October 23, 2019

Concept Paper

Harlem Health Advocacy Partners Community Health Worker Program

Background

Healthcare and social service systems in New York City have made efforts to improve the health of the most vulnerable populations; however, these systems were not designed to be equitable or to address the complex needs of communities suffering from historical and contemporary injustices, including poverty, racially-motivated segregated housing, disinvestment, and discrimination.

The Department of Health and Mental Hygiene's (DOHMH) Harlem Health Advocacy Partners (HHAP) is a place-based Community Health Worker program aiming to address this systems gap. Launched in 2014 as a Demonstration Project, the initiative operates in 5 NYC Housing Authority (NYCHA) public housing developments in East and Central Harlem, which are home to nearly 10,000 adults.

The overarching goal of HHAP is to improve the health of residents via 3 clusters of work:

- Navigation: Supporting access to health and social services to which they are entitled (Individual Health Advocacy)
- Health Coaching: Providing health coaching to individuals for roughly 6 months to increase self-efficacy for healthy behavioral changes and disease management (Direct Service)
- Community Advocacy: Building community capacity to seek and/or create healthy conditions and acceptable services through advocacy to government and other service providers (Community Health Advocacy).

An initial needs assessment of the selected population determined that among the adults 35 years or more, 74% were suffering from chronic conditions, including 54% diagnosed with hypertension, 29% with diabetes and 12% with current asthma. DOHMH surveillance programs, including hospitalization data and A1C registry data, suggest that in many instances these conditions are not well controlled among this population. On an individual level, these conditions impact quality of life. On a population level, they contribute to an excess number of avoidable emergency room visits and hospitalizations in the community district and associated costs.

Among enrolled HHAP health coaching participants, 739 completed an intake and subsequent follow-up assessment by December 31, 2018. Initial evaluation of these demonstrate that:

- The program increased the percent of people self-reporting excellent to good general health by 53%, from 49% to 75%.

- Among those with diabetes, the number with self-reported controlled diabetes increased by 42%, from 55% to 78%.
- Among those with hypertension, the number with directly measured controlled blood pressure increased by 17%, from 59% to 69%.

Additionally,

- An evaluation conducted by NYU School of Medicine that involved matching HHAP Year 1-2 participants with A1C registry lab reports found HHAP participants lowered average A1C by a net difference of 0.4% over an 18-month period compared to other NYCHA residents in the same neighborhood.

The program's Community Health Worker (CHW) component, comprised of the Health Coaching and Community Advocacy clusters, has been an essential part of HHAP's success. The CHW staffing is categorized into 2 groups: 1) Community Health Workers who primarily focus on Health Coaching, and 2) Community Health Organizers who primarily focus on Community Advocacy. Both groups receive cross-training in order to be proficient in both lines of work (Health Coaching and Community Advocacy) given the mutually reinforcing interconnectedness of the work as well as the occasional need to cross cover. This RFP covers both lines of work.

In particular, the Health Coaching primarily conducted by Community Health Workers has been integrated seamlessly into the broader program (linking with Navigation and Community Advocacy clusters) that provides insurance navigation and enrollment, health literacy education, post-enrollment support and the community organizing work. Their Health Coaching has empowered residents (including some with low literacy or English language proficiency) to acquire the knowledge and skills to better manage their chronic illness and support increased access to health-related services to which they are entitled. Since 2016, health coaching sessions conducted by CHWs have been provided to over 1,150 individuals living in NYCHA, reaching more than 10% of DOHMH's target population. Similarly, the Community Advocacy work conducted primarily by the Organizers has successfully elevated and addressed issues such as food security, public safety, housing repairs, etc. which often form a significant barrier to residents struggling to manage chronic disease. The Organizers have thereby enhanced the reach and outcomes of the two other clusters of work (Navigation and Health Coaching). Together, CHWs and Community Health Organizers have engaged over 5,000 residents in group wellness and advocacy activities since the program began in 2015.

Purpose of the Proposed RFP

As a result of the Demonstration Project's findings, the Department of Health and Mental Hygiene (DOHMH) proposes to issue an RFP for a contractor to provide continued health coaching and community advocacy for East and Central Harlem NYCHA residents, using the Community Health Worker Model to operate within the Harlem Health Advocacy Partners (HHAP) program. This RFP includes services pertaining to two of the three clusters of work

described above:

- Health Coaching: Providing health coaching to individuals for roughly 6 months to increase self-efficacy for healthy behavioral changes and disease management (Direct Service)
- Community Advocacy: Building community capacity to seek and/or create healthy conditions and acceptable services through advocacy to government and other service providers (Community Health Advocacy).

Please note that the third cluster (Navigation) is covered through a separate RFP procurement.

Rationale for Continued Services:

For multiple reasons, it is of vital importance to maintain the service of Community Health Workers in HHAP's placed based model:

1. Significant contributions were made by Community Health Workers during the program's initial four years toward helping residents improve health outcomes specific to management of poorly controlled hypertension and diabetes.
2. Resident participation in HHAP group wellness activities continues to grow and demand for Community Health Workers remains strong. More than 1,500 residents have participated in these activities since the program's inception.
3. Residents involved in HHAP's Community Organizing work have gone on to become active members of their resident association leadership who then support advocacy on a larger scale for environmental and quality of life improvements within public housing.
4. The rapidly changing world of complex medical care, health care access, advocacy and public policy necessitates the continued services of well-informed community health workers who are able to support the interpretation and implementation of new policy administration and rules (Smoke-Free NYCHA, for example).

Goals of the RFP

The goals of this solicitation are:

1. To provide health coaching, advocacy and care coordination for residents in New York City Housing Authority (NYCHA) developments in East and Central Harlem in order to improve their health outcomes and quality of life.
2. To empower residents to effectively advocate for improved health equity by providing high quality educational workshops and wellness activities, that include the social determinants of health and apply a racial equity lens.
3. To conduct health outreach and recruitment activities to engage residents and promote program services within East and Central Harlem.

Health

Service Location

Community Health Workers will work in East and Central Harlem, in the area around 115th Street and Lexington Ave. extending south and west, with a population living in low income public housing developments operated by NYC Housing Authority (NYCHA). The specific housing developments are Clinton, Johnson, King, Lehman, and Taft houses with possible plans for expansion. Each housing development has multiple apartment buildings and some have community centers. The population is predominantly Latinx and Black adults, many experiencing chronic conditions such as asthma, diabetes, hypertension, heart disease, cancer or disabilities. Roughly one-third speak Spanish.

Program Information

The Contractor will create a staff of (**12) full-time Community Health Workers (CHWs) and (5) full time Community Health Organizers** who will provide direct services to residents in the targeted community as follows:

The **Community Health Workers** will provide:

1. One-on-one health coaching sessions
2. Individual and group level educational workshops
3. Assistance in referring to insurance assistance and navigation
4. Referrals to clinical and social support services in the community
5. Advocacy Community Organizing in support of the Community Health Organizers

The **Community Health Organizers** will:

1. **Conduct base-building activities**: increase the number of residents mobilized to advocate for health equity and social change.
2. **Facilitate leadership development**: empower residents to organize and build collective power to achieve systemic (i.e., health care access, housing quality, public safety) change in segments that impact public health and health equity.
3. **Support civic engagement:** engage residents to build power to secure health equity and social justice for community members.
4. **Coordinate public health advocacy campaigns**: link residents to local groups working collectively to research and share experiences.
5. **Provide linkages to local actions**: community events to bring light on a public platform of issues impacting quality of life in NYCHA housing developments.

The contractor would also employ the following staff to support this program:

1. **One (1) full time Program Manager:** responsible for leading, guiding, supporting, and monitoring delivery of health coaching services, social support referrals, and wellness activities geared towards meeting program **goals.**
2. **Three (3) CHW Supervisors:** responsible for oversight of CHW and Community Health Organizing staff providing health coaching and organizing services for the

program.

3. **One (1) Evaluation and Monitoring Coordinator**: responsible for the programs data collection, reporting and evaluation activities.

The Contractor would be expected to have the Community Health Workers and Community Health Organizers trained within 60 days of contract registration.

The proposed scope of work consists of the following elements:

1. **Health Coaching**
   DOHMH anticipates that the contractor would engage 300 residents each year in health coaching consisting of diseases specific asthma, Diabetes, hypertension and provide support with social determinates of health. DOHMH estimates that 300 unique individuals would be served annually.

   a. **Health Coaching tasks consist of:**

      i. Delivery of peer health coaching support to chronically ill participants including health goal setting.
      ii. Creation of action plan and reinforcement sessions to help participants achieve their health goals.
      iii. Helping connect residents to social services and supports.
      iv. Occasionally accompanying participants to medical and social services visits as needed.
      v. Preparation of case related reports including but not limited to outcomes, successes and challenges.
      vi. Participation in group advocacy and community mobilization activities in support of the Community Health Organizers

2. **Community Organizing tasks that consist of:**

   a. Educating residents on community organizing and mobilization basics.
   b. Helping residents connect with local legislators and others to address issues and concerns.
   c. Helping to develop and run advocacy campaigns with local leaders and residents to address issues in public housing.
   d. Developing community engagement and recruitment strategies including but not limited to door knocking, lobby meetings etc.
   e. Developing a learning agenda that educates residents on inner workings of local government to support civic engagement efforts.
   f. Attending community meetings and events to increase knowledge of community issues and concerns.
   g. Helping link residents to local advocacy groups to support development of best practices in advocacies.
   h. Helping residents strengthen and build community groups through base building and grass roots organizing.

i. Helping residents to identify tools they can use to ensure their voices are heard.

3. **Workshops/Group Wellness Activities**

The Contractor would develop and conduct high quality workshops and group wellness activities. The workshop/group wellness activities would:

a. Be conducted four times per month (total of 48 per year) to educate a total of 1200 unduplicated residents in New York City Housing Authority (NYCHA) developments in East and Central Harlem.

b. Occur at easily accessible locations in the targeted geographic area, such as NYCHA Community Centers, Senior Centers, and DOHMH East Harlem Action Centers.

c. Be held primarily during normal business hours during the week (Monday – Friday), with some workshops scheduled during evenings and weekends to maximize attendance

d. Cover, at minimum, the following topics/activities:

i. Food Access and nutrition classes
ii. Chronic Disease Management and Control (Diabetes, Hypertension, Asthma)
iii. Stress Management
iv. Peer Support
v. Living Well, Mindfulness
vi. Smoking Cessation
vii. Chronic Disease Management
viii. Diabetes Prevention Workshops
ix. Mental Health
x. Walking Groups
xi. Blood Pressure Monitoring
xii. Art Therapy
xiii. Walking Groups
xiv. Shape up Classes
xv. Citi Bike Group Rides

4. **Outreach**

a. The Contractor would/update develop an annual multi-pronged outreach plan to engage and enroll 300unduplicated residents per year in East and Central Harlem.

b. The Contractor would implement a multi-pronged outreach plan to engage and enroll 300 unduplicated NYCHA residents in East and Central Harlem per year. The Contractor would promote HHAP to community residents and

increase participation through activities including, but not limited to:

i. Distributing consumer marketing materials such as the HHAP fact sheet and outreach flyers, as well as other materials provided by DOHMH.
ii. Distributing promotional items to promote the program and incentivize target residents to take advantage of Community Health Worker services and take part in workshop activities.
iii. Recruiting interns with the cultural competency and language skills to effectively engage hard-to-reach residents of various ethnic backgrounds and nationalities.
iv. Attending health fairs and other events in the community.
v. Posting program information in buildings and tabling inside and outside community and senior centers and other key locations in the five developments.
vi. Coordinating farmers' market tours and distributing DOHMH's health bucks to incentivize purchasing and consumption of fresh fruits and vegetables.

5. **Community Organizing**
Contractor would support HHAP's goal to build residents' capacity to seek and demand healthy conditions and acceptable services through advocacy and work with existing Resident Associations and grass roots organizing groups.

a. Support resident's community mobilization and advocacy efforts
b. Promote and support HHAP services and group wellness activities.
c. Support networking and partnership building activities
d. Oversee leadership development and wellness capacity building for community members

6. **Reporting Requirements**: DOHMH anticipates that the Contractor would submit a monthly program report to DOHMH, detailing contract delivery events for the previous month. Data points would include:
a. The number of unique residents in the targeted community reached and services provided.
b. The number of unique residents who attended workshops.
c. The names of participants who received Health Coaching and Social service referrals and agreed to have their first and last name shared with DOHMH for program evaluation purposes.
d. Quantitative data specific to the person served. They will also submit a monthly data report on all people they serve within the first ten business days of the following month. Data falls into six major categories: Health Coaching, Social Service Referrals, Program Completion, Group Wellness Billing Cases by

Insurance Type for Target Clients, Cases by Health Plan, Participants receiving Health Navigation and CHW services.

e. On a quarterly basis, Qualitative Data should be provided indicating major themes around issues and barriers faced by residents in programs target public housing development.

Proposed Term of the Contract(s)

It is anticipated that the term of the contract awarded from this RFP would be as follows:

- September 1, 2020 – August 31, 2026

Procurement Timeline

It is anticipated that the RFP issuance date would be in spring 2019, with an approximate proposal due date in summer 2019 and expected award decisions in fall 2019.

Funding Information and Proposed Payment Structure

The anticipated Maximum Reimbursable Amount of the contract would be $10,104,522.00 for the six-year term. The agency expects to make one award. The actual funding levels will depend upon the availability of funds.

The agency is particularly interested in feedback from the provider community on how to structure payments under the resulting contracts.

Planned Method of Evaluating Proposals

DOHMH anticipates that proposals will be evaluated based on proposers': relevant experience; approach to the scope of services; approach to program monitoring, data management, and reporting; organizational capacity, including proposed staffing plan; and proposed approach to budget management.

Use of HHS Accelerator.

To respond to the forthcoming Harlem Health Advocacy Partners Community Health Worker RFP, vendors must be appropriately qualified in the City's Health and Human Services (HHS) Accelerator System. The HHS Accelerator System is a web-based system maintained by the City of New York for use by its human services Agencies to manage procurement.

Only organizations with approved HHS Accelerator Business Application and Service Applications for one or more of the following service areas will be eligible to propose:

- **Community Engagement**
- **Life Skills**
- **Health Education and Supports**
- **Outreach**
- **Capacity Building**
- **Entitlements Assistance**
- **Financial Counseling**

To submit a Business and Service application to become eligible to apply for this and other

client and community services RFPs, please visit http://www.nyc.gov/hhsaccelerator.

Contact Information /Deadline for Questions/Comments

Comments are invited by December 6, 2019. Please email RFP@health.nyc.gov and indicate **HHAP CHW Concept Paper** in the subject line of the email. Alternatively, written comments may be sent to the following address:

Erik Vaklinov, Contract Manager
New York City Department of Health and Mental Hygiene
42-09 28th Street, CN 30A
Queens, New York 11101