policy on supporting self-employment | Policy development and adoption: 12-18 months |
| **10. Expand Access to Assistive Technologies**<br>• Implementation of TRAID with other state entities | *NYS Justice Center, NYSED Offices of Technology, Special Education, ACCES-VR, NYSCB, and OTDA* | A. Develop a cross-agency team to maximize the use of TRAID in NYS, and expand the availability of assistive technology | 12-18 months |
| **11. Outcome Measurement and Monitoring** | *OMH/NYESS* | A. NYS should engage a credible external academic body to review the ongoing progress toward attainment of the projected goals<br>B. NYS should utilize either the Olmstead employment sub-committee or the New York Employment Services steering committee to provide ongoing oversight and monitoring of the project goals<br>C. NYESS will exchange data with other state systems as appropriate | Engage external body: 6 months<br><br>Ongoing |

# APPENDIX B

Medicaid Redesign Team

Social Determinants of Health Workgroup

NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

## Social Determinants of Health Work Group

FINAL RECOMMENDATIONS

October 2014

# Medicaid Redesign Team

# Social Determinants of Health Work Group

# Final Recommendations – October 2014

## Work Group Charge:

Previous MRT Workgroups have made recommendations that either fund services through the Medicaid program to improve health, improve healthcare, and/or create Medicaid savings. The scope of the MRT Health Disparities Workgroup is being expanded, to provide guidance to the NYS Department of Health on how best to address the social determinants of health to promote health, improve wellbeing and decrease health disparities due to social determinants.

Social determinants of health have been defined as the circumstances in which people are born, grow up, work and age, and the systems put in place to deal with illness. Circumstances are shaped by the distribution of money, distribution of power, resources at global, national and local levels, and economics. Social determinants of health are mostly health inequities or the unfair and avoidable differences in health status between groups of people. These health inequities determine the risk of illness and the actions taken to prevent people from becoming ill or treat illness when it occurs.

The drivers of health equities include: income, education, occupation, employment opportunities, gender, race/ethnicity and other factors. Every aspect of government and the economy has the potential to affect health and health equity. Policy coherence is crucial: policies must complement each other to lessen health inequities. Progress is made when multiple sectors of society work together to address public health challenges caused by health inequities.

A primary charge to the new work group was to focus on issues related to employment, especially issues that impact Medicaid recipients. The Work Group was charged with identifying and discussing a full range of potential strategies, programs, and/or policies related to employment that could decrease disparities in health access, utilization, and outcomes.

These could include strategies to:

- Promote workforce development and job training
- Expand/continue Medicaid coverage to promote employment of persons with mental, physical or developmental disabilities
- Incentivize worksite wellness programs, especially those that target low-income employees who are likely to be Medicaid recipients
- Expand employment benefits to target low-income workers who are likely to be Medicaid recipients

As with other MRT Work Group recommendations, the goal was to identify proposals that will improve health or health care and provide cost savings or at least be cost neutral.

## Work Group Membership:

- **Co-Chair: Kristin Proud** - Commissioner, Office of Temporary Disability Assistance (OTDA)
- **Co-Chair: Elizabeth Swain** – President and CEO, Community Health Care Association of New York State (CHCANYS)
- **Noilyn Abesamis-Mendoza, MPH**, Health Policy Director, Coalition for Asian American Children & Families
- **Diana Babcock**, Advanced Level WRAP Facilitator (self-employed)
- **Oxiris Barbot**, First Deputy Commissioner, New York City Department of Health and Mental Hygiene (NYCDOHMH)
- **Jo Ivey Boufford, MD**, President of The New York Academy of Medicine
- **LaRay Brown**, Senior VP, Corporate Planning, Community Health and Intergovernmental Relations, NYC Health and Hospitals Corporation
- **Neil Calman, MD**, President and Co-Founder of the Institute for Family Health
- **J. Emilio Carrillo, MD**, Weill-Cornell/New York-Presbyterian Hospital
- **Vince Colonno**, CEO at Catholic Charities of the Albany Diocese
- **Marti Copleman, JD, MPH**, Executive Director and Co-Founder of Worksite for Wellness, New York, NY
- **Carol Corden**, Executive Director at New Destiny Housing
- **Trilby DeJung, JD**, CEO of Finger Lakes Health Systems Agency
- **Susan Dooha**, Executive Director at Center for Independence of the Disabled in NY (CIDNY)
- **Anthony Feliciano**, Director at Commission on the Public Health System
- **Dan Gentile**, Executive Director at Capital Region Workforce Investment Board
- **Rosa Gil**, Founder, President and CEO of Comunilife, Inc.
- **David Jolly**, COO at Greater Hudson Valley Family Health Center
- **Charles King**, President and CEO of Housing Works, Inc.
- **Jonathan Lang**, Director of Governmental Projects and Community Development for the Empire State Pride Agenda
- **Glenn Liebman**, CEO of the Mental Health Association of New York State (MHANYS)
- **Amy Lowenstein, JD**, Attorney at Empire Justice Center
- **Daria Luisi, PhD, MPH**, Manager of Employee Wellness Program, Consolidated Edison of NY
- **Jacqueline Martinez Garcel**, Vice President, New York State Health Foundation
- **Pamela Mattel**, COO, Acacia Network
- **Ngozi Moses**, Executive Director at Brooklyn Perinatal Network, Inc.
- **Joanne Oplustil**, President and CEO of CAMBA, Inc.
- **Theo Oshiro**, Deputy Director at Make the Road New York
- **Laurel Pickering**, Executive Director of Northeast Business Group on Health (NEBGH)
- **Nancy Rankin**, VP of Policy Research and Advocacy, Community Service Society
- **Harvey Rosenthal**, Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc.

- **Christine Schuyler, BSN, RN, MHA**, Director/Commissioner, Chautauqua County Department of Health & Human Services
- **Michael Seereiter**, President and CEO at NYS Rehabilitation Association/Rehabilitation Research and Training Institute
- **Curtis Skinner, PhD**, Director of Family Economic Security, National Center for Children in Poverty, Mailman SPH, Columbia University
- **Chau Trinh-Shevrin, DrPH**, Associate Professor in the Department of Population Health and Department of Medicine at the New York University (NYU) School of Medicine and Founder of the NYU Center for the Study of Asian American Health
- **Jackie Vimo**, Director of Health Advocacy at the New York Immigration Coalition
- **David Wright**, Senior Advisor for Economic Policy at Empire State Development

### Ex-Officio Members

- **John Allen**, Special Assistant to the Commissioner, New York State Office of Mental Health
- **Guthrie Birkhead, MD, MPH**, Deputy Commissioner, Office of Public Health (OPH)
- **Yvonne J. Graham**, Associate Commissioner, Office of Minority Health and Health Disparities Prevention
- **Elizabeth Misa**, Deputy Director of NYS Medicaid, Office of Health Insurance Programs (OHIP)
- **Janice M. Molnar**, Deputy Commissioner, Division of Child Care Services, Office of Children and Family Services (OCFS)
- **Daniel A. O'Connell**, Director, AIDS Institute
- **Peter M. Rivera**, Commissioner, Department of Labor
- **Kevin G. Smith**, Deputy Commissioner for Adult Career and Continuing Education Services, The State Education Department
- **Ann Marie T. Sullivan, MD**, Acting Commissioner, Office of Mental Health (OMH)

## Meeting Dates and Focus:

**Monday, July 7, 2014, 10:00 AM – 3:00 PM, New York, NY**

At the first meeting, work group members introduced themselves and described there are of expertise. The purpose and charge to the work group to address the social determinants of health was provided. The focus on initiatives and proposals affecting employment was discussed, and overviews of targeted topic areas, including strengthening employment benefits, developing more supportive employment opportunities for persons with disabilities, and workforce development strategies were presented. The work group divided themselves into three targeted work groups, each co-led by two leaders:

1. **Strengthening Employee Benefits**
    - Daria Luisi, PhD, MPH, Manager of Employee Wellness Program, Consolidated Edison of NY
    - Nancy Rankin, VP of Policy Research and Advocacy, Community Service Society
2. **Supportive Employment for All Persons with Disabilities**
    - Kevin Muir, MPA, Executive VP of CAMBA, Inc.
    - John Allen, Special Assistant to the Commissioner, Office of Mental Health
3. **Workforce Development Initiatives**
    - Michael Seereiter, President and CEO at NYS Rehabilitation Association/Rehabilitation Research and Training Institute
    - LaRay Brown, Senior VP, Corporate Planning, Community Health and Intergovernmental Relations, NYC Health and Hospitals Corporation

Each of the targeted work groups developed a preliminary list of proposed topic areas for recommendations. Members volunteered to research topics, obtain data, and draft proposals. Many conference calls and Webinars, open to all work group members and invited guests, were held during the month of August. A leadership team including the co-Chairs, Department of Health leaders, and the targeted Work Group Co-Chairs, held regular conference calls to discuss progress and all proposals under development. Agency staff from potentially-impacted agencies were included in the discussions.

**Friday, September 12, 2014, 10:00 AM- 2:30 PM, Rensselaer, NY**

Jason Helgerson, Deputy Commissioner, Office of Health Insurance Programs, NYS Medicaid Director, presented to the work group, discussing the charge to the group, and how this group fit into the larger Medicaid Redesign process and goal.

The three targeted work group co-chairs and members presented by slides and a written summary a total of fourteen (14) proposals. Each presenter provided a brief description of the proposal, and discussed the financial and health disparities impacts, benefits of the recommendation, concerns with the recommendation and impacted stakeholders. The entire work group asked questions, discussed and debated the merits of each proposal.

Following the meeting, the work group members preliminarily ranked each of the proposals; the results of which were shared with the entire work group.

Between the two meetings, the proposals were further developed, refined and revised to address the concerns raised. Additional input from potentially affected agencies was obtained. Two similar proposals were merged into one.

**Friday October 10, 2014, 10:00 AM – 3:00 PM, New York, NY**

During the time interval between the second and third meetings, the Governor issued an Executive Order establishing the New York Employment First Initiative to increase employment of New Yorkers with disabilities. Some of the activities listed in the Executive Order overlap to some extent with the proposed recommendations of the work group. John Allen, Special Assistant to the Commissioner, New York State Office of Mental Health, provided context and discussed the role of the Employment First Commission, and how the recommendations of this work group would be provided to the committee to be established.

Each of thirteen (13) proposals was briefly presented, with changes highlighted. Further discussions led to suggested addendums, clarifications, and additional supportive information being added to some proposals. At the conclusion of the presentation, each work group member: 1) voted whether he/she would recommend, or not, that a proposal be included in the Final Report; and 2) ranked each proposal in priority order.

The majority of members recommended that twelve (12) proposals be advanced and that one proposal be eliminated. Thus, the Final Report includes the twelve (12) recommended proposals.

## Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report:

At the September 2014 meeting, 14 proposals were presented and discussed. Following that meeting, work group members conducted a preliminary prioritization exercise. Two similar proposals were combined and several proposals were refined.

At the October 2014 meeting, the preliminary prioritization results guided the order of the presentations. After review of the 13 proposals, work group members voted: 1) to recommend that a proposal be included in the Final Report; and 2) to prioritize the recommended proposals. The majority of members voted to eliminate one proposal and to recommend that twelve proposals be included in the Final Report.

## Summary Listing of Recommendations:

Each recommendation is listed in order (high is listed first) based on the collective priority scores of the work group members.

1) **Earned Sick Time:** As the first priority, the Medicaid Redesign Team Social Determinants of Health recommends that New York pass legislation making sick leave a minimum labor standard statewide. Employees would earn one hour of sick time for every 30 hours worked, up to 40 hours a year, to care for themselves or a family member. For employers of five or more workers, the leave would be paid.

2) **Advancing the Community Health Worker (CHW) Workforce to Improve Health Outcomes:** The work group recommends that New York State adopt a statewide scope of practice, core competencies, and training and certification programs for CHWs; establish a statewide CHW leadership center; and allow for Medicaid reimbursement for Community Health Workers employed in clinical and non-clinical community-based settings (as authorized by CMS's rule offering states the option to reimburse for community-based prevention services).

3) **Paid Family Leave Insurance:** The work group recommends that New York should modernize its Temporary Disability Insurance (TDI) program to provide up to 12 weeks a year of insurance benefits to partly replace lost wages for workers who need to care for a newborn, newly adopted child or seriously ill family member. Weekly benefits would replace two-thirds of an employee's average weekly wage up to a cap of 50 percent of the statewide average weekly wage. Existing disability benefits, capped at $170 a week for the past 25 years, would also be gradually phased up over four years to meet today's cost of living and be consistent with the new family leave benefit. A new law should be accompanied by robust outreach to inform and educate workers and employers.

**4) Advancing Community-Based Prevention:** It is recommended that actions be taken to advance community-based prevention creating a coherent, sustainable model and providing accessible community-based delivery, including delivery by nonclinical organizations, of evidence-based prevention and self-care education for chronic diseases, HIV/AIDS, maternal and family health (doulas, lactation specialists, well baby education), and other key health promotion services. Recommendations include amending NYS Medicaid Plans using new authority under 42CFR 440.130 to allow non-licensed providers to provide preventive services and be reimbursed for services "recommended by a physician or other licensed practitioner in the healing arts within the scope of their practice under state law."

5) **Advancing Additional Peer Specialist Positions:** The work group recommends that standardized and coordinated credentialing programs for additional peer specialists beyond OASAS, AIDS and OMH be created. Recommendations include ensuring that training to achieve these credentials is accessible to persons with limited formal education, English language skills or disabilities; funding existing employment programs to include services for people with disabilities, etc.; developing a continuum of work experiences including time-limited volunteer opportunities; incentivizing employers to create part-time job opportunities that could be filled by individuals with disabilities; and enhancing/expanding peer education programs to be utilized in community settings.

6) **Strengthening Current Infrastructure:** It is recommended that the State take action to implement the use of the a single employment case management system (i.e., NYESS, OSOS, or a new multi-agency system) to increase coordination and information sharing among all state agencies that provide employment, vocational rehabilitation and training services to people with disabilities. Also, provide tiered funding for disability service providers to provide targeted tiered benefits advisement (including SSA work incentives and the Medicaid Buy-In for Working People with Disabilities).

7) **Development of Certified Peer Specialist – DSRIP:** The work group recommends that Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPSs) use some portion of their funds to develop Certified Peer Specialist Programs and provide funding for a new full and part-time employment of people with disabilities or chronic conditions who are Medicaid recipients or uninsured. PPSs that submit proposals to use funds to train and hire from this population will receive bonus points in the scoring of their applications.

**8) Disability Equity in State Contracting:** It is recommended that the State contracting policy be used to incentivize employment of people with disabilities by mirroring current federal contracting requirements created by the Final Rule published in the Federal Register on September 24, 2013, establishing the federal government as a model employer of individuals with disabilities by requiring federal contractors to take affirmative action to recruit, hire, promote and retain individuals with disabilities.

9) **Benefits Advisement and Web-Based Calculator:** The work group recommends that benefits advisement be enhanced through development of an enhanced electronic calculator system (such as DB101 and MyBenefits). The tool should encompass the implications of employment for health coverage, housing, utilities and phone assistance, nutritional supports, etc. and be accessible for those who use screen-readers.

10) **Providing Transportation & Employment Opportunities:** The work group recommends that State agencies need to educate providers, people with disabilities and employers on tax incentives related to transportation; help educate local government and disability providers in rural communities on the programs to make transportation available; and help train providers on the ride coordination provisions of federal transportation funding programs so that use of equipment can be maximized to meet local need.

11) **Regional Economic Development Councils (REDC):** It is recommended that NYS should incentivize REDC proposals to incorporate partner organizations that work with people in the Medicaid program and weight the scoring for REDC projects to favor those that commit to hire, create on-the-job training opportunities, and create internships/apprenticeships for individuals within the Medicaid program. This is similar to the focus on veterans in the 2014 REDC competition. Such actions could be put in place for the next round of REDC funding in 2015.

12) **Supported Employment/Education:** The work group recommends that actions be taken to introduce a comprehensive approach to the utilization of Supported Education across state systems which should include a set of individualized activities and supports consistent with the student's post-secondary educational goals that will lead to increased employment and the attainment of long-term career goals. This service should take place in community–based settings and assist students in making informed educational choices regarding

postsecondary education, navigating the post-secondary school environment and accessing additional information and resources.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **1**
**Recommendation Short Name:** **Earned Sick Time**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **Medium**
**Implementation Timeline:** **Medium-Term**
**Required Approvals:**

☐ **Administrative Action** ☒ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:

New York should pass legislation making sick leave a minimum labor standard statewide. Employees would earn one hour of sick time for every 30 hours worked, up to 40 hours a year, to care for themselves or a family member. For employers of five or more workers, the leave would be paid.

A sizeable proportion of the working age Medicaid population is employed and would benefit from this proposal. Based on the 2013 BRFSS, the state estimates that 38 percent of Medicaid/FHP recipients aged 18 to 64 are employed statewide, including 31 percent of those outside of New York City who are not yet covered by a sick leave law. Low-wage workers, such as employed Medicaid recipients, are the least likely to have access to paid sick leave. Nationally, 61 percent of private sector workers have paid sick leave. However, only 30 percent of workers in the lowest wage quartile have paid sick leave compared to 84 percent of those in the top quartile (BLS National Compensation Survey, March 2013).

The *absence* of paid sick leave imposes costs borne by workers, their families, the public, and taxpayers, as well as to employers themselves from lower productivity, higher turnover and spread of illness among co-workers on the job. Workers without access to paid sick leave are more likely to work sick, be forced to send sick children to school or day care, and use hospital emergency rooms because they are unable to get medical care during regular business hours (Reiss and Rankin, "Sick in the City." 2009). Further research shows that lack of sick leave results in greater spread of influenza (Kumar, et al. 2011 and 2013), contributes to higher on-the-job accident rates (NIOSH study, 2011), creates a barrier to getting cancer screenings (Peipins et al. 2012) and increases emergency room use (Miller et al., IWPR 2011)—all of which increase health care costs, including Medicaid expenditures. Lack of sick leave imposes costs on employers from lost productivity due to "presenteeism" when employees come to work despite an illness or medical condition that prevents them from fully functioning on the job (Hemp, Harvard Business Review, 2004). Presenteeism can increase transmission of infectious diseases to co-workers, fellow commuters, customers and vulnerable populations, such as the aged receiving care at home or in facilities (Widera et al., "Presenteesism: A Public Health Hazard," J Gen Intern Med, 2010). Job loss triggered by lack of sick leave could also increase Medicaid enrollment among New York's low-income families. A recent study found that paid sick leave decreases the probability of job separation by at least 25 percent, with the association strongest for workers without paid vacation and for mothers (Hill, "Paid Sick Leave and Job Stability," Work Occup, 2013).

Paid sick leave laws have been gaining momentum around the country, and have now been enacted in three states and 16 cities, including New York City. California's Governor signed legislation September 10, 2014 making it the second state after Connecticut to adopt a statewide requirement. As of November 4, 2014, the ballot initiative guaranteeing paid sick days was passed in the third state, Massachusetts. Paid sick days legislation is expected in a number of states and other cities like Chicago, Illinois, and Tacoma, Washington, in the coming year.

### FINANCIAL IMPACT:

The impact on the state budget would be neutral to positive. Resources should be included in the budget for public outreach and enforcement of earned sick time. Estimates can be based on the experience of other localities (for example, $4.8 million was added to New York City's budget to implement its new earned sick time law). These costs would be more than offset by expected Medicaid savings. Implementing a New York City-style law statewide would save an estimated $42.9 million annually in reduced emergency department costs in the rest of the state, including about $17.1 million annually in public health insurance programs (IWPR analysis, Jessica Milli, 2014). The New York State government would save an estimated $4.4 million annually due to reduced Medicaid expenditures (IWPR analysis, Jessica Milli, Oct. 2014). Additional long run savings could be realized from improved health and job stability.

While we do not have estimates of the cost to employers specifically for the state, the Institute for Women's Policy Research has previously estimated the cost of implementing New York City's sick pay law to be equivalent to 18 cents per hour for employees receiving new leave for the average New York City worker. This is significantly less than a typical phased-in increment to the minimum wage. The relatively small cost need not come out of a business's bottom line; once a law establishes a level playing field the cost could be shifted in part to consumers, absorbed by other changes in business operations, and offset from savings from lower turnover and higher productivity. Research on the minimum wage has shown that labor cost increases of this magnitude do not have negative impacts on employment (Dube, 2010). Studies of the impact of paid sick leave laws in San Francisco, Connecticut and other localities have found that once implemented these laws are generally supported by businesses and fears of possible job loss were not borne out. (See discussion of San Francisco by Dube and Levitt, "The Impact of Paid Sick Days on Jobs: What's the Real Story?" CSS, 1012; Appelbaum, Milkman et al., "Good for Business? Connecticut's Paid Sick Leave Law," CEPR, 2014; and Romich, Bignell et al., Implementation and Early Outcomes of the City of Seattle Paid Sick and Safe Time Ordinance," 2014).

### HEALTH DISPARITIES IMPACT:

Low-wage workers are far less likely to have access to paid sick leave than higher paid employees. Hispanics are the least likely among racial and ethnic groups to have access to paid sick leave because they disproportionately work in low-wage industries that often fail to provide sick leave, such as restaurants, non-union construction and retail. Nationally, only 55% of Hispanics have paid sick days compared to 61% of US workers overall (IWPR analysis of 2012 NHIS data), and in New York City 53% of Hispanic workers had paid sick leave prior to passage of the earned sick time law (Mehrotra and Rankin, "Latino New Yorkers Can't Afford to Get Sick", March 2013). Paid sick leave would reduce health disparities to the extent that, particularly among low-income and Hispanic working families, it enables employees and their family members to recover more quickly, get cancer screenings and obtain preventive care and early treatment for chronic conditions like asthma, diabetes and hypertension that have a higher

prevalence among the poor (CDC Health Disparities and Inequalities Report—United States, 2011).

Paid sick leave would also contribute to reducing gender disparities, because in most households, women are the managers of the families' health. According to a new report from the Kaiser Family Foundation (Ranji and Salganicoff, "Balancing on Shaky Ground: Women, Work and Family Health," Oct. 20, 2014) working mothers are ten times more likely to take time off to care for sick children than fathers. Family health responsibilities take the highest toll on low-income working mothers and those in part-time jobs, who have limited workplace benefits but are more likely to have to take time off to care for sick children because they cannot afford replacement childcare.

### BENEFITS OF RECOMMENDATION:

Paid sick leave would improve health outcomes, lower health care costs in the long run and strengthen the economic stability of families, particularly those with low-incomes, the majority of whom now lack access to paid sick leave. Children recover more quickly and miss less school when a parent is available to take care of them. Parents play essential, critically important roles in enabling their children to get necessary health care and recover from illnesses (Schuster, MA et al, "Time Off to Care for a Sick Child—Why Family Leave Policies Matter," NEJM, August 2014).

The state and counties could benefit from Medicaid savings associated with improved health outcomes and lower utilization of emergency rooms. More stable employment could also reduce Medicaid enrollment.

### CONCERNS WITH RECOMMENDATION:

Some upstate business associations may initially oppose this legislation. However, studies of paid sick days laws already in effect in other cities and statewide in Connecticut have found concerns about possible negative impacts on businesses unfounded. Once paid sick leave passed in New York City, there was little opposition to expansion enacted under the de Blasio administration. The law went into effect April, 2014 and implementation has gone smoothly.

### IMPACTED STAKEHOLDERS:

Employers and those employed in the state outside of New York City who are not already covered by an earned sick time law. Children are dependent on an employed family member for taking them to medical appointments and caregiving. The feasibility of implementing a statewide law is enhanced by the fact that a large proportion of the state's private sector jobs are already covered (approximately 46 percent are in New York City), and most of the issues related to developing regulations have been resolved.

Polling finds widespread and strong support for paid sick leave laws. A 2012 survey of New York City residents by CSS/Lake Research found that 83 percent of those asked favored passage of a paid sick leave law, including 65 percent who strongly favored it, with support nearly identical across income groups. Amidst mounting public concerns about the spread of enterovirus D68 and the threat of Ebola, there is heightened awareness of the need for paid sick time that allows workers to keep sick children home from school or pre-K, and to stay home from work themselves if they are ill.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **2**
**Recommendation Short Name:** **Advancing the Community Health Worker Workforce to Improve Health Outcomes**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **Medium**
**Implementation Timeline:** **Two Years**
**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:

Advance and formalize the Community Health Worker (CHW) Workforce in New York State to:
1) Address social determinants of health for low-income, Medicaid recipients
2) Create a pipeline of job opportunities for community members who understand the complex health and social needs of high-cost health care consumers.

Specifically, we propose that New York State:
1) Adopt a statewide scope of practice for CHWs—a set of standards that outline the roles that CHW performs;
2) Adopt statewide standards for core competencies of CHWs and CHW training and certification programs;
3) Establish a statewide CHW leadership center; and
4) Allow for Medicaid reimbursement for Community Health Workers employed in clinical and non-clinical community-based settings (as authorized by CMS's rule offering states the option to reimburse for community-based prevention services).

Community Health Workers (CHWs) are trusted members of the communities in which they live, sharing common racial and ethnic backgrounds, cultures, languages, and life experiences with the people they serve. In partnership with clinical health care providers and health care consumers, CHWs can play a pivotal role in reducing health disparities and improving health outcomes, while gaining entry to the healthcare workforce. The Department of Labor created a Standard Occupation Classification (SOC) that defined CHWs as frontline, public health workers who function as liaisons between individuals and health and social services delivery systems.

CHWs have been well positioned to break down barriers to help people receive the care they need when they need it. CHWs enable people to access and navigate the health care system and better manage their health conditions, coordinate services for people with multiple chronic conditions, and lead communitywide efforts to identify and address the underlying social determinants of health. CHWs' ability to facilitate consumers' access to timely primary and preventive care, while facilitating providers' capacity to improve the quality and cultural competence of medical/dental care, has been shown to reduce health care costs.

*(1) ADOPTING STATEWIDE SCOPE OF PRACTICE FOR CHWs*

The CHW Scope of Practice (see Attachment A) outlines the roles that CHWs perform, either in part or full. The CHW Scope of Practice should be seen as an all-inclusive list of roles and tasks that CHWs in New York may be expected to fulfill. The exact mix of these roles and tasks will vary among organizations at which CHWs may be employed and among CHW positions within the same organization. This structure also provides the opportunity for career development pathways through which CHWs may become "specialists" in one or two of the roles while others may advance by becoming "generalists" with expertise in a number of roles. Finally, the outlined scope of practices defines boundaries between the CHW and other professions.

Recommendations:

- The adoption of this Scope of Practice as statewide standard roles for CHWs;
- CHWs be considered a priori for roles and tasks described in this Scope of Practice;
- CHWs be employed to fulfill one or more of the roles of this Scope of Practice.

*(2) CHW TRAINING AND CREDENTIALING*

Recognizing the multiple institutions and contexts in which CHWs may be trained, and in order to leverage existing training resources, the recommendations provide training standards, but do not specify a single standard statewide curriculum, which might be difficult to implement across diverse institutions. In consultation with the regulatory office for the health professions at the New York State Department of Education, it was agreed that the work of CHWs is primarily concerned with providing support, advice, encouragement and information – all of which are legally exempt from state regulation in the form of licensing.

Recommendations (See Attachment B for full recommendations):

- We recommend that required training content include core competencies, social determinants of health, and field-based learning components;
- We recommend that experienced CHWs be part of curriculum development and as faculty/co-teachers, and that barriers such as limited writing/test-taking abilities and conventional requisites for entering colleges be mitigated so that CHWs who can be most effective are able to enter the CHW workforce; and
- We recommend that CHW credentialing be linked to CHW training programs that meet the curriculum standards proposed in this document. The State may choose to simply recognize proof of successful completion of an approved training program as a credential, or may issue a credential (through certification or a registry) for which completion of such training is one pathway to qualification.

*(3) ESTABLISH STATEWIDE CHW LEADERSHIP CENTER*

Recommendations:

- Establish a CHW Leadership Center as one option to train CHWs and connect them to employment opportunities, recruit and deploy CHWs in the field, and provide advice and guidance to current and potential employers of CHWs on best practices in order to maximize the investments in CHW-led interventions/programs.
- We recommend that the State convene and appoint a voluntary taskforce within a State's CHW Leadership Center, made up of CHW experts and CHWs, which will use established training standards and review training programs for certification.

*(4) ALLOW FOR MEDICAID REIMBURSEMENT FOR COMMUNITY HEALTH WORKERS.*
We are recommending these first two steps ((1) adoption of scope of practice and (2) adoption of training standards along with a governing body to oversee the adoption of the training standards) so that New York State will have the foundational pieces in place to implement the CMS Preventive Task Force ruling that allows states to reimburse for the role of CHWs.

Recommendation:
NYS Medicaid Reimburse CHWs that have undergone training through programs that meet the training standards outlined in the recommendation. The reimbursement would be limited to services provided in the recommended scope of practices outlined in this recommendation.

**FINANCIAL IMPACT:**
There will be costs associated with establishing a CHW Leadership Center to oversee training, job placement, and career development for CHWs. Private foundations in New York have expressed interest in partnering with the state to pursue this recommendation.

**HEALTH DISPARITIES IMPACT:**
CHWs work in a way that is directly responsive to the specific socio-economic, educational, racial, and ethnic backgrounds of participants and the needs associated with these backgrounds. CHWs will have a direct impact in improving health outcomes for community members who are most affected by chronic illness and who have historically been unable to access or maintain regular care. At the same time, our proposal will increase the employment opportunities of CHWs who come from communities who most suffer from health disparities – thereby improving on the economic stability of these communities.

**BENEFITS OF RECOMMENDATION:**
CHWs contribute to overall health system savings through their ability to improve prevention and chronic disease management, which reduces costly inpatient and urgent care costs. CHW programs for which the return on investment has been calculated fall in the range of savings or returns of $2.28 to $6.10 for every dollar spent on CHWs. For example, CHWs working with underserved men in the Denver Health system were able to shift the costs of care from costly inpatient and urgent care to primary care, achieving a $2.28 return on investment for every $1.00 spent and an annual savings of $95,941. Other studies have documented the reduction in emergency care or inpatient services associated with a CHW intervention, with savings ranging from $1,200 to $9,300 per participant in programs with CHWs. In Baltimore, African-American Medicaid patients with diabetes who participated in a CHW intervention had a 40% decrease in emergency room (ER) visits, a 33% decrease in ER admissions, a 33% decrease in total hospital admissions, and a 27% decrease in Medicaid reimbursements. The CHW program produced an average savings of $2,245 per patient per year and a total savings of $262,080 for 117 patients.

## Attachment A

**CHW Scope of Practice - Roles and Tasks**

**Role I: Outreach and Community Mobilization**

Community Strengths/Needs Assessment
Advocacy

**Role II: Community/Cultural Liaison**

Community Organizing
Translation and interpretation
Community Strengths/Needs Assessment

**Role III: Case Management and Care Coordination**

Family engagement
Individual strengths/needs assessment
Addressing basic needs: food, shelter, etc.
Promoting health literacy
Coaching on problem solving
Goal setting and action planning
Supportive counseling
Coordination, referrals, and follow-ups
Feedback to medical providers
Treatment adherence promotion

**Role IV: Home-based Support**

Family engagement Home visiting Environmental assessment
Coaching on problem solving
Treatment adherence promotion

**Role V: Health Promotion and Health Coaching**

Translation and interpretation
Teaching health promotion and prevention
Coaching on problem solving
Modeling behavior change
Promoting health literacy
Adult learning application
Harm Reduction
Treatment adherence promotion
Leading support groups

**Role VI: System Navigation**

Translation and interpretation
Promoting health literacy
Patient navigation
Coaching on problem solving
Coordination, referrals, and follow-ups

**Role VII: Participatory Research**

Engaging participatory research partners
Facilitating translational research
Interviewing
Computerized data entry and web searches

The development of this scope benefited from a significant body of literature, including the National Community Health Advisor Study (NCHAS) and the Community Health Worker National Education Collaborative (CHW-NEC). In addition, the work was informed by published research and market analysis conducted by the CHW Network of NYC and Columbia University Mailman School of Public Health.

## Attachment B

### Full Training and Credentialing Recommendations

#### *Training Content*

- We recommend that training in specified core skills/competencies be a required standard for all CHW training throughout the state. Core competencies are directly tied to the scope of practice outlined earlier in this document. Training in specialty tracks (i.e., disease topics, community development, employment, etc.) can be considered as an addition to core competencies.
- We recommend that CHW training include content on the social determinants of health, social justice and poverty, in order to be responsive to the work CHWs perform.
- We recommend that CHW training programs include field-based learning, practicums/internships or other forms of mentored integrative learning opportunities, and that training lead to informed action for social change.

#### *Training Methodology*

- We recommend that CHW training programs use methods appropriate for adult learners, including a mix of pedagogies that includes interactive, participatory and experiential training methods, as well as for adult language learners who might be in the process of increasing English-speaking capacity.
- We recommend that training programs leverage the knowledge of CHWs, based heavily in lived experience.
- We recommend that CHW training be available in a variety of settings, including community-based organizations, faith-based organizations, colleges, non-profits and proprietary training organizations, in order to leverage existing resources and offer learning in familiar and comfortable settings. This will also minimize financial and other barriers that may impede the workforce from building on its strength of inclusivity and diversity.

#### *Institutional Requirements*

- We recommend that CHWs be involved in all aspects of curriculum planning, development and implementation in order to advance a mutually supportive relationship and develop appropriate education programs.
- We recommend that CHW training programs promote experienced CHWs as faculty and co-trainers to the extent possible.
- We recommend that training and evaluation of CHWs be made flexible, so that CHWs with limited test-taking or writing skills can excel.

- We recommend that college-supported CHW training programs consider prior learning/experience; including offering credit for documented life/employment experience.
- We recommend that college-supported CHW training programs mitigate existing barriers to college entrance, for example, immigration status or criminal background. CHWs represent the communities they serve and these barriers exclude members of the community who could be effective CHWs.

***Credentialing (must be integrated into recommendation concerning Consolidating, Unifying and Coordinating Credentialing of CHW and Peer Positions)***

- We recommend that CHWs and consumers of CHW services be involved in developing and implementing any statewide credentialing process. We recommend that CHWs be guaranteed a minimum of 25% representation on any group that governs the CHW certification or the practice in general.
- We recommend that CHW credentialing be linked to CHW training programs that meet the curriculum standards proposed in this document. The State may choose to simply recognize proof of successful completion of an approved training program as a credential, or may issue a credential (through certification or a registry) for which completion of such training is one pathway to qualification.
- We recommend that a statewide CHW credentialing system include both core skills credentials (at one or more levels) and optional specialist credentials, based on specific health issues such as diabetes, oral health or mental health, and/or advanced qualifications in specific CHW roles such as health system navigation.
- We recommend that a State-recognized CHW credentialing program develop reciprocity with other states that have similar programs.
- We recommend that alternative pathways to credentialing (“grandfathering” or “credit for prior learning”) be made available for experienced CHWs or those with a mix of prior training and experience.
- We recommend requiring periodic renewal of CHW credentials based in part on completion of continuing professional development experiences (CEUs).

## Attachment C

### Advancing the Role of CHWs: What other states are up to?

**Massachusetts Board of Certification of Community Health Workers**

The Board of Certification of Community Health Workers was established through an act of the legislature, Chapter 322 of the Acts of 2010, and signed into law by Gov. Deval Patrick in 2010, with an effective date of January 1, 2012. It was created as a result of state health care reform and intended to help integrate community health workers into the health care and public health systems in order to promote health equity, cost containment, quality improvement, and management and prevention of chronic disease. The Board will establish standards for the education and training of community health workers and community health worker trainers, standards for the education and training program curricula for community health workers, and requirements for community health worker certification and renewal of certification. It is chaired by a designee of the commissioner of the Department of Public Health and includes ten additional members appointed by the governor and nominated by organizations named in the authorizing legislation. Note that this state effort is not directly linked to financing.

**Minnesota Medicaid Reimbursement for Community Health Worker Services**

In December 19, 2007, Minnesota Health Care Programs (MHCP) received federal approval to reimburse services provided by community health workers (CHWs) enrolled as fee-for-service (FFS) MHCP providers. Coverage of CHW services for enrollees of managed care organizations (MCOs) began in February, 2008. CHWs provide patient education in clinics, outpatient and community settings to increase access to health care and promote health and disease prevention.

To enroll as an MHCP provider, a CHW must have a certificate from the Minnesota State Colleges and Universities (MnSCU) approved community health worker curriculum. MN has one single approved curriculum for CHW certification. MHCP will cover supervised, diagnosis-related patient education services provided by a CHW as long as the CHW is an MHCP-enrolled physician/dentist or an advanced practice RN. Reimbursable CHW services must involve teaching the patient how to effectively self-manage their health in conjunction with the health care team and the service is provided face-to-face with the recipient (individually or in a group) in an outpatient, home, or clinic setting.

MN based their cost estimate based on programs run by the Minnesota Department of Human Services. They estimated that a one-hour; one-on-one CHW intervention would be reimbursed at $12.50, while health education classes taught by CHWs would be reimbursed at $6.25 per hour per client. Using data from a community clinic and tracking annual activities for a subset of CHWs, DHS officials estimated yearly reimbursement cost for one CHW at $17,646. Estimating 400 full-time Minnesota CHWs in FY 2008, the up-front cost of supporting a statewide CHW initiative is $7,058,400. For the sake of erring on the side of caution, DHS officials have suggested that rather than the 2.28:1 return on investment ratio

in the Denver study, they instead applied a 1.14:1 ratio. By that analysis, $7,058,400 of CHW reimbursement buys $8,046,576 of health care savings. Currently, MN has increased the reimbursement rate to $19.00 per hour for CHWs.

**Texas Statewide 1115 Waiver**

In December 2011, Texas received federal approval of an 1115 waiver that would preserve Upper Payment Limit (UPL) funding under a new methodology, but allow for managed care expansion to additional areas of the state. Delivery System Reform Incentive Payment (DSRIP) pool funds local projects to enhance access, improve quality and cost-effectiveness of care. Of the nearly 1,500 3- and 4-year approved DSRIP projects, unofficial estimates by the Texas Department of State Health Services suggest that 200-300 involve CHWs in activities such as system navigation for ER users, care coordination and care transitions, and chronic disease self-management support.

**South Carolina Medicaid CHW Initiative**

This project was initiated by the State Medicaid Office. A CHW is embedded in each of 14 primary care practices, including two FQHCs and one rural health clinic (RHC). The CHW is an integral part of the clinical care team, and participates in daily huddles, meetings and communication with clinical staff about patient barriers to receiving care. Each practice received a grant for CHW training and a partial subsidy for supervision; claims for CHW services are reimbursed by Medicaid. Preliminary results indicate the primary health conditions being addressed are diabetes and hypertension. While the FQHCs cannot be reimbursed separately for the CHWs, they have agreed to document services as if they were billing Medicaid. At the end of the demonstration, evaluation data will be used to negotiate modification to the health centers' per-visit prospective payment rates.

**Oregon Coordinated Care Organizations (CCOs)**

CCOs are Oregon's version of the ACO, created under an 1115 waiver in 2012, which includes provision for "health related non-benefit (flex) services; "it's implied that this is where expenditures for CHWs are classified, meaning that CHW expenditures are service-related and not administrative. CCOs are required under statute to provide their members with access to "traditional health workers," a term that specifically includes CHWs and doulas. One of the metrics for the Oregon Health Authority itself in their "midpoint evaluation" was their degree of support for CHW workforce development and certification. They have a goal to train 300 certified CHWs by the end of 2015; a comparable figure for NY would be about 1,500. The CCO enabling legislation also created a credentialing commission for CHWs and other traditional health workers.

**Vermont Enhanced Medical Homes (EMHs)**

Original statutory authority was created in 2006. The "Community Health Team" in the EMH is an innovative approach to coordinating both care and preventive services in the community. The Team has five full-time staff to support a population of about 20,000 active patients who are served by the medical home practice. The team composition varies from site to site, but typically includes a CHW along with a nurse care coordinator and mental

health staff. Vermont's Multi-Insurer Payment Reform means that Medicaid shares the costs of these teams with the other payers contracting with the PCMH, and all patients in the practices have access to them. Another innovation is the "Extended Community Health Team," which includes home health agencies, and CHWs based in low-income housing. In the 2013 annual report of the "Vermont Blueprint for Health," CHWs were cited as contributing to successful efforts to reduce hospital readmissions and improve palliative care.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **3**
**Recommendation Short Name:** **Paid Family Leave Insurance**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **Medium**
**Implementation Timeline:** **Short-Term**
**Required Approvals:**

- ☐ **Administrative Action** ☒ **Statutory Change**
- ☐ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:

New York should modernize its Temporary Disability Insurance (TDI) program to provide up to 12 weeks a year of insurance benefits to partly replace lost wages for workers who need to care for a newborn, newly adopted child or seriously ill family member. Paid family leave insurance complements paid sick time by enabling workers to meet critical family needs that require more than a few days leave through a social insurance program. There is strong support for this type of legislation as evidenced by opinion polls of New York State voters and small businesses, as well as by bills introduced this year in both the State Senate and Assembly, and passed in the Assembly (A1739B). Weekly benefits would replace two-thirds of an employee's average weekly wage up to a cap of 50 percent of the statewide average weekly wage. Existing disability benefits, capped at $170 a week for the past 25 years, would also be gradually phased up over four years to meet today's cost of living and be consistent with the new family leave benefit. A new law should be accompanied by robust outreach to inform and educate workers and employers.

A sizeable proportion of the working age Medicaid population is employed; they and their families would benefit from this proposal. Based on the 2013 BRFSS, the state estimates that 38 percent of Medicaid/FHP recipients aged 18 to 64 are employed statewide, including 43 percent in New York City. Medicaid recipients who are not employed, but dependent on working family caregivers for occasional periods of intense support would also benefit.

State action is needed because job-protected leave required under the federal Family and Medical Leave Act (FMLA) is unpaid and only covers about 60 percent of the workforce (those employed for at least a year and working at least 1,250 hours in firms of 50 or more). Only 12 percent of all private sector workers now have paid family leave from their employers. Low-wage workers, such as employed Medicaid recipients, are the least likely to receive paid family leave on their jobs; nationally just five percent of workers in the lowest wage quartile have access to paid family leave (BLS: NCS, March 2013). Inadequate pay makes it impossible for them to accumulate savings to fall back on during a period of unpaid leave, and these same low-wage workers often lack paid vacation and sick leave they can save up to use to meet family needs. Job loss triggered by caregiving responsibilities can also increase Medicaid enrollment among New York's low-income families.

Research evidence suggests that longer leave for new mothers is associated with longer duration of breastfeeding (Guendelman et al., 2009; Ogbuanu et al., 2011) which has important

benefits for maternal and child health (Policy Statement, Breastfeeding and the Use of Human Milk, American Academy of Pediatrics, Pediatrics, 2012). Early return to work for new mothers has been associated with reductions in well-baby health care and immunizations (Berger, Hill & Waldfogel, 2005) and longer maternity leave with a decline in maternal post-partum depression (Staehelin, K., et al., 2005). Studies have also shown that paid family leave increases job continuity with the pre-birth employer and raises labor force participation rates among women (Baker and Milligan,2008; Rossin-Slater, Ruhm and Waldfogel, 2011; and Blau and Kahn, 2013). In addition, employed adults play critically important roles as family caregivers, especially to our aging population (Feinberg et al. 2011), persons with disabilities and seriously ill children (Schuster, M., "Time Off to Care for a Sick Child—Why Family-Leave Policies Matter," NEJM, Aug. 7, 2014). Family caregivers are needed to facilitate transitions from hospitals to home or rehabilitation care, to help with increasingly complex post-discharge care and medications, to communicate with health providers and coordinate care, to accompany seriously ill adults and children to medical appointments and procedures, and to serve as patient advocates and provide comfort—all of which can reduce readmissions, shorten or avert institutional stays, improve health outcomes and produce health care savings.

Adopting this proposal would put New York at the forefront of providing paid family leave for workers, joining other TDI states, including CA, NJ and RI.

**FINANCIAL IMPACT:**

The impact on the state budget would be neutral to positive. Relatively small costs are associated with public education and enforcement. These would be more than offset from lower spending over time to the extent that Medicaid costs are reduced. Medicaid savings are anticipated from improved infant, child and maternal health, enabling family caregiving that could reduce inpatient and long term care costs, and by reducing job-loss induced Medicaid enrollment among low-income mothers and family caregivers.

By piggybacking on the existing TDI system, administrative costs to the state and employers are minimized. Spreading the cost through social insurance makes paid family leave extremely affordable: premiums would be employee-paid through weekly paycheck deductions of 45 cents a week rising to an estimated 88 cents a week when the benefits are fully phased in over four years (based on calculations by the Fiscal Policy Institute). Raising TDI benefits for existing purposes to a more adequate level would cost about $2 a week per employee when fully phased in over four years according to FPI estimates. The cost of this long overdue adjustment would be shared between employers and employees as under current law.

**HEALTH DISPARITIES IMPACT:**

Breastfeeding initiation rates for the total US population are 75 percent, but only 37 percent for low-income non-Hispanic black mothers (National Immunization Survey, data cited in Pediatrics, 2012). Paid family leave would reduce health disparities to the extent that, particularly among low-income mothers, it increases the duration and exclusivity of breastfeeding with its associated benefits to infant health including reduced infections, protection against obesity up to age three (AAP, *Breastfeeding and the Use of Human Milk;* 2012, S. Arenz, et al, 2004), as well as profound benefits to premature infants. Health departments and hospitals have invested in efforts to increase breastfeeding, but while 80 percent of New York mothers initiate breastfeeding, that percent quickly declines to only 37.1 percent exclusively breastfeeding at three months (CDC Breastfeeding Report Card, 2014). According to pediatricians interviewed, one factor contributing to the large drop-off is anxiety about weaning among low-income mothers who need to return to work quickly for fear of losing their jobs. While many variables are involved, it is notable that California, which has had statewide paid family leave in effect

since 2004, reports a 56.1 percent exclusive breastfeeding rate at 3 months, compared to 37.1 percent in New York. Additionally, paid family leave has been shown to reduce parental stress and post-partum depression, which can negatively impact childhood development (Dagher, et al., 2013). Enabling low-wage adult workers, who cannot afford to take unpaid leave now, to care for seriously ill children and aging parents, could further reduce health disparities. Realizing these potential reductions in health disparities will depend in part on effective outreach to insure that low-wage workers are aware of and able to take advantage of paid family leave.

Because black and Latino workers in the state are somewhat more likely than whites or Asians to work in low-wage jobs paying $10 an hour or less without employer-sponsored paid leave (CPS, 2013), a paid family leave program may be expected to reduce health disparities among these groups.

### BENEFITS OF RECOMMENDATION:

Paid family leave offers dual benefits: enabling workers to better care for a new child or seriously ill family member has a positive impact on health outcomes for the person cared for and could lower health care costs; paid leave also strengthens labor force attachment and the financial stability of workers using leave. Businesses stand to gain from lower turnover and policies that make New York more competitive as a place to work. Women still bear most caregiving responsibilities, and policies that enable them to remain in the workforce boost the overall economy. Paid family leave is also fundamental to achieving women's economic equality. Women who leave the labor market because of caregiving responsibilities suffer not just temporary lost earnings, but long term consequences that contribute to the gender pay gap.

The state and counties could benefit from Medicaid savings associated with improved health outcomes, increased family caregiving and more stable employment.

According to the American Academy of Pediatrics (AAP), "Strategies that increase the number of mothers who breastfeed exclusively for about 6 months would be of great economic benefit on a national level" (2012 Policy Statement on Breastfeeding). A detailed cost analysis cited by the AAP estimated a savings of $13 billion per year if 90 percent of U.S. mothers complied with that recommendation.

### CONCERNS WITH RECOMMENDATION:

Studies of California's family leave law (Milkman and Appelbaum, *Unfinished Business*, 2013), operating for a decade, as well as new research interviewing employers in New Jersey (Lerner and Appelbaum, *Business as Usual*, CEPR, 2014), found concerns about a possible negative impact on businesses were not borne out. Eighty-seven percent of employers said California's paid family leave law had not resulted in any cost increases. Small businesses were no exception: 9 out of 10 employers with fewer than 50 employees said the paid family leave program had either a positive or no noticeable effect on profitability or performance. Smaller businesses may raise concerns about covering work usually performed by an employee on leave. Since employers do not have to pay wages to an employee on leave, businesses can use the savings to pay for temporary help or overtime pay. However, research shows that employers generally assign work temporarily to other employees to cover tasks performed by a worker on leave (Milkman and Appelbaum, *Unfinished Business*, 2013). Moreover, since the vast majority of leaves are used to care for newborns (87% of claims were for bonding with a new child in California in 2011-12), an employer generally has ample time to plan for the employee's absence. Employers of 50 or more are already covered by the FMLA; so for these firms, the proposed law does not create any new entitlement to leave, but would provide insurance benefits to partially replace wages for workers during those leaves. Some business

associations may object to the small increase in costs associated with raising existing TDI benefits. However, the maximum TDI benefit, frozen for a quarter century, lags dramatically behind every other TDI state (where the maximum weekly benefits average $742 per week compared to the $170 cap in New York). TDI is long overdue for an increase, apart from action on paid family leave. Some employers already pay for enhanced disability plans because of the inadequacy of state-required benefits, so the change would not increase their costs. Employers now providing paid family leave would realize savings.

### IMPACTED STAKEHOLDERS:

Employees and employers
Labor
Children, elderly, and persons with disabilities dependent on an employed family member for caregiving
Medicaid and Medicare dual eligible
Health services providers
New York State and counties

Polls show that New Yorkers overwhelmingly favor enacting a paid family leave policy in the state. That support has been growing in intensity in recent years as laws have been adopted in other TDI states and proposed at the federal level. A 2009 Marist poll found that 76% of registered voters statewide favored extending TDI to provide paid family leave. A new (not yet released) 2014 telephone survey by CSS/Lake Research found that 84% of New York City residents favor modernizing the state's TDI program to provide paid family leave (up from 76% when a similar question was asked in 2005). That includes a striking 67% who *strongly* favor doing so, up significantly from 42% who strongly favored it in 2005.

Creating a paid family leave insurance program is highly feasible in New York because it is one of the five states that already has a temporary disability insurance system that can serve as its basis.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **4**
**Recommendation Short Name:** **Advancing Community-Based-Prevention**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **Medium**
**Implementation Timeline:** **One Year and Ongoing**
**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☒ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:

Advancing community-based prevention creates a coherent, sustainable model for widespread community-based prevention. It provides accessible community-based delivery, including delivery by nonclinical organizations, of evidence-based prevention and self-care education for chronic diseases, HIV/AIDS, maternal and family health (doulas, lactation specialists, well baby education and other key health promotion services. It focuses on delivery by trained local health educators---particularly CHW's and peer facilitators---enabling residents of low-income communities, especially those without high school degrees, and those who have chronic disease, disabilities and who are on Medicaid themselves, to take key roles In advancing community health. See Trust for America's Health. Medicaid Reimbursement for Community-Based Prevention, Based on Convening Held October 31, 2013 and Nemours. Medicaid Provision of Preventive Services Regulation Questionnaire, Prepared December 16, 2013.

**Recommendations for New York State:**

1. Amend NYS Medicaid Plans using new authority under 42CFR 440.130(c) to allow non-licensed providers to provide preventive services and be reimbursed for services "recommended by a physician or other licensed practitioner in the healing arts within the scope of their practice under state law."

2. Support infrastructure enabling community groups to bill Medicaid for approved services including electronic referral system connecting physicians/clinicians to community group services and non-profit Medicaid billing mechanisms for community groups.

3. Incentivize Health Home, DSRIP, managed care, insurance and PCMH entities to contract with community organizations to conduct preventive services.

**Examples of non-license providers include:**

**Community Health Workers/ Patient Navigators Services Providers:** Outreach and community mobilization, case management and care coordination, home-based support; health promotion and coaching. (See Community Health Worker proposal for suggested training/qualifications.)

**National Diabetes Prevention Program (NDPP) Provider:** NDPP Lifestyle Coaches Services: Facilitate CDC-approved lifestyle modification course for pre-diabetics, consisting of minimum 22 sessions, and well-documented to reduce their diabetes risk by 58%.

**Stanford Chronic Disease Self-Management Programs:** Stanford's suite of self- management programs, including prominently the Diabetes Self-Care Course and the Chronic Disease Self-Care are designed to be given in community settings, such as senior centers, churches, and community centers. The workshops of 2 ½ hours, once a week for 6 weeks are facilitated by two trained leaders, one of both of whom is non-professionals with chronic disease themselves.

Provider: All trained CDSMP leaders

Service: Facilitation of 6-week CDSMP Courses.

**Lactation Counseling:** NYS Medicaid now requires that lactation counseling (group or individual) be provided by an International Board Certified Lactation Consultant (IBCLC) AND who is a licensed NY State provider. This service (lactation counseling) can be provided by an individual with an IBCLC alone.

Provider: IBCLC Credential alone

Service: Lactation counseling: individual and group education.

**Doulas:** Doulas provide one-on-one support to expectant mothers and through birth. They assist mothers to plan and carry out preferred birth plans; provide support for maternal needs, from emotional support to assuring low-income women have cribs, baby supplies, etc.; and provide one-on-one support throughout labor and the birth process and post-partum. Doulas generally are community-based, not clinically-based, including in a current NYCDOH-supported demonstration project in Brooklyn.

Provider: Trained Doulas for NYCDOHMH must live in the target area of services, and complete a 4-day training approved by the DONA (Doulas of North America).

### FINANCIAL IMPACT:

The Medicaid savings from providing community-based, evidence-based prevention and self-care strategies are well documented to be consistently impressive: The NDPP has twice the impact in preventing diabetes among people with high blood sugar as starting them on standard medication. Studies in 22 countries show the Stanford Courses consistently reduce health costs and hospitalizations. Higher breast feeding rates promote lifelong improved health for babies. Doula programs have consistently recorded 50% fewer Cesarean sections and major decreases in post-partum depression.

### HEALTH DISPARITIES IMPACT:

Accessible, community-focused models using evidence-based strategies have a well-researched impact on improving individual health and reducing health disparities while being feasible to implement on the wide basis needed to improve population health.

### BENEFITS OF RECOMMENDATION:

Benefits include: Widely-improved health, community skills building and empowerment, significant Medicaid savings, and health career development in low-income communities.

### CONCERNS WITH RECOMMENDATION:

1. This fast changing field---with a range of preventive and self-care protocols that can be effectively delivered by non-licenses providers expected to receive Medicaid approval---may require that the state have an ongoing process to make recommendations for waiver purposes and for standardization of core skills and training for individual services.

2. Lack of funding to support community organizations' infrastructure for implementation of the services/program.

### IMPACTED STAKEHOLDERS:

New York State Department of Health, CMS, PPS's, health-oriented community groups, Medicaid, insurers, Health Homes, disability, chronic disease, and AIDS-impacted populations.

**Addendum:**

Another example of a non-licensed provider is Mental Health First AID:

Mental Health First AID provides an 8-hour training for family/responders/ providers/community members to be able to appropriately help and support persons experiencing a mental health crisis, including a drug reaction or overdose.

Provider: First AID Instructor who has completed a 5-day training authorized by Mental Health First AIDS USA.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **5**
**Recommendation Short Name:** **Advancing Additional Peer Specialist Positions**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **High**
**Implementation Timeline:** **2-3 Years**

**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

**PROPOSAL DESCRIPTION:**
The 1915i waiver established credentialing requirements and funding for peer specialists in OASAS, Office of Mental Health, and AIDS Institute licensed programs. Next steps are to:

- Create standardized and coordinated credentialing programs for additional peer specialists in a Department of Health credentialing program for peer health navigators, such that a single consumer of health services could obtain multiple credentials to provide Medicaid-reimbursable peer services through a single coordinated training curriculum.
- Develop programing that supports a continuum of employment-related activities, including training and development, resume preparation, volunteering, internships, part-time and full-time employment.
- Ensure that training to achieve these credentials is accessible to persons with limited formal education, English language skills or disabilities.
- Enrich funding for existing employment programs to include services for people with disabilities, etc. to develop a continuum of employment.
- Develop of a continuum of work experiences including time-limited volunteer opportunities (programs) which may ultimately lead towards competitive paid employment.
- Incentivize employers to create part-time job opportunities that could be filled by individuals with disabilities.
- Enhance and expand peer education programs to develop trained peer educators to be utilized in community settings, e.g. healthcare, CBOs, etc.

Models for funding include Career Pathways and other existing OTDA- funded employment initiatives.

**FINANCIAL IMPACT:**
There would be no additional costs as the money could be set aside for workforce development as part of the 1915i Waiver. OASAS and OMH have already retained consultants to develop credentialing standards for peers. The AIDS Institute plans to do the same for its Needle Exchange Programs as they become Medicaid-reimbursable services. The Department of Health would need to develop credentialing standards for peer specialists and all parties would have to work together to insure that these various requirements are standardized and training is coordinated to facilitate multi-credentialing.

### HEALTH DISPARITIES IMPACT:

Facilitating the training and credentialing of health care consumers as peer specialists addresses multiple social determinants of health (including homelessness, poverty, unemployment and inadequate social supports) to reduce health disparities. Data from a New York-based peer specialist program has shown that after six months, participants' utilization of both hospital and behavioral health services decreased significantly:

- 47.9% decrease in percentage who use inpatient services (from 92.6% to 48.2%)
- 62.5% decrease in number of inpatient days (from 11.2 days to 4.2)
- 28% increase in number of outpatient visits (from 8.5 visits to 11.8)
- 47.1% decrease in total behavioral health costs (from $9,998.69 to $5,291.59)
- Approximately 83% maintain sobriety while receiving peer coaching services

The committee wants to be certain that in the implementation of this recommendation that special populations such as individuals with forensic backgrounds, youth at risk including youth in foster care, gay / lesbian / bi / transgendered / queer individuals, and individuals with HIV are included and given appropriate attention in the process.

### BENEFITS OF RECOMMENDATION:

This recommendation would support and enhance efforts already underway to promote innovative and cost-effective peer-provided services, while expanding opportunities for peer trainees through multiple certifications, all at no additional cost to the state. Additional dollars can be leveraged through a companion proposal that would encourage DSRIP-funded Performing Provider Systems to dedicate resources for training and employing people with disabilities or chronic conditions that are Medicaid recipients or uninsured as peer specialists. This recommendation will leverage a system in place, enhance quality of life and independence for consumers, and promote innovative peer-provided services that have been demonstrated to support retention in care and improved health outcomes.

### CONCERNS WITH RECOMMENDATION:

This recommendation would require cross-agency collaboration and the commitment of resources to a new coordinated training system.

### IMPACTED STAKEHOLDERS:

Center for Medicaid and Medicare Services (CMS)
Department of Health
Office for People with Developmental Disabilities
Medicaid Population of People on Disabilities and their Families
Office of Alcohol and Substance Abuse Services
Office of Mental Health
OCFS
NYS SED
DSRIP Performing Provider systems (PPS)
Community Support Providers

**Addendum 1**

There are many types of existing peer specialist positions. A single coordinated training curriculum would not cover the general spectrum of peer activities. Different curriculums would be needed based on the type of peer specialist position and the services being provided. Some training programs may be specific yet brief and others would need to be more intense.
A peer specialist in behavioral health would require quite a different training in length and content than a peer who is going to deliver a Stanford Chronic Disease Self-Care Course, which has its own required 4-day training.

**Addendum 2**

**Recommendations:**

i. More than one type of Peer Specialist and related activities be identified and supported with provision of extra points, equally weighted, to PPSs who use evidence-supported peer activities. There should be no bias nor only one peer type.

ii. Include the use of extra funding for community-based programs and groups in partnership/agreement with PPSs for conducting the peer specialist activities that help to strengthen the PPS peer capacity development.

iii. Support for multiple peer activities/responsibilities/protocols mentioned in workgroup dialogue, e.g. CHWs with peer backgrounds and the range of peer activities used as examples in other proposals.

iv. Urge DSRIP incentives for evidence-based peer activities, especially those that train local peer representative of low income, medically underserved communities.

v. Support for PPSs alignment with and implementation of existing peer programs which already have defined evidenced-supported protocols.

vi. Development of a single coordinating Peer Specialist Curriculum might be an overreach for the implementation, likely delay implementation given the time period and otherwise be cumbersome. However, developing a small number of curriculums with basic underpinning guidelines that allow tailoring for training for specific functional service areas might be a more realistic and useful achievement.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **6**
**Recommendation Short Name:** **Strengthening Current Infrastructure of General Employment**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **High**
**Implementation Timeline:** **5 Years**

**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

**PROPOSAL DESCRIPTION:**
This recommendation involves the following:

1. Implement the use of the a single employment case management system (i.e. NYESS, OSOS, or a new multi-agency system) to increase coordination and information sharing among all state agencies that provide employment, vocational rehabilitation and training services to people with disabilities.
2. Provide tiered funding for disability service providers to provide targeted tiered benefits advisement (including SSA work incentives and the Medicaid Buy-In for Working People with Disabilities) that leads to employment with payment to providers only after employment milestones are realized thus insuring cost savings for Medicaid. This will address the number one barrier to individuals with disabilities seeking employment.
3. State agencies will train disability providers to Increase the use of Disability Resource Coordinators in New York State. DRCs work at One Stops Centers to help individuals with disabilities to find employment and to connect with available resources. RFP is being issued to increase the availability of DRCs to help enhance the employment rate of people with disabilities.
4. Ensure that funding, strategies and staff to engage individuals with disabilities are included in the Career Pathways Program, a program that provides job training to individuals with lower incomes as well as the Wage Subsidy Program. Having the support for individuals with disabilities to participate in these programs will help this population learn the skills they need in the workforce and obtain and retain successful employment. In order to do this, the payment points of these existing programs must be modified to meet the needs of the providers, employers and individuals with disabilities.
    a. Subsidize/incentivize employers to create opportunities and hire disabled individuals (NYS tax credits, Medicaid $ savings), and paid subsidized placements (like Senior Service America).
    b. Payment point for (any) part time employment. Perhaps this can be tied to the number of hours that research shows is sufficient to improve health outcomes.
5. Funding services focused on cultivating and customizing relationships w/ employers to develop employment opportunities that work for this population and the employer.
6. Insure NYSDOL business outreach staff are trained to begin addressing employers hiring individuals with disabilities, including knowledge of recruitment strategies for

employers hiring individuals with disabilities, sources of technical assistance on reasonable accommodation and knowledge or work incentives including tax credits for employers.

### FINANCIAL IMPACT:

Any financial impact would be directly offset by the cost savings anticipated in Medicaid spend as evidenced by the Mathematica Study and the Cornell Study showing have a high success rate which show a Medicaid spend cost reduction of $73 per member per month for individuals with disabilities who become employed. Additional IT resources would need to be made available to fully implement a single case management system for some state agencies if using a current system such as NYESS or OSOS, or all state agencies if creating a new system.

### HEALTH DISPARITIES IMPACT:

Even a few hours of work per week have been shown to significantly improve the health outcomes of disabled individuals. Successful workforce development initiatives focused on the specific needs of disabled individuals will reduce their health care costs and Medicaid spending. There will be limited cost for upkeep and implementation while relying on systems that already exist. These recommendations will ensure NYS has adequate resources and appropriate programs to provide supportive employment services to people with disabilities. The committee wants to be certain that in the implementation of this recommendation that special populations such as individuals with forensic backgrounds, youth at risk including youth in foster care, gay / lesbian / bi / transgendered / queer individuals, and individuals with HIV are included and given appropriate attention in the process.

### BENEFITS OF RECOMMENDATION:

These recommendations reduce Medicaid Health expenditures, improve individuals with disabilities quality of life, and increase the economic viability of individuals with disabilities by moving them off public entitlements into taxpaying citizens.

### CONCERNS WITH RECOMMENDATION:

There will need to be close monitoring of the progress and a substantial amount of coordination and organization across agencies. Full utilization and adoption of NYESS will take time and resources and will necessitate the set-aside of additional resources.

### IMPACTED STAKEHOLDERS:

Department of Labor
OTDA
Office of Mental Health
Office for People with Developmental Disabilities
OASAS
OCFS
DOH
WIOA Program
Department of Education
Individuals with disabilities and their family along with community support providers

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **7**
**Recommendation Short Name:** **Development of Certified Peer Specialist As Part of DSRIP Programs**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **High**
**Implementation Timeline:** **2 – 3 Years**
**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

**PROPOSAL DESCRIPTION:**
Encourage Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPSs) to use some portion of their funds to develop Certified Peer Specialist Programs and provide funding for a new full and part-time employment of people with disabilities or chronic conditions who are Medicaid recipients or uninsured. This consumer-driven workforce will provide outreach, health navigation and health education. PPSs that submit proposals to use funds to train and hire from this population will receive bonus points in the scoring of their applications.

Through these programs, peers will receive structured employment opportunities as Health Navigators (HNs) and community health outreach workers (CHOWs) and can serve in the following roles:

- Peer and Family Coaches: Peer Bridgers or Peer Linkers; Recovery Coaches; Family Support Partners; Whole Health Coaches (for co-occurring disorders)
- Trainers and Group Leaders: WRAP, Pathways to Recovery, Seeking Safety, NAMI Family to Family, Basics, Peer to Peer, WHAM, Mutual Support Groups, Mental Health First Aid, QPR for Suicide, Prevention
- Facility Staff: Welcome and Orientation; Intake Coordination; Recovery Planning; Creation of Advance Directives; Community Resource Connection; Staff training; Part of case consultation
- Targeted Outreach: Work with individuals who are at risk of falling out of care or need to be connected to health and/or behavioral health care services. Outreach can occur in temporary places of residence, community centers, parks and on the street, with an emphasis on individuals in need of behavioral health care services. Once the CHOWs or HNs engage with a potential client, they would be charged with explaining what services are available to them, addressing any potential concerns raised by the individuals and escorting them to appointments.
- Other roles: WARM Lines; Phone Recovery Check-ins; Online Support Groups; Navigators; Peer Respite

Recommended Components include:

1. Work Readiness Assessment, with support for benefits considerations;
2. Job Training, followed by
3. Stipend Peer Work, Job Placement/Supported Employment (≤ 18 months) or direct hires at community health centers, OMH or OASAS licensed providers or Health Homes.

### FINANCIAL IMPACT:

Data from a New York-based peer specialist program has shown that after six months, participants' utilization of both hospital and behavioral health services decreased significantly:

- 47.9% decrease in percentage who use inpatient services (from 92.6% to 48.2%)
- 62.5% decrease in number of inpatient days (from 11.2 days to 4.2)
- 28% increase in number of outpatient visits (from 8.5 visits to 11.8)
- 47.1% decrease in total behavioral health costs (from $9,998.69 to $5,291.59)
- Approximately 83% maintain sobriety while receiving peer coaching services

### HEALTH DISPARITIES IMPACT:

The proposed proposal addresses multiple social determinants of health (including homelessness, poverty, unemployment and inadequate social supports) to reduce health disparities. It is critical to address the social determinants of health in designing a collaborative system- one that will enable and empower individuals to live healthier lives and stay out of the hospital, maintain housing stability and avoid preventable behavioral health crises. This proposal will help to ensure access to a more proactive system of care that addresses the significant health disparities for the target populations.

### BENEFITS OF RECOMMENDATION:

Certified Peer Specialist Programs will support the Medicaid Redesign Team goals, focusing on individuals with multiple chronic conditions (HIV, SMI and SUD), offering innovative, evidence-based programs that support retention in care and promote improved health outcomes. The initiative not only enhances quality of life and independence for people with disabilities or chronic conditions who are Medicaid recipients or uninsured but eventually leads to: an improved and modernized workforce; peer-run programs, which will support health navigation, outreach, and health education at lower costs than clinical professionalized models; and programs that build off elements of the clubhouse, day treatment, AIDS Adult Day Health Care and Targeted Case Management models, which will emphasize crisis diversion and inform supportive housing programs.

While not an immediate goal, this initiative will create a health transformation environment where:

- ☑ Health Homes ability to successfully engage eligible clients will be strengthened, thereby supporting the State's "Care Management for All" goals;
- ☑ Advanced Medical Homes will be infused with a life-experienced, trained, highly motivated consumer workforce that advances DSRIP goals; and
- ☑ Future transitions from health care coverage through disability-based programs (traditional Medicaid/Medicare) are facilitated to employer-sponsored health plans and/or subsidized New York State of Health exchange plan coverage associated with successful re-entry or initial engagement in the workforce.

**IMPACTED STAKEHOLDERS:**
DSRIP Performing Provider Systems (PPSs)
Medicaid beneficiaries and Uninsured Health Care Consumers
CBOs engaged in CHW/Peer Work
Labor

**Addendum 1**

New York State should not stress one kind of PPS model and one selected peer position. The state can include a range of peer activities by using the phrase "extra points for evidence-based peer activities" and also, after "providing funding" making the addition "including through subcontracting with community groups." It should be clear that the many PPSs, who currently don't have peer capacity, can compete by looking to the community to develop peer capacity. These changes would fully embrace the multiple peer activities/responsibilities/protocols which the workgroup has backed, from CHWs with peer backgrounds to the range of peer activities used as examples in other proposals---which also, not incidentally, urge DSRIP incentives for evidence-based peer activities, especially those that train local peer representatives of poor communities. These changes would also align the proposal to PPSs implementing existing peer programs which already have defined protocols (for example, the Stanford Diabetes Self-Care Course for which Medicare now pays part, which is by definition delivered by peers and which has its own required 4-day training) or which are expected to become Medicaid reimbursable in the not distant future.

Most of all, these changes would make it clear that PPSs focusing on physical health/chronic diseases have an equal chance to compete for extra points and can/should look to strategically funding community groups to develop their peer capacity and effectiveness.

**Addendum 2**

**Recommendations:**

vii. More than one type of Peer Specialist and related activities be identified and supported with provision of extra points, equally weighted, to PPSs who use evidence-supported peer activities. There should be no bias nor only one peer type.

viii. Include the use of extra funding for community-based programs and groups in partnership/agreement with PPSs for conducting the peer specialist activities that help to strengthen the PPS peer capacity development.

ix. Support for multiple peer activities/responsibilities/protocols mentioned in workgroup dialogue, e.g. CHWs with peer backgrounds and the range of peer activities used as examples in other proposals.

x. Urge DSRIP incentives for evidence-based peer activities, especially those that train local peer representatives of low income, medically underserved communities.

xi. Support for PPSs alignment with and implementation of existing peer programs which already have defined evidenced-supported protocols.

xii. Development of a single coordinating Peer Specialist Curriculum might be an overreach for the implementation, likely delay implementation given the time period and otherwise be cumbersome. However, developing a small number of curriculums with basic underpinning guidelines that allow tailoring for training for specific functional service areas might be a more realistic and useful achievement.

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **8**
**Recommendation Short Name:** **Disability Equity in State Contracting**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **Low**
**Implementation Timeline:** **1 year**
**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:

New York State could use State contracting policy to incentivize employment of people with disabilities by mirroring current federal contracting requirements created by the Final Rule published in the Federal Register on September 24, 2013, establishing the federal government as a model employer of individuals with disabilities by requiring federal contractors to take affirmative action to recruit, hire, promote and retain individuals with disabilities. The new Section 503 Regulations became effective on March 24, 2014 and: (i) set a 7 percent utilization goal for qualified individuals with disabilities; (ii) require that contractors document and update quantitative comparisons of job data to measure effectiveness of outreach; (iii) require contractors to invite applicants to self-identify and employees to self-identify using prescribed language; (iv) require that specific language be used to alert sub-contractors of their obligations; (v) clarify that OFCCP may review documents for compliance purposes.

According to New York State Comptroller DiNapoli, New York State spends $5.7 billion on goods and services each year through contractors. New York State promotes equality of opportunity and eliminates barriers to economic inclusion of women and minorities through its purchasing power. It created the MWBE program to create opportunities for individuals in protected classes who were previously underutilized in State contracting. It could similarly promote the employment of people with disabilities by State contractors to address disparities in employment of this population.

The employment rate of people with disabilities in New York State was 31.3 percent in 2011, according to the 2011 New York State Disability & Employment Report published by Cornell University. People with disabilities are less likely than non-disabled to be working full-time/full-year. Employment participation varies by industry, ranging from 3 percent in some sectors up to 6.2 percent in others.

## FINANCIAL IMPACT:

None

## HEALTH DISPARITIES IMPACT:

For people with disabilities there is a bi-directional relationship between health and employment. A person with disabilities ability to manage secondary health conditions helps them to become and remain employed. Employment can be beneficial to the health of people with disabilities.

**BENEFITS OF RECOMMENDATION:**
Employment has been seen to reduce Medicaid costs of people with disabilities who participate in the Medicaid Buy-in for the working Disabled.

**CONCERNS WITH RECOMMENDATION:**

**IMPACTED STAKEHOLDERS:**
OMH; OPWDD; ACCES-VR; Medicaid

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **9**
**Recommendation Short Name:** **Benefits Advisement and Web-based Calculator**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **High**
**Implementation Timeline:** **2 years**
**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

**PROPOSAL DESCRIPTION:**
**Coordination of Supports Investment:**

Less than one-third of working age New Yorkers with disabilities have jobs. When employed, they are more likely to be concentrated in low-wage, entry level positions and are less likely to have full-time, full-year employment than people without disabilities. People with disabilities have lower earnings than people without disabilities. Median household income for people with disabilities lags behind that of people without disabilities. One-third of New Yorkers with disabilities live below the poverty line.

Given the difficulty obtaining sufficiently remunerative employment and the difficulty associated with obtaining benefits and navigating benefits systems, it is little wonder that many people with disabilities who rely upon benefits, such as Medicaid, SSI, and, SSDI supports are reluctant to give up that safety net. This phenomenon is clearly illustrated in data contained on the StateData.info website. Of the 574,000 New Yorkers with disabilities who received Supplemental Security Income (SSI) in 2012, only 26,300 (4.5%) of those individuals worked that year. Only 329 of those 26,300 took advantage of the Impairment-Related Work Expense (IRWE) deductions that do not count toward SSI benefit calculations. Perhaps more alarmingly, only 113 of the entire 574,000 utilized a Plan for Achieving Self Support (PASS), which can prevent money spent on getting a job or starting a business (including education) toward SSI benefit calculations.

These examples clearly demonstrate the need for benefits advisement on the wide array of benefits that would be affected by an individual's transition to work. Benefits advisement would be enhanced through development of an enhanced electronic calculator system (such as DB101 and MyBenefits). The tool should encompass the implications of employment for health coverage, housing, utilities and phone assistance, nutritional supports, etc. It must be accessible for those who use screen-readers.

The tool could be used by counselors who would need to be available to ensure the accessibility of the tool for all people with disabilities. For example, trained staff may be needed to help individuals with cognitive or physical disabilities complete applications. Individuals may need face to face interaction to convey accurate information and get answers to questions.

Independent Living Centers (ILCs) can play a key role. ILCs are located in communities across New York State offer the services required to empower and educate people with disabilities on how safety-net benefits will be affected as individuals strive for greater financial independence through employment. Some independent living centers are familiar with using web-based benefits advisement applications such as "Benefits Check-up." Individualized goal setting and benefits planning offered by centers provides a roadmap to greater independence.

Centers are led by peers and a majority of center staff are people with disabilities. Counselors at independent living centers provide benefits advisement for people seeking employment so that individuals know the impact of employment on: Ticket to work referrals, PASS plans; health coverage programs including Medicare, Medicaid Buy-in for the Working Disabled and other Medicaid eligibilities, pharmaceutical assistance programs, private and employer health coverage, AIDS health coverage; housing assistance including DRIE and SCRIE and rental programs, housing authority programs, HUD rental assistance programs, student loan debt assistance, eligibility for certain vocational rehabilitation services, utility assistance programs, phone assistance programs; SNAP; transportation assistance programs; and more. Independent living centers provide advisement regarding rights of consumers in employment; reasonable accommodations; considerations of self-disclosure of disability at the workplace; and confidentiality. Many independent living centers contract with OMH, OPWDD and ACCES-VR to provide assistance to people with disabilities, including those transitioning to employment.

### FINANCIAL IMPACT:

Employment of people with disabilities is associated with reduced health care utilization and costs. Significant savings will accrue from the transition from Medicaid to the Medicaid Buy-in for the Working Disabled. These savings have been calculated by OMH and accepted by the Work Group. A portion of such savings can be reinvested in developing additional capacity for benefits advisement so that independent living centers can increase the reach of benefits advisement programs.

### HEALTH DISPARITIES IMPACT:

Through benefits advisement people with disabilities will be encouraged to work because they will be informed about the impact on their safety-net benefits. Employment is associated with improved health status for people with disabilities.

### BENEFITS OF RECOMMENDATION:

By making benefits advisement systems more accessible, people with disabilities will become more self-sufficient and independent. Employment of people with disabilities is associated with improved health status, reduced utilization of health care and health care costs.

### CONCERNS WITH RECOMMENDATION:

ACCES-VR, the DOL Disability Employment Initiative, OMH, OPWDD and NYMWP; OTDA; Commission on the Blind; local social service districts; etc. will need to improve referrals of individuals with disabilities for benefits advisement related to employment. Counseling during the vocational rehabilitation and employment search process should be automatic.

The DB101 and MyBenefits systems would need to be coordinated.

Independent living centers currently reach 90,000 New Yorkers each year with a State expenditure of $12 million; a reinvestment of savings from this initiative could broaden their reach.

**IMPACTED STAKEHOLDERS:**

Office of Temporary Disability Assistance
Independent Living Centers
ACCES-VR
OASAS
OPWDD
OMH
Commission on the Blind
OTDA
DOL
DD Planning Council

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **10**
**Recommendation Short Name:** **Providing Transportation and Employment Opportunities to People with Disabilities**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **High**
**Implementation Timeline:** **3+ Years**

**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☒ **Federal Waiver**

## PROPOSAL DESCRIPTION:

1. State agencies serving people with disabilities will educate people with disabilities and providers about transportation planning process, to help maximize transportation opportunities for employment, vocational rehabilitation, Work Based Learning, etc.
2. Provide bus passes/gas card to help negate the cost of travel to employment opportunities.
3. State agencies will educate providers, people with disabilities and employers on tax incentives related to transportation.
4. State agencies serving people with disabilities will help educate local government and disability providers in rural communities on the programs to make transportation available.
5. State agencies will help train providers on the ride coordination provisions of federal transportation funding programs so that use of equipment can be maximized to meet local need.
6. Convene state agency partners to examine impact of MA changes on transportation to employment providing policy recommendation which would address any negative impacts.

## FINANCIAL IMPACT:

Use 1915 I option to help negate the costs of paying for additional services for providers.

## HEALTH DISPARITIES IMPACT:

As the proposal covers both urban and rural populations it will help populations in both settings have easier access to vocational services, and employment opportunities. It will provide these populations who might not have the money to travel or the capacity to drive to also be employed, and thereby create a reduction in Medicaid expenditures. The committee wants to be certain that in the implementation of this recommendation that special populations such as individuals with forensic backgrounds, youth at risk including youth in foster care, gay / lesbian / bi / transgendered / queer individuals, and individuals with HIV are included and given appropriate attention in the process.

### BENEFITS OF RECOMMENDATION:

Transportation is one of the greatest barriers preventing people with disabilities from working. By providing a recommendation to remedy this issue, it will encourage more people to become employed and also mitigate fears of income lost due to transportation. Given the opportunity to work, outcomes have shown clients have a better adherence to medications and medical appointments, which will lower the number of hospital admissions.

### CONCERNS WITH RECOMMENDATION:

State agencies and provider networks appear to be unaware of the various resources that exist to assist with transportation and how to impact local planning to maximize transportation opportunities for individuals with disabilities.

### IMPACTED STAKEHOLDERS:

DOT
OPWDD
OMH
OASAS
DVR
OCFS
DOH
Conference of Local Mental Hygiene Directors
OFA
Individuals with disabilities and their family along with community support providers

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **11**
**Recommendation Short Name:** **Regional Economic Development Councils (REDC)**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:**
**Implementation Timeline:** **6 months**
**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☐ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:
NYS' Regional Economic Development Council (REDC) process serves as the central mechanism by which funding for economic development activities in NYS are distributed, the vast majority of which involve the development or retention of job opportunities. Similar to the focus on veterans in the 2014 REDC competition, NYS should incentivize REDC proposals to incorporate partner organizations that work with people in the Medicaid program and weight the scoring for REDC projects to favor those that commit to hire, create on-the-job training opportunities, and create internships/apprenticeships for individuals within the Medicaid program. Such actions could be put in place for the next round of REDC funding in 2015.

## FINANCIAL IMPACT:
None, this is above and beyond already planned expenditures on economic development through the REDC process.

## HEALTH DISPARITIES IMPACT:
This will address the fact that economic development efforts in NYS have never truly incorporated Medicaid beneficiaries, especially the subset of those with disabilities. This will match the policy goals of NYS to advance employment options for people in the Medicaid program with the general economic development and job creation efforts already in place.

## BENEFITS OF RECOMMENDATION:
This would provide a means for including the population of people in the Medicaid program – many of who have never benefitted from economic development initiatives – in the mainstream economic development activity in NYS. This will create a link between the state's policy goals to advance employment of people in the Medicaid program and the state's economic development policies/activities. Additionally, this should also cause businesses and organizations seeking to secure REDC funding to consider populations of people they may never have fully considered before.

## CONCERNS WITH RECOMMENDATION:
There are likely many competing interests for REDC focus.

## IMPACTED STAKEHOLDERS:
REDC Co-Chairs from each region; businesses/organizations that submit REDC proposals; state agencies involved with REDC (e.g. DOL, ESD, DOS).

# Medicaid Redesign Team
# Social Determinants of Health Work Group
# Final Recommendations – October 2014

**Recommendation Number:** **12**
**Recommendation Short Name:** **Supported Employment/Education**
**Program Area:** **Social Determinants of Health**
**Implementation Complexity:** **High**
**Implementation Timeline:** **3+ Years**

**Required Approvals:**
☒ **Administrative Action** ☐ **Statutory Change**
☒ **State Plan Amendment** ☐ **Federal Waiver**

## PROPOSAL DESCRIPTION:
Introduce a comprehensive approach to the utilization of Supported Education across state systems. Supported Education should include a set of individualized activities and supports consistent with the student's post-secondary educational goals that will lead to increased employment and the attainment of long-term career goals. This service will take place in community–based settings and will assist students in making informed educational choices regarding postsecondary education, navigating the post-secondary school environment and accessing additional information and resources. Supported Education will increase post-secondary completion, which leads to increased employment, increased earnings, and an overall reduction in the reliance of public benefits including Medicaid.

## FINANCIAL IMPACT:
Access to this service will potentially reduce the re-placement of individuals with disabilities into entry-level jobs, which raises systemic costs associated with the placement and training. These additional services will qualify individuals with greater education and skills which has been demonstrated to increase earnings over a lifetime.

## HEALTH DISPARITIES IMPACT:
This will help provide additional resources to students with disabilities. This will reduce reliance on Medicaid, and therefore the overall Medicaid expenditures. The committee wants to be certain that in the implementation of this recommendation that special populations such as individuals with forensic backgrounds, youth at risk including youth in foster care, gay / lesbian / bi / transgendered / queer individuals, and individuals with HIV are included and given appropriate attention in the process.

## BENEFITS OF RECOMMENDATION:
Creating this program allows the team to utilize information on best practices, and to create an expectation of "careers" for individuals with disabilities in NYS. This allows for room for new ideas and new approaches. It will provide educational opportunities for youth while also leading to more meaningful and financially-stable employment opportunities. This will create longitudinal cost savings related to the provision of employment services, decreased Medicaid expenditures, and decreased benefit reliance.

### CONCERNS WITH RECOMMENDATION:

There will need to be close monitoring of the progress and a substantial amount of coordination and organization across agencies. The team will need to work from the beginning creating a plan with limited references towards successful implementation of this idea.

### IMPACTED STAKEHOLDERS:

Department of Education
ACCES-VR
NYS Commission for the Blind
Office for People with Development Disabilities
Office of Mental Health
Department of Health
Individuals with disabilities and their family along with community support providers

# References


1. Appelbaum E, Milkman R, et al. Good for business? Connecticut's Paid Sick Leave Law. March 2014.

2. Arenz S, Rucher R, Koletzko B, Von Kries. Breast-feeding and childhood obesity—a systematic review. International J Obesity. 2004;28:1247-1256.

3. Babamoto KS, Sey KA, Camilleri AJ, Karlan VJ, Catalasan J, Morisky DE. Improving diabetes care and health measures among Hispanics using community health workers: Results from a randomized controlled trial. Health Education & Behavior. 2009;36(1):113-126.

4. Baker M, Milligan K. Maternal employment, breastfeeding and health: Evidence from maternity leave mandates. Journal of Health Economics. 2008;27:871-887.

5. Balcazar H, Rosenthal EL, Brownstein JN, Rush CH, Matos S, Hernandez L. Community health workers can be a public health force for change in the United States: Three actions for a new paradigm. AJPH. 2011;101(12):2199-2203.

6. Berger LM, et al. Maternity leave, early maternal employment, and child health and development in the U.S. The Economic Journal. 2005;115(501):F7-F28.

7. Blau F, Kahn L. Female labor supply: Why is the US falling behind? IZA Discussion Paper No. 7140; January 2013.

8. Brownstein J, Chowdhury F, Norris S, Horsley T, Jack JL, Zhang X, Satterfield D. Effectiveness of community health workers in the care of people with hypertension. American Journal of Preventive Medicine. 2007;32(5):435-447.

9. Bryant-Stephens T, Kurian C, Guo R, Zhao H. (2009). Impact of a household environmental intervention delivered by lay health workers on asthma symptom control in urban, disadvantaged children with asthma. AJPH. 2009;99(Suppl 3):S657-S665.

10. Cherrington A, Ayala GX, Elder JP, Arredondo EM, Fouad M, Scarinci I. Recognizing the diverse roles of community health workers in the elimination of health disparities: From paid staff to volunteers. Ethnicity and Disease. 2010;20:189-194.

11. Chung PJ, Garfield CF, Elliott MN, et al. Need for and use of family leave among parents of children with special care needs. Pediatrics. 2007;119(5):e1047-e1055.

12. Culica D, Walton JW, Harker K, Prezio EA. Effectiveness of a community health worker as sole diabetes educator: comparison of CoDE with similar culturally appropriate interventions. J Health Care Poor Underserved. Nov 2008;19(4):1076-1095.

13. Dagher R, et al. Maternity leave duration and postpartum mental and physical health: Implications for leave policies. J Health Politics, Policy and Law. 2014;39(2):369-416.

14. Davis KL, O'Toole ML, Brownson CA, Llanos P, Fisher EB. Teaching how, not what: The contributions of community health workers to diabetes self-management. The Diabetes Educator. 2007;33(Supplement 3):208S-215S.

15. Eidelman A, Schanler R. American Academy of Pediatrics Policy Statement, Breastfeeding and the use of human milk. Pediatrics. 2012;129(3):e827-e841.

16. Fedder DO, Chang RJ , Curry S, Nichols G. The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. Ethn Dis. Winter 2003;13(1):22-27.

17. Feinberg L, Reinhard S, et al. Valuing the invaluable: 2011 update: The growing contributions and costs of family caregiving. AARP Public Policy Institute, 2011.

18. Felix HC, Mays GP, Stewart MK, Cottoms N, Olson M. The care span: Medicaid savings resulted when community health workers matched those with needs to home and community care. Health Affairs. 2011;30(7):1366-1374.

19. Findley S, Matos S, Hicks A, Chang J, Reich D. Community health worker integration into the health care team accomplishes the triple aim in a patient-centered medical home: A Bronx tale. J Ambulatory Care Management. January/March 2014;37(1):82-91.

20. Gaul B, Hartman H, et.al. Paid parental leave in the United States: What the data tell us about access, usage, and economic and health benefits. Institute for Women's Policy Research, March 2014.

21. Gilmer TP, Roze S, Valentine WJ, Emy-Albrecht K, Ray JA, Cobden D, Palmer AJ. Cost effectiveness of diabetes case management for low income populations. Health Services Research. 2007;42(5):1943-1959.

22. Guendelman, et al. Juggling work and breastfeeding: Effects of maternity leave and occupational characteristics. Pediatrics. 2009;123(1):38-46.

23. Hemp P. Presenteeism: At work—but out of It. Harvard Business Review; October 2004.

24. Hill H. Paid sick leave and job stability. Work and Occupations. 2013;40(2):143-173.

25. Hunter JB, de Zapien JG, Papenfuss M, Fernandez ML, Meister J, Giuliano AR. The impact of a promotora on increasing routine chronic disease prevention among women aged 40 and older at the U.S.-Mexico border. Health Educ Behav. Aug 2004;31(4 Suppl):18S-28S.

26. Ingram M, Sabo S, Rothers J, Wennerstrom A, de Zapien JG. Community health workers and community advocacy: Addressing health disparities. Journal of Community Health. 2008;33(6):417–424.

27. Krieger J, Takaro TK, Song L, Beaudet N, Edwards K. A randomized controlled trial of asthma self-management support comparing clinic based nurses and in-home community health workers: The Seattle-King County Healthy Homes II Project. Archives of Pediatrics and Adolescent Medicine. 2009;163(2),141-149.

28. Krieger JW, Takaro TK, Song L, Weaver M. The Seattle-King County Healthy Homes Project: A randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. AJPH. 2005;95(4):652-659.

29. Kumar S, et al. “Policies to reduce Influenza in the workplace: Impact assessments using an agent-based model. AJPH, August 2013;103(8):1406-1411.

30. Kumar S, et al. The impact of workplace policies and other social factors on self-reported influenza-like illness incidence during the 2009 H1N1 pandemic. AJPH. 2012;102(1): 134-140.

31. Lerner S, Appelbaum E. Business as usual: New Jersey employers’ experiences with family leave insurance. Center for Economic and Policy Research; June 2014.

32. Mack M, Uken R, Powers J. People improving the community’s health: community health workers as agents of change. J Health Care Poor Underserved. Feb 2006;17(1 Suppl):16-25.

33. Martinez J, Frye L., Perez L. Community Health Workers in the Black Community: Building Trust, Alleviating Pain, and Improving Health Access. Health Issues in the Black Community. San Francisco, CA: Jossey-Bass; 2009.

34. Martinez J, Ro M, Villa NW, Powell W, Knickman JR. Transforming the delivery of care in the post–health reform era: What role will community health workers play? AJPH. 2011;101(12):e1-e5.

35. Martinez Garcel J. Casting an A-team to deliver results: Embedding and sustaining the role of community health workers in medical homes. Medical Home News. 2012;4(2):6-7.

36. Matos S, Findley S, Hicks A et al. Paving a path to advance the community health worker workforce in New York State. October 2012. Available at: www.chwnetwork.org. Accessed October 2014.

37. Mehrotra A, Rankin N. Latino workers can't afford to get sick. New York: Community Service Society; 2013. Available at: http://www.cssny.org/publications/entry/latino-new- yorkers-cant-afford-to-get-sick.

38. Michelen, W, Martinez J, Lee A., Wheeler DP. Reducing Frequent Flyer Emergency Department Visits. Journal of Health Care for the Poor and Underserved. 2006;17:59-69.

39. Milkman R, Appelbaum E. Unfinished business: Paid family leave in California and the future of U.S. work-family policy. Ithaca, NY: Cornell University Press; 2013.

40. Milli J. Paid sick days in New York would lower health care costs by reducing unnecessary emergency department visits. Washington, DC: Institute for Women's Policy Research; Oct. 2014. [Internal report prepared for Nancy Rankin, not yet publicly released]

41. Miller K, et.al. Paid sick days and health: Cost savings from reduced emergency department visits. Institute for Women's Policy Research; Nov. 2011.

42. Norris SL, Chowdhury FM, Van Le K et al. Effectiveness of community health workers in the care of persons with diabetes. Diabetes Med. May 2006;23(5):544-556.

43. Ogbuana C, et al. The effect of maternity leave length and time of return to work on breastfeeding. Pediatrics. 2011;127(6):1414-1427.

44. Parker EA, Israel BA, Robins TG, et al. Evaluation of community action against asthma: A community health worker intervention to improve children's asthma-related health by reducing household environmental triggers for asthma. Health Educ Behav. 2008;35(3):376-395.

45. Peipins L, Soman A, Berkowitz Z, White MA. The lack of paid sick leave as a barrier to cancer screening and medical-care seeking: Results from the National Health Interview Survey. BMC Public Health, 2012;12-520:1-9.

46. Peretz P, Matiz L, Findley S, Lizardo M, Evans D, McCord M. Community health workers as drivers of a successful community-based disease management initiative. AJPH. 2012;102(8):1443-1446.

47. Perez L, Martinez J. Community health workers: Social justice and policy advocates for community health and well-being. AJPH. 2008;98(1):11-14.

48. Perez M, Findley SE, Mejia M, Martinez J. The impact of community health worker training and programs in NYC. J Health Care Poor Underserved. Feb 2006;17(1 Suppl):26-43.

49. Perez M, Martinez J, Frye L. Community health workers: A successful strategy for restoring the health of a community. Mobilizing the community for better health: What the rest of America can learn from Northern Manhattan. New York, NY: Columbia University Press; 2010.

50. Ramsay A, Schneider J. Improving cancer prevention and control: How state health agencies can support patient navigators and community health workers. Arlington, VA: Association of State and Territorial Health Organizations; 2012.

51. Ranji U, Salganicoff A. Data note: Balancing on shaky ground: Women, work and family health. The Henry J. Kaiser Family Foundation; October 20, 2014.

52. Rankin N. New York needs paid family leave. Available at: Polling data for voters and businesses. http://www.cssny.org/page/-/Paid%20Family%20Leave/Family%20Leave%20Brochure%20V27%203%207%2014.pdf.

53. Reiss J, Rankin N, Pietrangelo K. Sick in the city: What lack of paid leave means for working New Yorkers. New York: Community Service Society; 2009. Available at: http://www.cssny.org/publications/entry/sick-in-the-cityOctober2009.

54. Rosenthal EL, Brownstein JN, Rush CH, et al. Community health workers: Part of the solution. Health Affairs. 2010;29(7):1338-1342.

55. Rossin-Slater M, Ruhm C and Waldfogel J. The effects of California's paid family leave program on mothers' leavetaking and subsequent labor market outcomes. NBER Working Paper 17715. Cambridge, MA: National Bureau of Economic Research; 2011.

56. Rush CH. Return on investment from employment of community health workers. Journal of Ambulatory Care Management, 2012;35(2):133-137.

57. Small business majority/lake research poll, 2013. Available at: http://www.smallbusinessmajority.org/small-business-research/other/.

58. Schuster MA, Chung PJ. Time off to care for a sick child—why family-leave policies matter. NEJM. 2014;371:493-495.

59. Spencer MS, Rosland A-M, Kieffer EC, et al. Effectiveness of a community health worker intervention among African American and Latino adults with Type 2 diabetes: A randomized controlled trial. AJPH. 2011:101(12):2253-2260.

60. Spencer MS, Gunter KE, Palmisano G. Community health workers and their value to social work. Social Work. 2010;55(2):169-180.

61. Staehelin K, et al. Length of maternity leave and health of mother and child: A review. International Journal of Public Health. 2007;52:202-209.

62. Swider SM. (2002). Outcome effectiveness of community health workers: An integrative literature review. Public Health Nursing. 2002;19(1):11-20.

63. U.S. Department of Labor, Bureau of Labor Statistics. National Compensation Survey. March 2013.

64. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2014. Breastfeeding Report Card. Available at: http://www.cdc.gov/breastfeeding/data/reportcard.htm.

65. Viswanathan M, Kraschnewski J, Nishikawa B, et al. Outcomes and costs of community health worker interventions: A systematic review. Medical Care. 2010;48(9):792-808.

66. Viswanathan M, Kraschnewski J, Nishikawa B, et al. Outcomes of community health worker interventions. Evid Rep Technol Assess (Full Rep). Jun 2009(181):1-144,A141-142,B141-114,passim.

67. Volkmann K, Castanares T. Clinical community health workers: Linchpin of the medical home. Journal of Ambulatory Care Management, 2011;34(3):221-233.

68. Waxmonsky JA, Giese AA, McGinnis GF, Reynolds RT, Abrahmson A, McKitterick ML, Thomas MR. Colorado Access' enhanced care management for high-cost, high-need Medicaid members: Preliminary outcomes and lessons learned. Journal of Ambulatory Care Management, 2011;34(2):183-191.

69. Widera E, Chang A, Chen HL. Presenteeism: A public health hazard. J Gen Intern Med, 2010;25(11):1244-1247.

70. Zahn D, Matos S, Findley S, Hicks A. Making the connection: The role of community health workers in health homes. September 2012. Available at: www.chwnetwork.org. Accessed October 2014.

# Appendix C

Listening Sessions – Dates and Times

# Employment First Commission

On September 17, 2014, Governor Andrew Cuomo signed an executive order establishing the Employment First Commission. This commission is tasked with creating an employment first policy for New York, which will make competitive, integrated employment the first option when considering supports and services for people with disabilities. The goals of this initiative are to increase the employment rate and decrease the poverty rate for working-age New Yorkers with disabilities.

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## Employment First Commission Meetings

Anyone wishing to attend a commission meeting is asked to RSVP to Sheri Senecal at Sheri.Senecal@exec.ny.gov no later than 24 hours prior to the meeting. Please include your name and affiliation. Individuals who require accommodations or auxiliary aids should include this information in the email.
Space is limited and is on a first-come, first-served basis.

**January 22, 2015**
**3:30-5:00 pm**
Location: NYC
633 Third Avenue
Press Conference Room

**February 26, 2015 (RESCHEDULED)**
**1:00-3:00 pm**
Location: Albany
New York State Capitol
Room 131

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## Employment First Commission Listening Sessions for Public Comment

Written public comments, feedback, and testimony may be submitted to employmentfirst@exec.ny.gov and/or at the following public listening sessions:

**January 29, 2015**
**3:00-5:00 pm**
OPWDD Metro New York State Operations Office
25 Beaver Street, 3rd Floor, Room 3100, New York, NY

*OPWDD Finger Lakes State Operations Office
620 Westfall Road, Room 25, Rochester, NY

*OPWDD Western New York State Operations Office
1200 East and West Rd., Room 1-153, West Seneca, NY

*(*Rochester and WNY are videoconference locations)*

**February 19, 2015 (**NEW DATE)**
**3:30-5:00 pm**
University at Albany School of Public Health
Auditorium
1 University Place
Rensselaer, NY 12144

*(**Rescheduled twice due to inclement weather)*

Oral testimony will be limited to 5 minutes duration; please plan to summarize your comments accordingly. Those wishing to present pertinent testimony are asked to preregister at employmentfirst@exec.ny.gov and submit prepared written testimony at that time. All testimony should begin with the individual's name, affiliation if applicable, and city/town of residence. Opportunity for presentation will be limited to a first come first served basis as time permits, and therefore entities may wish to work together to submit comments through their umbrella organization. The listening session sites will be accessible to individuals with disabilities. Sign language interpreters will be provided. Individuals who require other accommodation or auxiliary aids should contact Sheri.Senecal@exec.ny.gov no later than 24 hours prior to the hearing date.

Topics the commission is particularly interested in include:

- Policies and procedures to eliminate barriers or disincentives for the employment of individuals with disabilities;
- Strategies to maximize opportunities to hire individuals with disabilities;
- Creating more opportunities for students with disabilities transitioning from educational settings to competitive integrated employment as the first option; and
- Any other matter you believe to be important to the Commission's purpose.