New York Alliance for Careers in Healthcare:

10-Year Anniversary Report

March 2022

Looking Back:

A Letter from NYACH and its Partners Council

March 2022

The COVID-19 pandemic shocked our healthcare infrastructure, and now more than ever the workers and businesses of our industry need our help, attention, and resources. The efforts of NYC's health professionals have been nothing short of heroic—from the unceasing efforts of workers on the frontlines of patient care, to the creativity of business leaders struggling to keep their organizations going and workers protected. Beyond that heroism, however, is a healthcare system with many long-standing challenges, a public that struggles to grasp the complexity of healthcare service delivery, persistent inequities in patient outcomes based on race and socio-economic status, and now overwhelming burnout among members of the healthcare workforce.

The pandemic highlighted how inextricably linked healthcare and public health is to our economy and daily lives. The healthcare system's capacity to respond to the pandemic—and our community's shifting attitudes and actions—dictates how jobs can be done, which businesses stay open, how we socialize, and who must turn to unemployment or other social assistance for survival. The healthcare industry itself is also one of the largest sectors in the NYC economy with an estimated 750,000 workers. The strength, therefore, of the healthcare sector matters not only as foundational to the health of our city, but also as a contributor in its own right to the city's economic engine. In short, a strong healthcare system matters to us all.

And despite its size and strength, we also recognize that the healthcare system was far from perfect before the pandemic. For years, healthcare costs have been rising faster than inflation and GDP growth. While some of this growth has been alongside positive changes, such as those in technology and in the development of more patient- and value-centered policies and business models, we have not seen universal improvement for this increased cost. We still have communities with inequitable and poor health outcomes, a large subset of workers who earn barely enough to sustain their families—especially in non-acute settings—and businesses grappling with financial fragility and operating on diminishingly thin margins. As NYACH and its partners have worked to address these problems since long before the pandemic, we have also understood that the healthcare system is too complex and interconnected to create meaningful systems change without collaboration.

It was in this spirit that the New York Alliance for Careers in Healthcare (NYACH) was created ten years ago, challenged with the question: "How can we work cooperatively to improve things across the whole city, building on our system's strengths and innovating to address its weaknesses?" New York City has a wealth of institutional healthcare resources: everything from world-renowned academic medical systems to hundreds of home and community-based care organizations, to strong industry associations, advocacy groups, and labor unions. Similarly, the city is home to a robust healthcare workforce development ecosystem with strong private and government funding that supports community-based bridge programs, academic degree and continuing education programs, union-sponsored programs, and programs directly run by employers.

For a decade, NYACH staff and members of its Partners Council, in collaboration with other industry and educational partners, have come to clearly understand the system's economic and workforce challenges, design careful industry-informed solutions, and leverage trusted relationships to change this complex system for the better. Building on our past successes and an even greater spirit of collaboration brought on by the pandemic, we are optimistic about the future of healthcare in New York City. NYACH and its partners are happy to share our history with you in this report that celebrates our 10-year anniversary, and we welcome you in our ongoing mission to realize a more effective and equitable healthcare system in New York City.

NYACH Leadership

Daniel Liss
(2019-present)

Shawna Trager
(2013-2019)

Jenny Tsang-Quinn, MD
(2011-2013)

NYACH Partners Council

1199SEIU Training and Employment Funds

City University of New York (CUNY)

Community Health Care Association of New York State (CHCANYS)

Greater New York Hospital Association (GNYHA)

PHI

Southern New York Association (SNYA)

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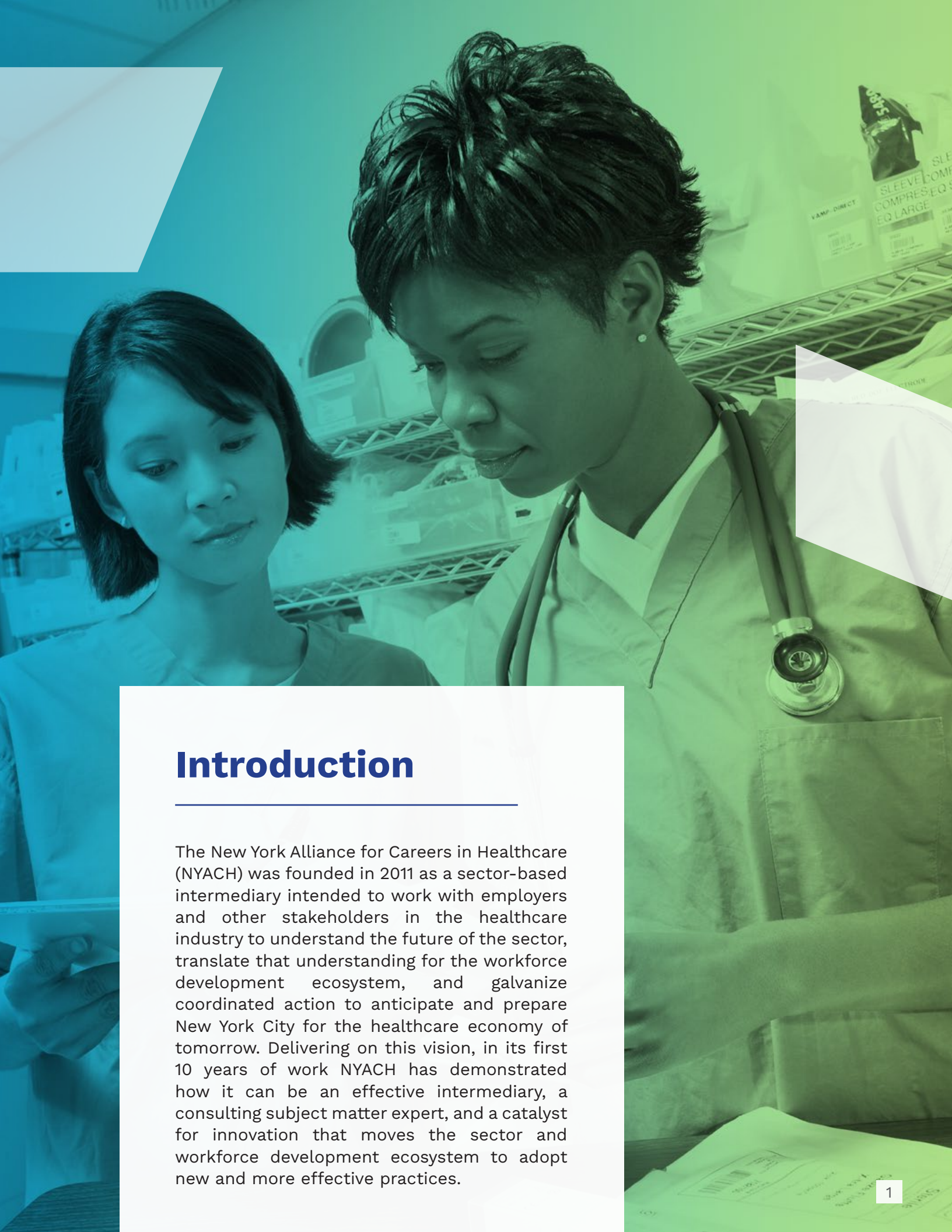


Introduction

The New York Alliance for Careers in Healthcare (NYACH) was founded in 2011 as a sector-based intermediary intended to work with employers and other stakeholders in the healthcare industry to understand the future of the sector, translate that understanding for the workforce development ecosystem, and galvanize coordinated action to anticipate and prepare New York City for the healthcare economy of tomorrow. Delivering on this vision, in its first 10 years of work NYACH has demonstrated how it can be an effective intermediary, a consulting subject matter expert, and a catalyst for innovation that moves the sector and workforce development ecosystem to adopt new and more effective practices.

Throughout the COVID-19 pandemic, NYACH was well-positioned to leverage its historical work and its excellent longstanding relationships to help bridge the gap between local government and the healthcare industry, ensuring our healthcare system was heard and supported, and–where possible–that emergency programs were designed to serve the real needs of both businesses and workers in a time of unprecedented need. As the urgency of the pandemic subsides and NYACH reflects upon a decade of accomplishment, it is not nearly enough to celebrate our successes or to document lessons learned, as the healthcare sector–both its businesses and workers–continues to be in serious need of support. NYACH is steadfast in its commitment to the sector at this current moment, bringing our relationships, expertise, and capabilities to today's acute challenges while investing for the long-term needs of tomorrow.

This report is a look back at the 10 years since NYACH's founding and a look forward to NYACH and industry priorities going into 2022 and beyond. The report begins with context for the healthcare industry and its transformation to value-based care as well as NYACH's founding, advisory structure, and approach. The report then moves to discuss 10 years of innovation and impact, including a discussion of NYACH-sponsored research, the foundational articulation of Core Competencies, and six workforce innovation case studies. The report then describes NYACH's work during the COVID-19 pandemic, and concludes with five priorities for NYACH's work and the healthcare economic and workforce development ecosystem going forward.

Healthcare Reform & NYC's Healthcare Landscape

Overview

Think about someone you know who has gone through a health crisis. Maybe the person is a family member or close friend, or perhaps it was you yourself. Maybe the health crisis was acute–short in duration and particularly challenging–or maybe it was simply the difficulties of managing a chronic disease, substance use, or a mental health challenge.

How many times did that person have to tell their story? How many health professionals or support staff working in a healthcare setting did they need to interact with? In how many different settings did they receive care? Were they in their home, at a community health center, or in an emergency room? Did they see a primary care provider or a specialist? Maybe the person had a lengthy stay at a hospital or a nursing home. Maybe they needed to return to a hospital a few days or weeks after a first visit.

How much money did it cost them? How much did it cost insurance? How much wasn't paid by anyone and simply stayed as a cost to the healthcare delivery system?

How challenging was the experience for the person? In their time of need, did the healthcare system ease their suffering, or did it make the experience more frustrating? How about the burden on loved ones and family caregivers?

Undoubtedly, some of these experiences were positive and helpful, but when capturing the operational and administrative complexity a patient faces, it is painfully clear that New York City (NYC) (and the whole country) needs a better healthcare system. It is also clear that any attempt at improving the healthcare system requires widespread collaboration and compromise among stakeholders who often have competing economic interests and values. There have been many efforts to change the healthcare service delivery system over the past 20 years–the implementation of medical advances and evidence-based practices, technological innovation, the creation of new health financing models, targeted efforts to improve patient experience, and many other aspects of reform. At its core, however, healthcare reform looks at the health, cost, and the experience of health in our communities and says that today's system does not work.

For that loved one who went through a health crisis, what if all of the health professionals they interacted with were able to simply talk to each other? What if services were organized in a way that helped them feel empowered rather than diminished?

And now take into account the effect of the COVID-19 pandemic, where the complexity of care faced by that patient in crisis is now compounded by a cascade of challenges that impact nearly every aspect of healthcare and the businesses and workers responsible for delivering it.

The NYC Healthcare and Workforce Development Ecosystem

New York City (NYC) has a wealth of healthcare resources: everything from world-renowned academic medical systems, to hundreds of community and home-based care organizations, to strong industry associations, advocacy groups, and labor unions. Similarly, NYC has a robust healthcare workforce development ecosystem with strong private and government funding supporting community-based bridge and vocational programs, academic degree and continuing education programs, union-sponsored programs, and programs run directly by employers.

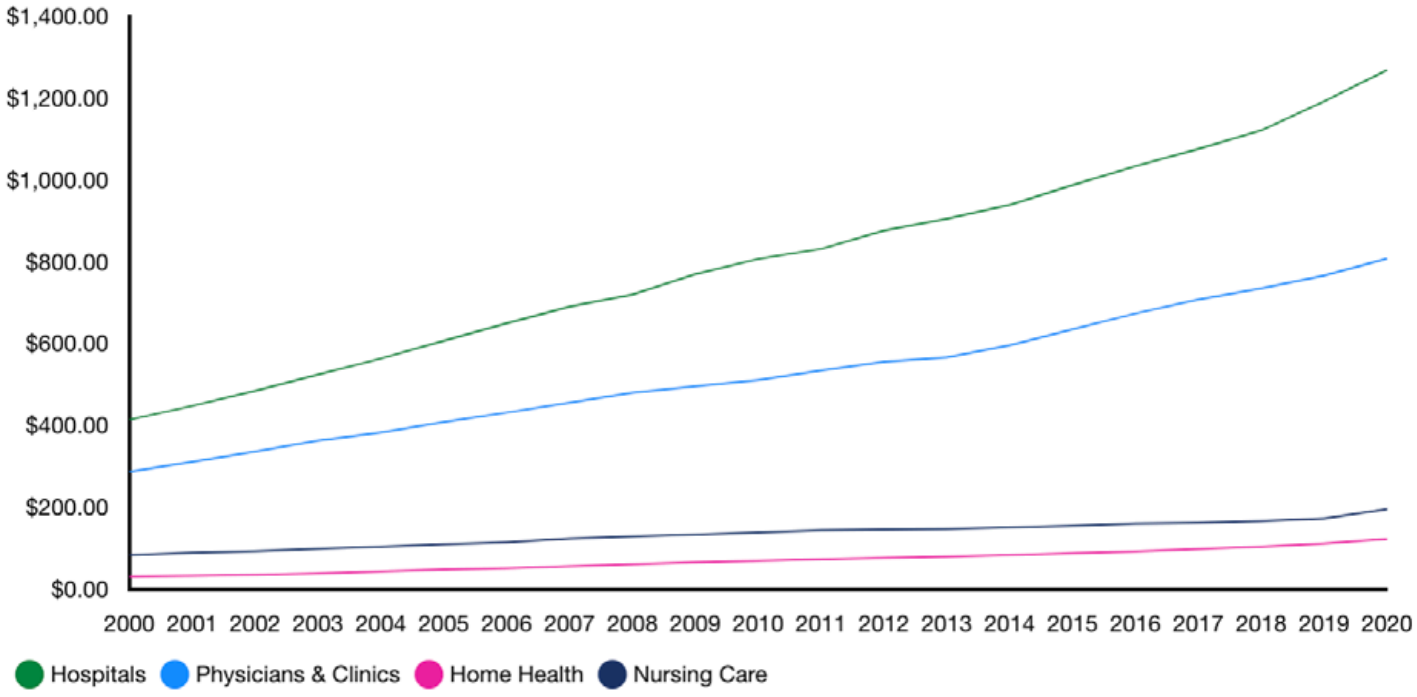
At the same time, NYC has deep inequity in its distribution of resources and its corresponding impact on health. Over and over again it is the same New Yorkers, predominantly people of color, who have to suffer the most severe consequences of the inadequacies of NYC's health and social supports system. The pre-pandemic distribution of the disease burden of asthma, diabetes, cardio-vascular disease, or substance use intersects with the incidence of COVID-19 death, pandemic job loss, and vaccine adoption in our city. A correlation that also tracks with poverty, the number of healthcare facilities and doctors in a neighborhood, the accessibility of social services, the availability of healthy food options and many more population health challenges.

In addition, the healthcare sector has an inequitable distribution of resources within the sector, with most funding and attention going to name-brand hospitals and comparatively less going to community health centers or long-term care providers. Data for the national trend can be found in the chart below from the Kaiser Family Foundation,[1] and data from NYC, while less publicly available, follows the same trend.

1 Peterson-KFF. (n.d.). National Health Spending Explorer. Health System Tracker. Retrieved from https://www.healthsystemtracker.org/health-spending-explorer/

FIGURE 1. Health expenditures 2000 - 2020

On Hospitals, Physicians & Clinics, Home Health, Nursing Care by All Sources



This inequitable distribution of funding leaves small community hospitals, community-based clinics, nursing homes, and homecare agencies continually on unstable financial footing, a vulnerability that extends to well before the onset of the COVID-19 pandemic. Similarly, as these businesses are financially fragile, their workers are paid less than their large hospital counterparts.

From a macro-level, there are over 750,000 people in NYC who work in healthcare across care settings[2] and even more who work in our social service nonprofit sector. It is often observed that the healthcare sector employs a diverse workforce that is increasingly reflective of the diversity of the patient population. While we celebrate the demographic diversification of the pipeline, the sheer volume of workers can obscure unevenness in how education, titles, and compensation are distributed, which not surprisingly tracks with trends of race and gender inequity in our greater society.

NYC's healthcare resources were severely taxed by the pandemic, which only further exacerbated the inequities in how they are distributed. Businesses had higher costs and reduced revenue, such as increased PPE expenses and reduced elective care. Healthcare workers continued to show up day after day on the frontline and are now suffering from burnout and acute staffing shortages. Both the early pandemic costs and present day workforce challenges are more acutely felt at institutions that serve NYC's most at-risk populations and neighborhoods,[3] as safety net hospitals saw more COVID-19 patients that exhausted their already thin profit margins, which further challenges their ability to compete for an in-demand workforce.[4]

At the same time, all New Yorkers were taxed by the pandemic. COVID-19 had a dramatic impact on mental health,[5] and NYC unemployment soared to 20% at its peak during the pandemic and has struggled to recover, with unemployment still elevated. This matters both to our families and neighbors facing harsh economic times, but also in the kind of healthcare resources those people need. NYC Medicaid enrollment grew by ~22% during the pandemic, an addition of roughly 750,000 New Yorkers.[6] This means that over 47% of NYC residents are now on Medicaid, almost half of the city. In addition to the social and economic burden of increased poverty, increased need for Medicaid services means ever increasing burden on the healthcare safety net system and its workers.

All health professionals–from doctors and nurses to janitors and homecare workers–continued to show up for their patients, demonstrating more clearly than ever how their work provides a universal public health value. In exchange, it is our duty to ensure they have adequate resources and recognition extending to every care setting and every type of worker.

2 The total number of healthcare workers in NYC is challenging to count accurately, as data sets vary in how they categorize workers: in industry-based data workers can be labeled healthcare, human services, or even government workers depending on their occupation and setting. If instead, you try to count based on healthcare-related occupations, you can get a more accurate count of clinical workers, but it becomes impossible to can an accurate count of non-clinical workers – both those in professional administrative roles as well as those in support roles such as environmental services, dietary, security, etc. NYACH uses 750,000 as an estimate based on available data and what we know about the local labor market.

3 Caress, B. (2020, April 29). Covid-19 and Hospital Inequality; Why It's Getting Worse, and How to Fix It. The New School: Center for New York City Affairs. Retrieved from https://www.centernyc.org/urban-matters-2/2020/4/28/covid-19-and-hospital-inequality-why-its-getting-worse-and-how-to-fix-it

4 Coughlin, T. A., Ramos, R., & Samuel-Jakubos, H. (2020, December). Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/103483/safety-net-hospitals-in-the-covid-19-crisis-how-five-hospitals-have-fared-financially_0_0.pdf

5 NYC Health, Epi Data Brief: Impacts of COVID-19 on Mental Health in New York City, 2021 (2021). Retrieved from https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf.

6 NYS Medicaid Enrollment Databook. (2022, February 7). Retrieved from https://www.health.ny.gov/health_care/medicaid/enrollment/historical/all_months.htm.

Healthcare Reform

New York City (NYC), and for that matter the healthcare industry, does not exist separate and apart from national challenges and forces, a reality brought into greater relief during the pandemic.

Before the turn of the 21st century, the healthcare financing mechanism and its workforce had largely stabilized. Employer-based insurance had become the norm after World War II,[7] fee-for-service reimbursement had become the payment norm across the industry, and the types of jobs (largely unionized) that were employed in hospitals and other healthcare settings had settled on many of the same titles we see used today. Starting in the late 1990s and early 2000s, however, technological changes such as electronic medical records were becoming more common and there was a growing realization that healthcare had to operate differently for the sake of both community health and cost outcomes.

By 2010, with the passage of the Affordable Care Act, the tidal wave of changes in healthcare were coming into focus. Policy makers and industry leaders alike were lining up behind the triple aim[8] as a rallying cry for healthcare reform: simultaneously improving patient experience and population-based quality care while reducing costs. Similarly, we began to see the system take up a widespread, if slow, transition from a fee-for-service (FFS) financial model to value-based payments (VBP) model, which was seen as a promising way to incentivize a better system. In brief, a FFS financial model pays for each healthcare service individually, incentivizing

healthcare professionals and organizations to provide as many services as possible, which may not be in the best interest of the medical and/or social health of the patient or the financial health of the sector. In contrast, a VBP model pays for the "value" of health services. For example, under VBP, a network could receive payment if it is able to reduce the rate of uncontrolled diabetes in a population. In theory, VBP allows healthcare providers to prioritize good health outcomes and still get paid. In practice, many organizations use a combination of FFS and VBP models, as implementing effective VBP models is incredibly challenging, and it is not suited to all types of care and circumstances.[9]

This reform was largely attempting to address rising healthcare costs across the United States, which have risen faster than inflation and GDP growth for decades without a commensurate improvement in quality of care. The following three charts are pulled from a 2021 analysis by Eric Schneider and colleagues at the Commonwealth Fund[10] and illustrate challenges in United States healthcare costs, quality, and equity.

7 Carroll, A. E. (2017, September 5). The Real Reason the U.S. Has Employer-Sponsored Health Insurance. The New York Times. Retrieved from https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html.

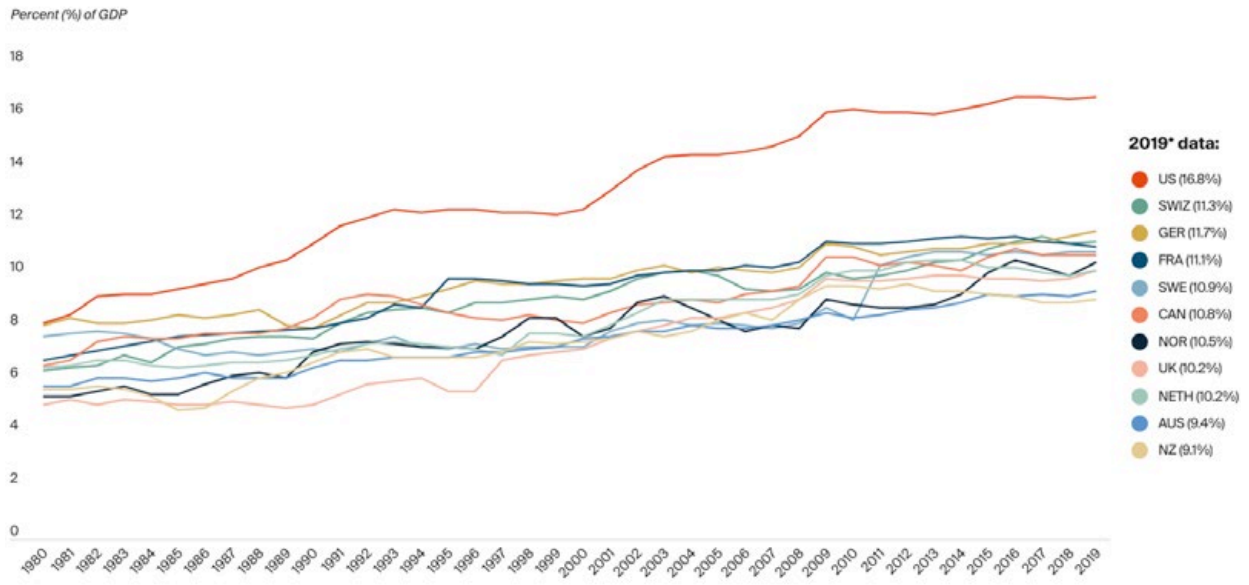
8 The Institute for Healthcare Improvement's (IHI) "Triple Aim" is a framework that advocates for the development of new health system designs that simultaneously:

- Improve the patient experience of care (including quality and satisfaction);
- Improve the health of populations; and
- Reduce the per capita cost of health care.

9 For a good overview of related topics, NYACH recommends reading the Population Health Curriculum Guide and Value-Based Payment Fundamentals created by the Greater New York Hospital Association (GNYHA) in 2017-18.

10 Schneider, E. C., Shah, A., Doty, M. M., Tikkanen, R., Fields, K., & Williams II, R. D. (2021). (rep.). Mirror, Mirror 2021: Reflecting Poorly Health Care in the U.S. Compared to Other High-Income Countries. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly.

FIGURE 2. Health care spending as a percentage of GDP, 1980-2019

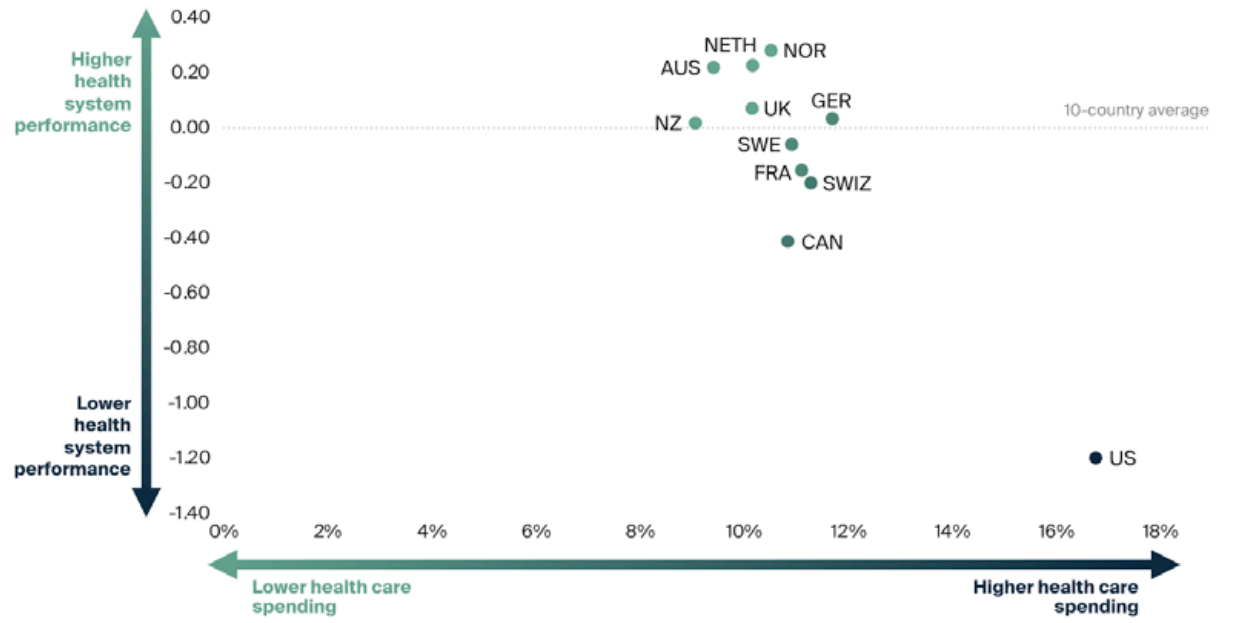


Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP refers to gross domestic product.

* 2019 data are provisional or estimated for Australia, Canada, and New Zealand. | Data: OECD Health Data, July 2021.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

FIGURE 3. Health care system performance compared to spending

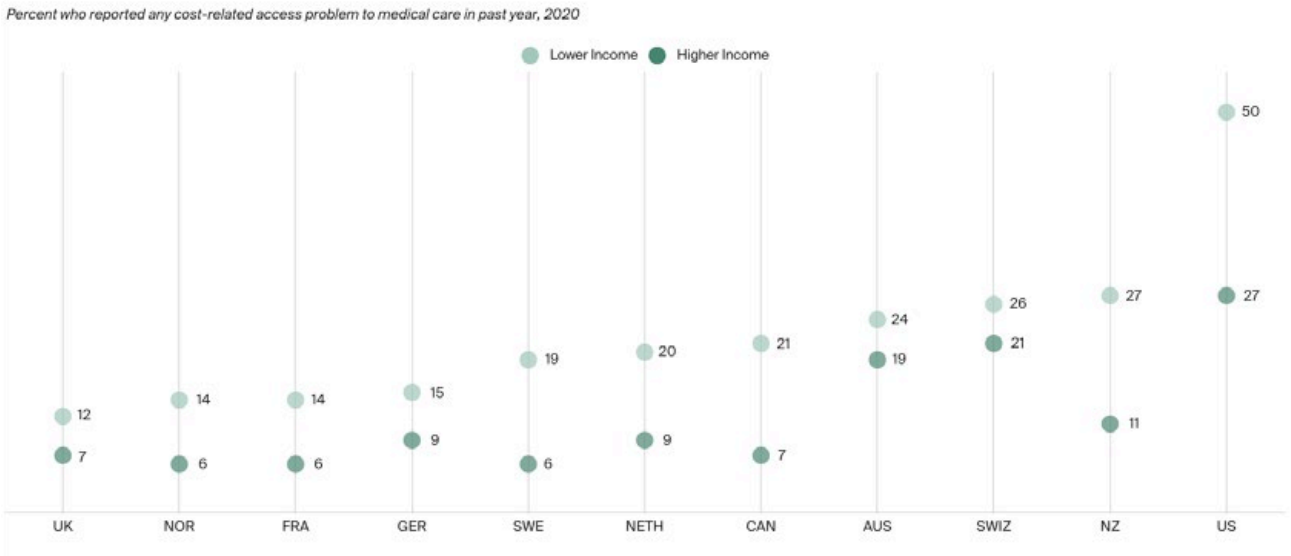


Note: Health care spending as a percent of GDP. Performance scores are based on standard deviation calculated from the 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Spending data are from OECD for the year 2019 (updated in July 2021).

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

FIGURE 4. Cost-related access problems affect low populations, especially in the U.S.



Definition of cost-related access problem: Skipped needed doctor visits, tests, treatments, follow-up, or prescription medicines because of cost in the past year.

Data: 2020 Commonwealth Fund International Health Policy Survey.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

One prominent example of this sort of transformation was the 2014-2020 New York State Delivery System Reform Incentive Payment (DSRIP) program, a Medicaid-funded demonstration project using ~$8 billion to build the industry-based infrastructure necessary to improve population health and perform against value-based financial arrangements.[11] Importantly, not only did DSRIP provide the funding and organizational structure to adopt new financial models, clinical workflows, and enabling technologies, but it explicitly identified workforce development as necessary for successful transformation. While final DSRIP workforce spend numbers are not publicly available, as of the midpoint in 2017, provider networks had spent a collective $246.5 million of an initial $415 million commitment towards workforce development efforts.[12] Importantly, and as many NYC-based workforce development professionals will remember, this infusion of funding and outcome-based orientation created a rich opportunity for industry collaboration and programmatic innovation.

11 The New York State Delivery System Reform Incentive Payment (DSRIP) program was an innovative demonstration project approved by the federal Centers for Medicare and Medicaid Services (CMS) in 2014 under the authority of an 1115 waiver and overseen by the NYS Department of Health (NYS DOH). This Medicaid redesign effort involved the creation of 25 Performing Provider Systems (PPS) across the state, which were broad networks of health and human service organizations who worked together to build more coordinated care, adopt value-based payment models, and improve population health outcomes for the Medicaid population. These networks usually included organizations from across the health and social service delivery spectrum, including hospitals, ambulatory care, long-term care, and social service community-based organizations. Each PPS had a population of Medicaid patients they were responsible for in their region, a total amount of funds they were eligible to receive based on process and performance measures, and specific clinical/population health projects they had selected to advance (such as improving diabetes care or improving care coordination). In August 2021, the independent evaluator for NYS's DSRIP program released its final evaluation, which found the program had significant positive impacts on the health of Medicaid patients and cost of the program. For additional information, NYACH suggests reading the report put out by NYS DOH, *DSRIP Stories of Meaningful Change in Patient Health*, and the companion review of promising practices created by the United Hospital Fund at the request of NYS DOH.

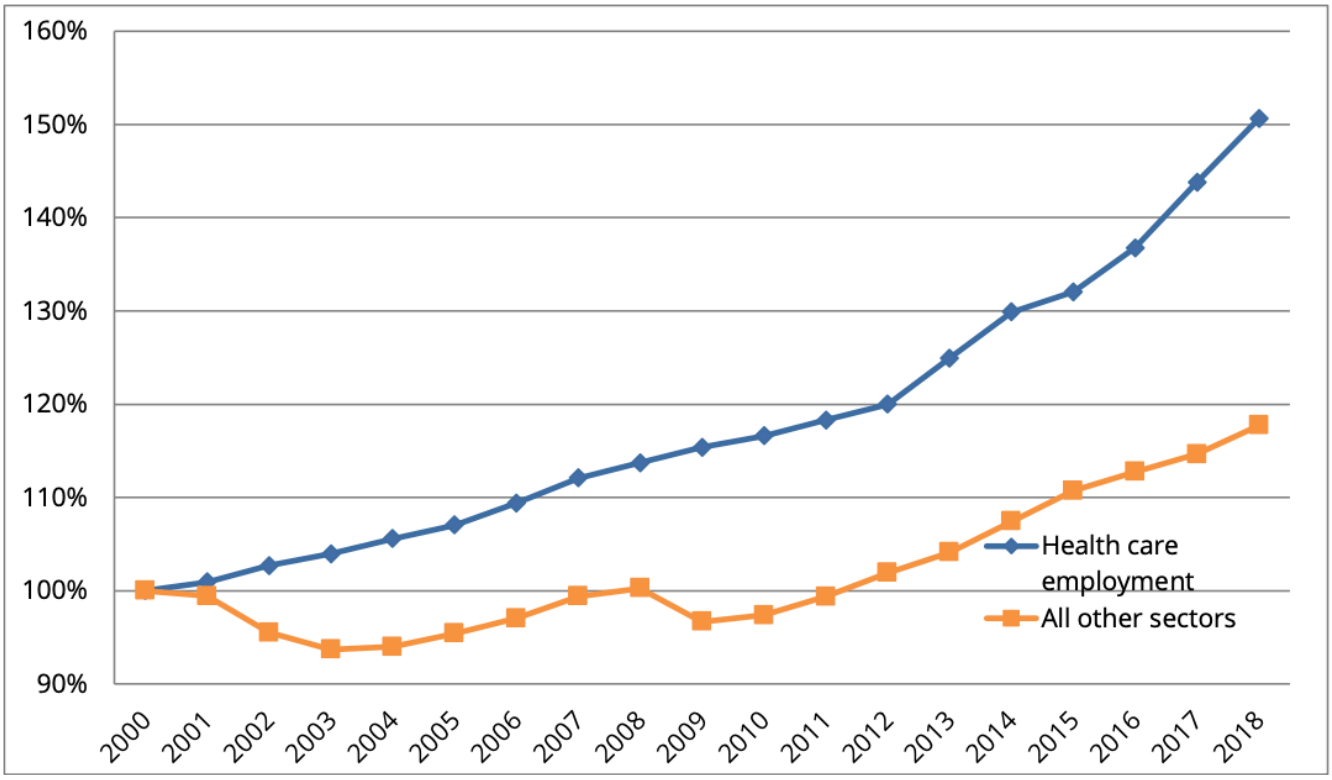
12 New York State Department of Health, DSRIP Workforce Impact Analysis Report (2018). Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/workforce_docs/2018-02_workforce_impact.htm.

Healthcare Workforce Trends

Healthcare employment has grown steadily in New York City (NYC) since 2000, and, at least before the COVID-19 pandemic, that growth was faster than employment growth in all other sectors and decoupled from economic downturns. On closer look, however, it becomes clear that almost all employment growth happened in homecare with some growth in ambulatory care, trends NYACH had anticipated and planned for as it was the logical result of healthcare reform efforts moving care away from inpatient settings and intersecting with the known reality of NYC's aging population. These trends are illustrated in the following two charts, which were created by the Center for Health Workforce Studies and are available in their comprehensive 2020 report on New York State (NYS) healthcare workforce trends.[13]

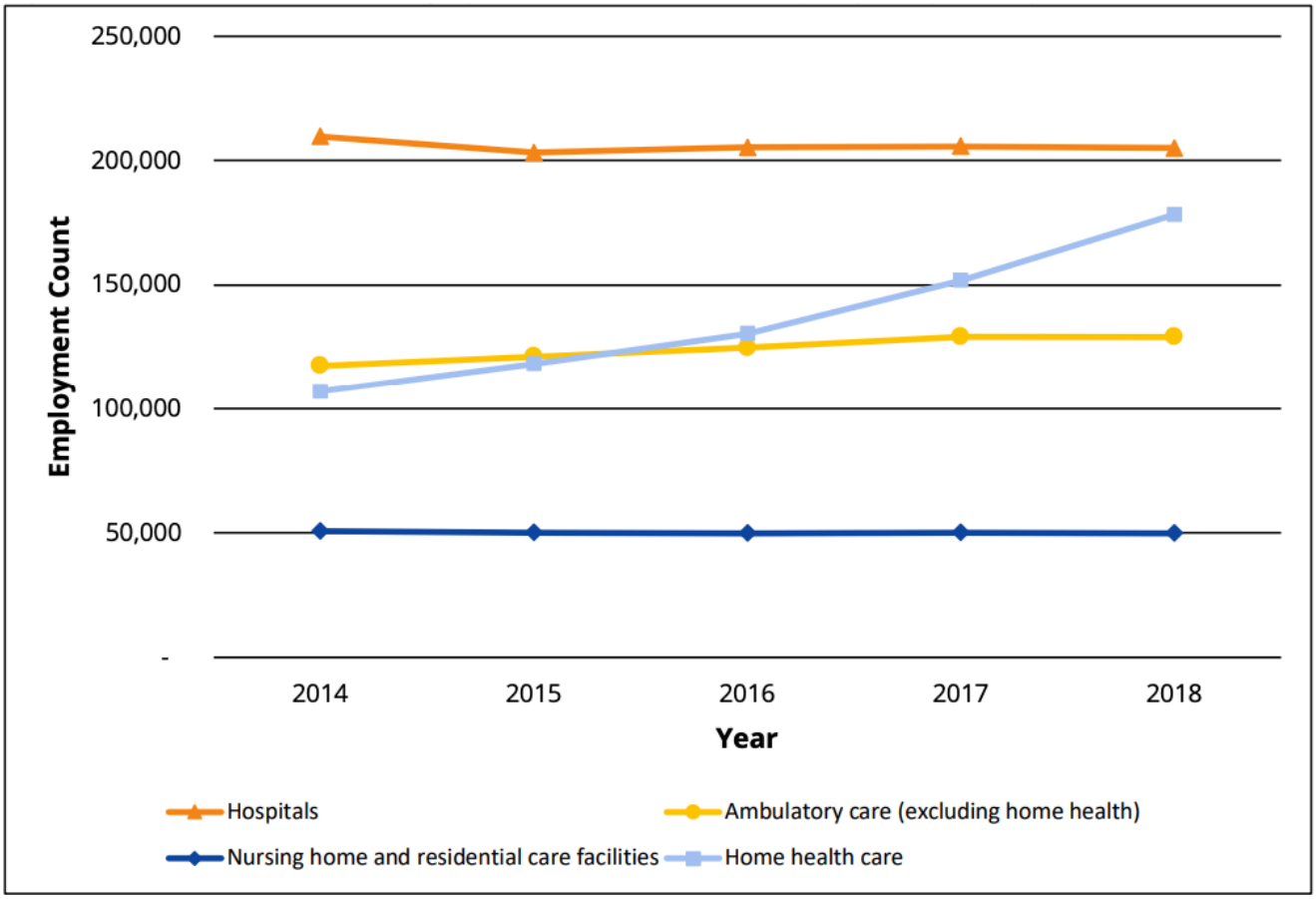
13 Stiegler K, Martiniano R, Moore J, et al. (2020). (rep.). The Health Care Workforce in New York State: Trends in the Supply of and Demand for Health Care Workers. Center for Health Workforce Studies. Retrieved from https://www.chwsny.org/wp-content/uploads/2020/04/NY_Health_Workforce_Tracking_Report_2020.pdf.

FIGURE 5. Employment growth in the New York City region, 2000-2018



Source: New York State Department of Labor, Quartlery Census of Employment and Wages.

FIGURE 6. Health care sector employment in the New York City region by setting, 2014-2018

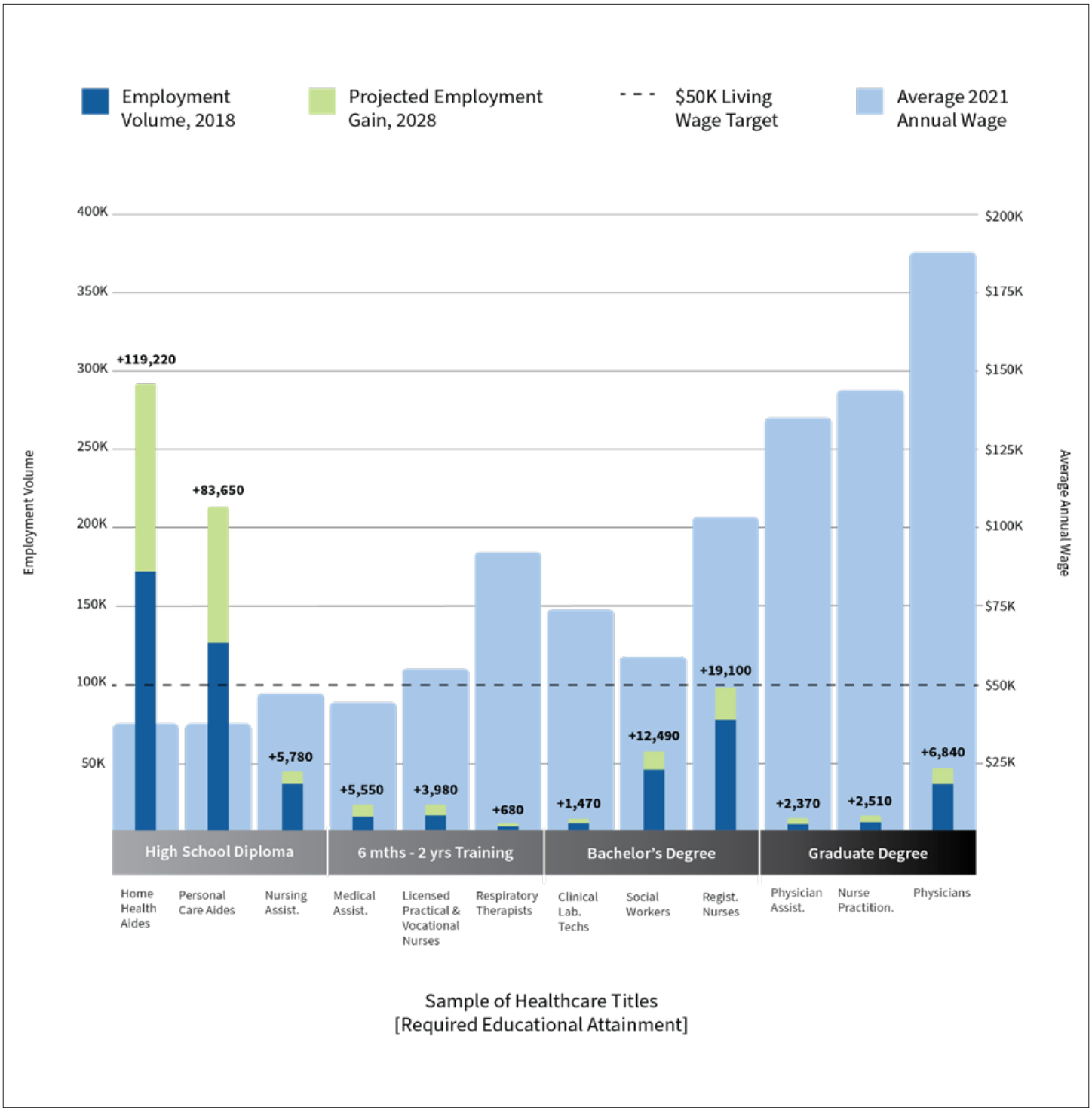


Source: New York State Department of Labor, Quartlery Census of Employment and Wages.

One particularly stubborn challenge in healthcare workforce development is that the staffing models that have now been in place for decades involve a high volume of low-paying jobs and many high-paying jobs, but relatively few jobs in the middle-income range. To further complicate this uneven distribution, the healthcare staffing structure–largely driven by patient safety regulation–is strongly bound to educational attainment, with the majority of low-wage jobs requiring only a low level of educational attainment such as a high school diploma (e.g. Home Health Aide), while most high-paying titles requiring a high or very high level of education, meaning a bachelor's or graduate degree (e.g. Nurse or Doctor). There is very little in the way of jobs that require six months to two years of education–jobs that in other sectors might afford someone without prior education a pathway to earning a living wage, or accelerated degree programs that give credit for prior work experience. This challenge is illustrated in the chart on the next page, which pulls data from the NYS Department of Labor 2018-2028 projections about three common occupations in each educational band.

Imagine what the barbell structure looks like on the ground for workers without a bachelor's degree. No matter how smart, hard-working, or passionate about the health of your patients and communities you may be, the only way to earn more in healthcare is by going back to school. This is an obvious roadblock for someone in a low-wage healthcare job, which, despite its rate of pay, is often incredibly physically and emotionally demanding. It might require juggling multiple part-time healthcare jobs across the five boroughs (as many Home Health Aides do) while still relying on social services to help you and your family stay afloat; the prospective costs and other demands of pursuing a college degree are daunting.

FIGURE 7. NYC Projected Healthcare Employment Growth 2018-2028 & Average Wages



Source: NYACH analysis of NYS Department of Labor Long-Term Occupational Employment Projections, 2018-2028

And while the healthcare system continues to implement value-based reforms—focusing on new technology and models of care—we need to ensure that the workforce development ecosystem is brought along and in lockstep with new industry needs. While NYC certainly has success cases in healthcare career advancement, especially with the support of union-affiliated training funds, these are exceptions to the norm. Due to the fact that healthcare career advancements are so tied to educational attainment, it is an especially difficult workforce development challenge that requires we move industry and academia simultaneously and that we do so at scale.

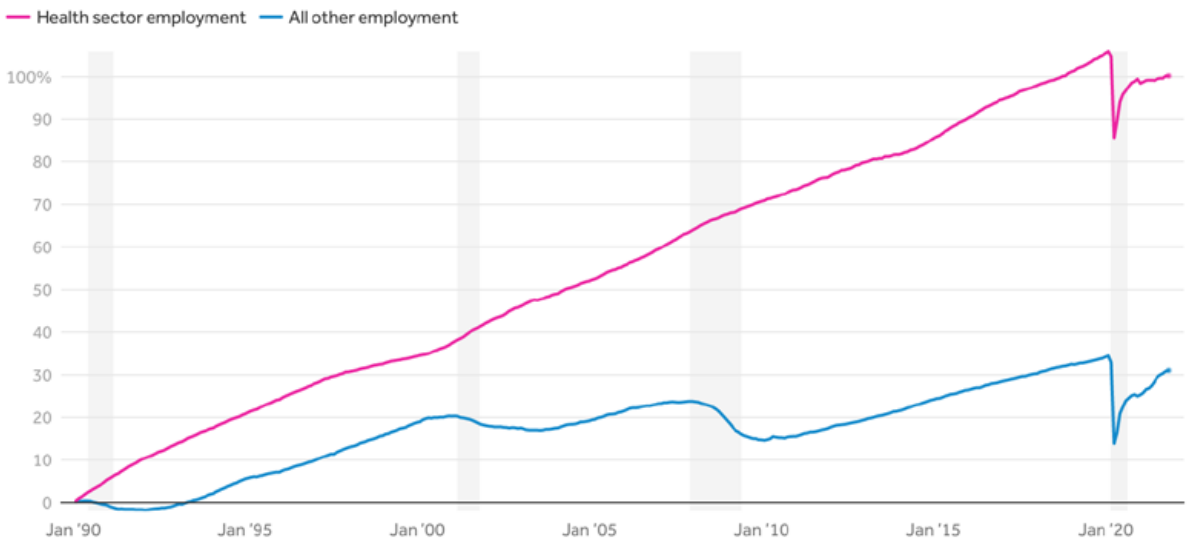
We need to create efficient pathways for advancement that help hard-working New Yorkers get into high-paying jobs at scale; we need to create more jobs in the middle that are easier to reach; and importantly, we need to ensure that jobs requiring a lower level of educational attainment–and which are essential to our healthcare delivery system–are nevertheless good jobs, in which workers can find fulfillment and earn a living wage, and which are structured in ways that do not reinforce pre-existing systemic inequities.

The pandemic also exacerbated these workforce challenges. When more money became available, it was largely invested in inpatient settings. The lack of workers in shortage titles that require longer term education or training across all settings of care became more greatly felt. And furthermore, the barriers between siloed elements of healthcare and workforce development systems became more obvious than ever.

Unfortunately, unlike previous economic downturns, the healthcare industry was substantially less insulated from the economic impact of the COVID-19 pandemic and the sector has seen dramatic job loss, especially in nursing homes. While local NYC data is not available as of writing, it is safe to assume that the national trend found in the three charts below from the Kaiser Family Foundation[14] applies equally to NYC.

14 Wager, E., Amin, K., Cox, C., & Hughes-Cromwick, P. (2021, December 10). What impact has the coronavirus pandemic had on health employment? Health System Tracker. Retrieved from https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment/

FIGURE 8. Cumulative change in health sector and non-health sector employment since January 1990

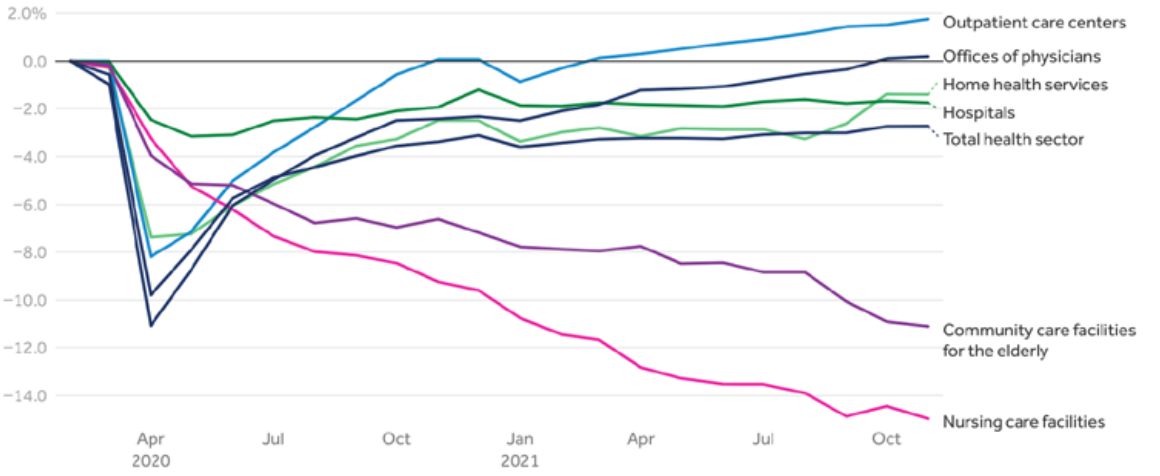


Note: Data from October and November 2021 is preliminary. Grey regions represent periods of economic recession.

Source: Bureau of Labor Statistics

Peterson-KFF Health System Tracker

FIGURE 9. Cumulative % change in health sector by setting since February 2020, seasonally adjusted

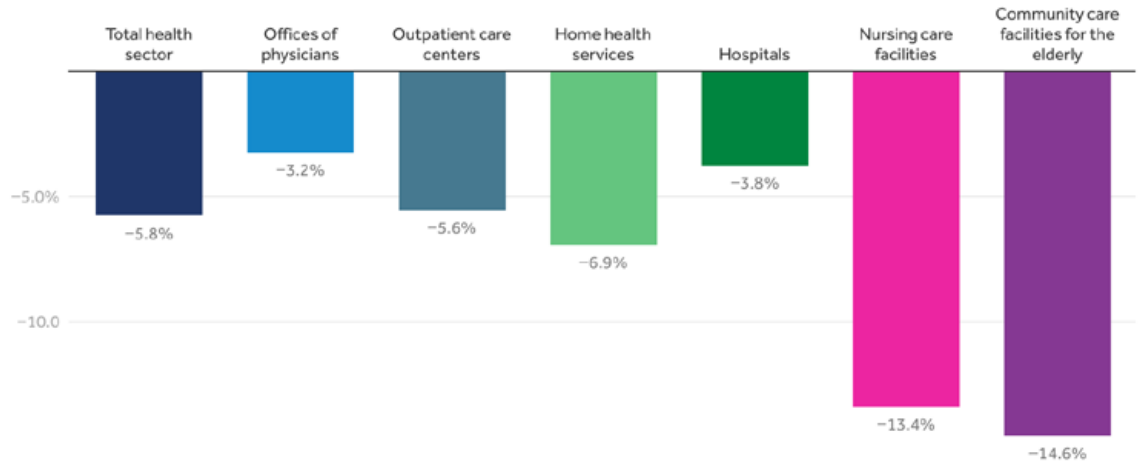


Note: Data for October and November 2021 are preliminary.

Source: Bureau of Labor Statistics Current Employment Survey (CES)

Peterson-KFF Health System Tracker

FIGURE 10. Percent difference in November 2021 health employment by setting, actual vs. projected (in the absence of a pandemic), seasonally adjusted



Note: November 2021 data are preliminary. Projected values are calculated by applying the average monthly growth rate between January 2017-January 2020 to March 2020 through the latest month.

Source: Bureau of Labor Statistics Current Employment Survey (CES)

Peterson-KFF Health System Tracker

Both at NYACH's founding and today, healthcare businesses need workers, New Yorkers need jobs, and fundamentally the industry itself is changing. At the same time, the NYC healthcare workforce development ecosystem is both crowded and siloed, with disconnected involvement from employers, industry associations, educational institutions, nonprofit workforce development organizations, unions and union training funds, and government. While a fragmented workforce development ecosystem might have been sufficient if the needs of the industry had continued in the same way they had for much of the previous 100 years, a fragmented ecosystem with multiple and various incentives cannot notice or adapt to the speed of change the healthcare industry needed then and needs again today.

Who is NYACH?

The New York Alliance for Careers in Healthcare (NYACH) was formed in 2011 as a collaboration between the NYC Workforce Funders and the NYC Department of Small Business Services with system-level challenges in mind. At its founding, NYACH was imagined as a sector-based intermediary, intended to work with employers and other stakeholders to understand the future of the industry, translate that understanding for the workforce development ecosystem, and galvanize coordinated action to ensure a better future.

To realize this vision, NYACH began its work by creating a Partners Council, an Advisory Group structure, and a Common Agenda.

NYACH Partners Council

The perspective of the NYACH Partners Council is foundational to NYACH's work. The group, which has remained stable in membership since NYACH's founding, includes representatives from industry, education, and organized labor across the healthcare and workforce development ecosystems.

The NYACH Partners Council consists of the following members:

- 1199SEIU Training and Employment Funds
- City University of New York (CUNY)
- Community Health Care Association of New York State (CHCANYS)
- Greater New York Hospital Association (GNYHA)
- PHI
- Southern New York Association

Subsector Advisory Groups

NYACH also convenes three employer-based subsector advisory groups, one for the hospital/inpatient subsector, one for ambulatory and primary care, and one for long-term services and supports. These advisory groups, which together include more than 50 major local healthcare employers, ensure that NYACH understands what is happening in the industry, and that initiatives we support or design are industry informed. NYACH will also at times convene topic specific workgroups, such as when we work with specialty populations (such as young adults or recent immigrants) or specific occupations (such as in behavioral health or nursing).

Common Agenda

One of the early acts of the NYACH Partners Council, was to create a Common Agenda, which articulated a set of goals for joint action. This Common Agenda was agreed to and made public in early 2015.

Priorities articulated in the NYACH Common Agenda and agreed to by the NYACH Partners Council in 2015

1. Ensure that training and education meets the healthcare industry's needs
2. Support access to career opportunities and advancement for in-demand occupations for low-income and unemployed individuals
3. Develop multi-stakeholder partnerships and coordination across the healthcare workforce system
4. Serve as a platform to inform educational programming, policy, and advocacy

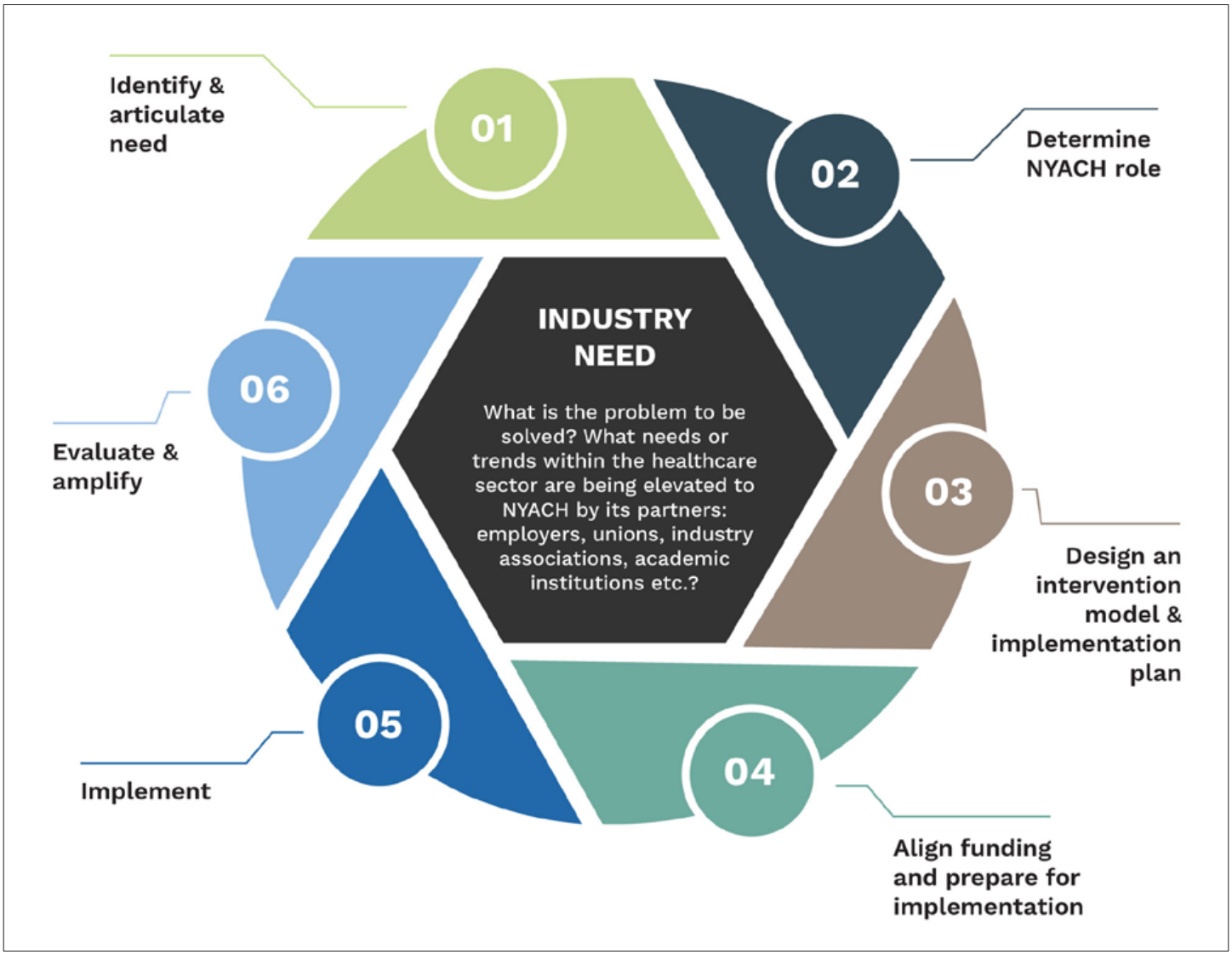
The NYACH Common Agenda, as well the advice and insight of Partners Council and advisory group structure, has provided NYACH with critical direction and perspective as we have tried to support New York City's healthcare sector and workforce development ecosystem since our founding in 2011.

Industry Partnerships as Innovation

Over the past 10 years, NYACH has honed a strategic orientation and approach in how it decides, builds, and executes its innovative initiatives. NYACH understands that for a system as large as healthcare, there is no one-size fits all solution. Over the years, we have designed careful interventions that advance the healthcare industry's transformation to value-based care models, while at the same time supporting job quality for lower paid workers, expanding the availability of jobs that require a middle-level of education and training, and creating accessible pipelines for workers into higher paying jobs.

NYACH's approach to identifying and intervening on system challenges is, at its core, an evidence-based and industry-informed process. NYACH begins by listening to its industry partners and helps to articulate and scope a shared need. Then, should it fall within NYACH's capacity and mission, we propose and build an intervention, ultimately helping the system learn from the results of that intervention. See below for a more detailed articulation of NYACH's process.

FIGURE 11. NYACH's Process



NYACH Intake Criteria

Is addressing the problem in the public interest?

- Does the problem matter to businesses and workers in NYC's healthcare service delivery system?
- Would addressing the problem make for a fairer, more prosperous, and healthier NYC?

Is there a systems change opportunity?

- Can an intervention successfully change the behavior of the system in a way that is better and that sticks?
- Is there a viable offramp for NYACH involvement?

Is NYACH scoped or resourced sufficiently to meet the problem?

- Does the staffing, funds, or authorization of NYACH match the scale or complexity of the problem at hand?

NYACH Process Steps

01 Identify & articulate need

- Work with partner & employer network to understand the scope/scale of the challenge
- Validate and research the challenge, building an understanding of how it operates within the NYC economic and workforce development ecosystem

02 Determine NYACH role

- Determine what role, if any, NYACH ought to have in addressing this challenge
  - Does it fit within NYACH's intake criteria?
  - Is NYACH well-suited to solve this challenge, or are there other stakeholders better positioned to tackle it?

03 Design an intervention model & implementation plan

- Design an industry-informed intervention model
- Determine appropriate timeline, implementation partners, and data collection plans

04 Align funding and prepare for implementation

- Ensure there is buy-in from funding partners in government and/or private philanthropy
- Ensure there are firm implementation commitments from industry

05 Implement

- NYACH may manage contracts, grants, or programs directly
- Alternatively, NYACH may consult to the implementation of a partner's program

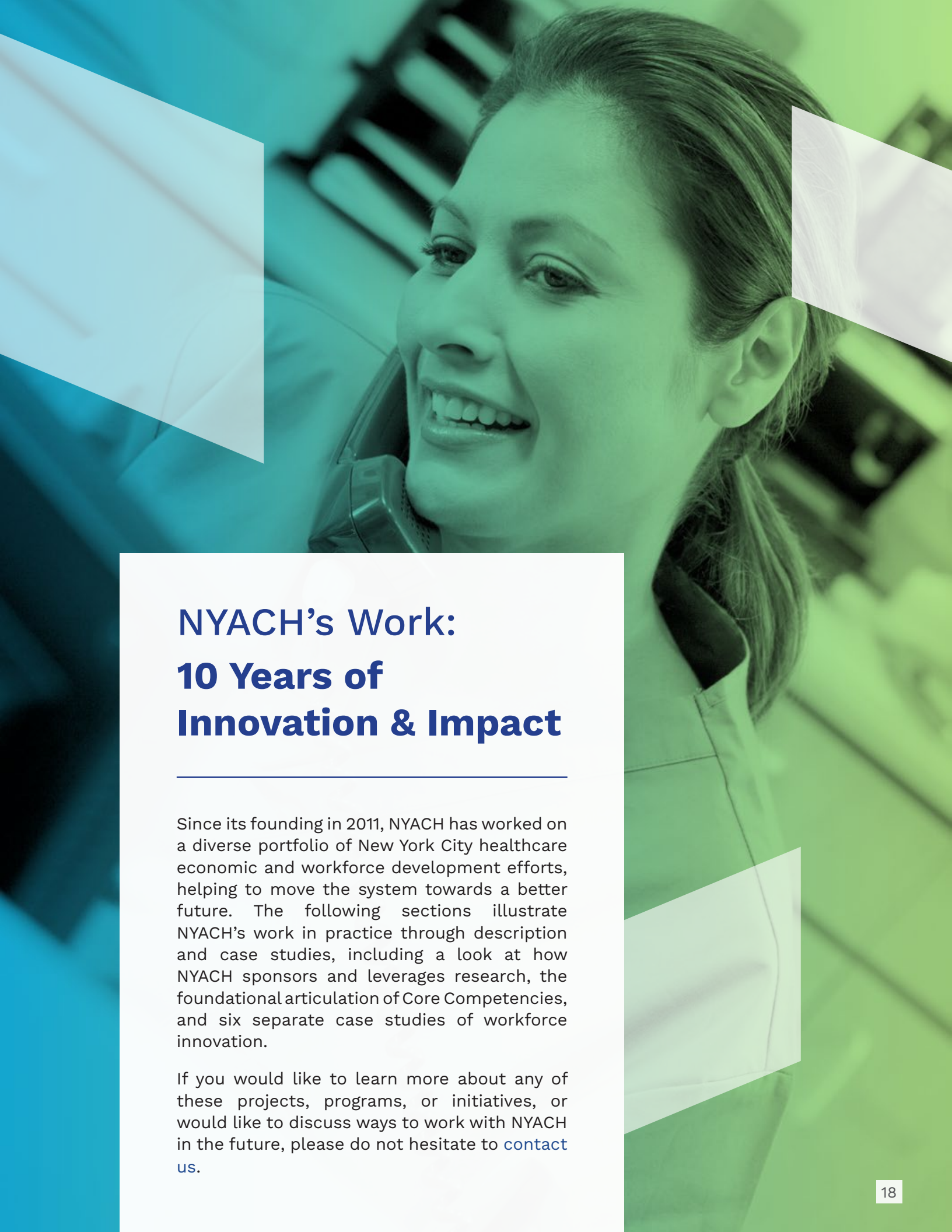
06 Evaluate & amplify

- Analyze data and evaluate the intervention model
- Share results with system partners, particularly those who can scale and embed lessons learned in standard operating practices
- Propose improvements or iterations to intervention model, as needed

NYACH is specifically interested in enabling long-term system change and in working on things that overcome inertia to nudge the New York City (NYC) healthcare industry and workforce development ecosystem in a better direction than business as usual. Sometimes that involves directly funding a program as a catalyst for innovation, and at other times it means simply leveraging our convening power or role as a subject matter expert and translator.

In addition to following a standard process, it is also critically important in an ecosystem as vast as NYC that, after every successive project or initiative, partners have more faith in a cooperative process and more trust in NYACH's ability to serve as an intermediary. To that end, NYACH has developed not only a strategic orientation and process, but also a 'relationships-first' approach to partnerships. This style identifies and celebrates collaborative solutions, thereby reinforcing the value of multilateral cooperation, and prioritizes building long-term trusting partnerships over securing short-term programmatic wins.

This industry-informed cooperative, work is needed more today than ever before as the city faces the acute ramifications of the COVID-19 pandemic and tries to tackle deeply rooted systemic challenges. NYACH is excited to take this opportunity and moment of transition to reflect on the past 10 years and, looking forward, to bring its role as an intermediary, its relationships, and its expertise to bear on the urgent and critically important challenges of 2022.



NYACH's Work:
10 Years of Innovation & Impact

Since its founding in 2011, NYACH has worked on a diverse portfolio of New York City healthcare economic and workforce development efforts, helping to move the system towards a better future. The following sections illustrate NYACH's work in practice through description and case studies, including a look at how NYACH sponsors and leverages research, the foundational articulation of Core Competencies, and six separate case studies of workforce innovation.

If you would like to learn more about any of these projects, programs, or initiatives, or would like to discuss ways to work with NYACH in the future, please do not hesitate to contact us.

NYACH-Sponsored Research & Publications

Empirical evidence plays a crucial role in how NYACH does its work, ensuring our attention is directed towards what is really going on in the healthcare system and increasing the lasting impact of piloted solutions. While NYACH works with all sorts of data and analytics collaborators to gather information, there are two areas where NYACH directly sponsors research: market analyses and program evaluations.

First, the market analyses that NYACH sponsors are designed to help define something about the function of the system that is not widely understood and that contributes to an economic or workforce challenge or opportunity. NYACH always begins its work by deeply understanding a challenge before attempting to design an intervention or activating stakeholders to take action. Sometimes the contours of a challenge can be understood simply from talking to industry and workforce partners. In other cases, however, there is something about the way the system works that is not easy to articulate or not quite understood yet. In these cases, NYACH drives research that informs its focus and uses that research to help stakeholders literally "get on the same page" about what a smart investment could look like.

The second type of research that NYACH undertakes are evaluations of innovative workforce programs. Once we move all the way through our process of understanding a problem, building a solution, and piloting that solution on the ground, we need to understand if the solution worked, or if there are lessons learned that should inform a future attempt to intervene on the system challenge. These program evaluations are designed to document lessons learned, celebrate successes, and inform next steps–either for the development of a revised intervention or for scaling the new and better practice.

An index of NYACH-sponsored research and publications is included at the end of this section. Below we spotlight two instances of NYACH-sponsored research to illuminate our research in practice.

RESEARCH SPOTLIGHT:

Identifying Emerging Occupations and Related Skills Gaps

Overview

In 2014, it was clear to NYACH that anticipated funds through New York State's Delivery System Reform Incentive Payment (DSRIP) program would accelerate the industry adoption of population health and value-based care models, and that this would be an opportunity to build smarter workforce practices. To transition to value-based care models, the industry would need to adopt new staffing models and staff behaviors to achieve new performance outcomes in care coordination, patient-centered communication, and clinical quality. The workforce system, however, was largely unaware of this pending influx of funding and attention on these skills and titles. To better understand what these trends looked like on the ground in industry, and to be able to translate these changes for workforce stakeholders in an actionable way, NYACH commissioned the Greater New York Hospital Association (GNYHA) to survey dozens of downstate primary care practices and compile an analysis of their findings.

Key Findings

GNYHA shared the findings of this survey in the report Emerging Positions in Primary Care (2014), which anticipated a 27% overall growth in the primary care workforce in the following two years, and a huge 127% expected increase in need over the same period for a host of new emerging occupations in ambulatory care settings, including: care coordinators, care managers, community health workers, peer support workers, and patient navigators. The research also surfaced the difficulties employers faced in recruiting for these relatively new positions, underscoring the need to standardize job descriptions and related education and experience, and also to support the workforce training pipeline in enabling skills training for both new and incumbent workers in patient communication, teamwork and team-based care, and care coordination. This research was foundational to NYACH's work in emerging occupations over the subsequent years, though it should be added that the industry's early hiring enthusiasm for emerging occupations was later tempered by the realities of revenue and funds flow–some discussions of which are included in later sections of this report.

RESEARCH SPOTLIGHT:

Evaluating the Success of the Certified Recovery Peer Advocate (CRPA) Training and Hospital-based Care Intervention Model

Overview

One way to improve patient engagement and value-based care performance outcomes for hard-to-reach populations is to employ a peer support worker, someone who uses their own lived experience and specialized training to engage patients struggling with a similar health challenge. Peers have been part of the healthcare workforce for decades, but the workforce has largely been disconnected from standard healthcare staffing models. Services have largely been paid for by grants or other short-term funding in lieu of insurance, while the impacts and value of the work were unknown or unclear to other health professionals on a care team (such as a primary care provider).

Excitingly, in 2015, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) announced new statewide certification and educational criteria for peers who work with those with a substance use diagnosis, Certified Recovery Peer Advocates (CRPA). Shortly thereafter, CRPA services became reimbursable by New York State (NYS) Medicaid at an increased rate. Jumping on this opportunity, NYACH and its employer and educational partners created what became the first comprehensive training model for the CRPA role in NYS. Learn more about the CRPA training program on page 31.

Many graduates of this training program were hired by NYC Health + Hospitals (NYC H+H), which also provided input into the training program's creation, as the hospital system was in the middle of designing an emergency department-based pilot program for the incorporation of CRPAs into patient care. Each year, over 13,000 individuals arrive at NYC H+H emergency departments with a substance use diagnosis (SUD), accounting for nearly 40,000 annual visits and necessitating new ways of working with patients to serve this growing need.

NYACH believes that CRPAs can play a key role in patient care, and importantly, that the CRPA occupation can also provide an entry point into the healthcare workforce for individuals with nontraditional employment histories, many of whom have a personal history of substance use and/or former interactions with the criminal justice system. If the comprehensive training program and new staffing model implemented by NYC H+H proved to be effective, we wanted to make sure that that information was evaluated and shared broadly with the industry. With this goal in mind, NYACH partnered with NYC H+H to fund an academic study with researchers at New York University's Steinhardt School to evaluate the impact of the model.

NYC Health + Hospitals ED Peer Pilot Program and Academic Evaluation

CRPAs in this NYC H+H pilot provided services in its emergency department (ED) and served as an introductory bridge from the ED to the SUD treatment clinic. Successful implementation

involved not only recruiting well-trained staff, but also considering how staff would be incorporated into existing staffing models and workflows. This included considerations about the physical workspace, shifts, supervision/training, and integration into preexisting ED workflows.

The academic evaluation included in-depth interviews with CRPAs, supervisory staff, ED staff and administrators, as well as an analysis of Medicaid claims data to evaluate patient outcomes pre- and post-implementation of the pilot program. The evaluation found many implementation lessons learned and best practices to share with the field around implementation and impact, especially around patient experience and engagement. As reflected in the patient quote that serves as the title of the resulting article–"if it wasn't for him, then I wouldn't have talked to them"–CRPAs were able to reach patients who would otherwise have been disinclined to engage with healthcare providers. The evaluation also found the program had modest, yet measurable positive impacts on patient outcomes, particularly for patients with no history of substance use treatment in the last 12 months.

Key patient outcome findings from the early stages of implementation

(For the period covered during the research):

- The likelihood of patients with no history of treatment in the last 12 months entering rehab/detox treatment within the first two months post-ED visit increased from 4.2% to 8.1%.
- The proportion of patients attending counseling sessions also substantially increased, from 9.9% to 13.1% within two months and 11.5% to 17.4% within three–six months, post-ED visit.
- In comparing initiation of medications for addiction treatment (MAT), the program almost doubled the proportion of untreated patients who received MAT from 2.5% to 4.6% within three–six months post-ED visit.
- The proportion of patients receiving methadone increased from .4% to .9% and .7% to 1.9% in months one–two and three–six months post-ED visit, respectively.

Learn more by reading a Summary Report released by NYACH and NYC H+H in 2021, and by reading the academic article published in the Journal of General Internal Medicine.

Research Index

An index of research and publications NYACH was involved with can be found below:

- Final Report of the Evaluation of the NYC Health + Hospitals ED Certified Recovery Peer Advocates (CRPA) Pilot Program (2020)
- Emergency Department Peer Pilot Program Evaluation Summary Report (2021)
- Expanding Nurse Residency Programs Through Regional and Statewide Collaborative Partnerships (2021)
- Hybrid Virtual Home Health Aide Training Pilot: Lessons Learned (2020)
- NYC COVID-19 Emergency Response in Long Term Services and Supports (2020)
- The Integration of Certified Recovery Peer Advocates: Lessons from NYACH's Behavioral Health Conference (2019)
- Meeting a Demand for Bilingual Medical Assistants: Overview and Lessons on the Training Model (2019)
- Prepare to Care: Key Findings and Training Recommendations for NYC FQHC's Emerging Titles (2016)
- Program Evaluation of the Credited Certificate in Care Coordination and Health Coaching (2015)
- Emerging Positions in Primary Care: Results from the 2014 Ambulatory Care Workforce Survey (2015):
- CUNY Consortium of Nursing Programs Post-Graduate Outcomes Report (2014)
- Planning Your Career in Health Information (2014)
- Emerging Career Pathways in the NYC Healthcare Workforce: Changes in the Nursing Career Ladder (2013)
- Emerging Career Pathways in the NYC Healthcare Workforce: Credited College-Level Certificates for Assistive Health Personnel (2013)
- NYC Emerging Healthcare Workforce: Health Homes Case Study Project (2013)
- New York State's Community Health Center Workforce: A Mixed-Methods Analysis (2012-2013)

NYACH Core Competencies for Today's Healthcare Workforce

Overview

One of the early and foundational pieces of work NYACH did was in creating the NYACH Core Competencies for Today's Healthcare Workforce. This document, first released in 2016, was the culmination of multiple years of working with NYACH's partners to review relevant literature, understand changes on the ground related to new models of care, and inventorying and compiling educational resources that workforce development professionals could use in creating or modifying their programming. This articulation was one of the first efforts to identify those skills and competencies that all health professionals need to deliver patient-centered, coordinated care, and created a standardized, common language that all stakeholders (i.e. educators, employers, philanthropy, government) could use.

2016 was also a perfect time to release the Core Competencies, with its common language and inventory of learning resources, given the new attention and resources that were devoted to workforce transformation for population health through New York State (NYS) Medicaid Redesign. 2016 marked a turning point in Delivery System Reform Incentive Payment (DSRIP) workforce development as most of the required implementation planning had been complete, clinical leadership had built new workflows, and networks were looking to build training programs that moved the needle on population health performance outcomes. As a result, many NYACH employer partners used or otherwise referenced the Core Competencies in the in-house training they implemented. In addition, the document was foundational to the work of the NYS Department of Health's DSRIP/SIM Workforce Workgroup, which released state-wide guidance on care coordination training further reinforcing the standardized common language.

To further propel the adoption and use of the Core Competencies, NYACH ran workshops for workforce development professionals across New York City, and has embedded this language and learning objectives in all NYACH-sponsored trainings and research completed since.

Next Steps

NYACH is currently working with the Greater New York Hospital Association (GNYHA)—which collaborated on the initial creation of the Core Competencies document and serves on the NYACH Partners Council—to identify new learning objectives for telehealth and compile related learning materials.

New York City saw an overnight rapid adoption of telehealth care modalities because of the COVID-19 pandemic and the need to physically distance to reduce infection exposure. In discussion with industry partners, NYACH anticipates that both the original Core Competencies and those skills necessary to work with telehealth will continue to be critically important for better patient care. These competencies will continue to be foundational to industry-based workforce transformation, and workforce development's ability to prepare workers with these competencies continues to be critical both to a well-functioning workforce system and the employability of trained workers.

FIGURE 15. The NYACH Core Competencies for Today's Healthcare Workforce

01 Introduction to New Models of Care and Healthcare Trends

- Overview of the US healthcare system
- Introduction to care coordination
- New models of care

02 Interdisciplinary Teams

- Working on interdisciplinary teams
- Building positive relationships on a team
- Communication with team members
- Participating in team huddles
- Dealing with team conflict

03 Person-Centeredness and Communication

- Basic technology skills and the electronic health record
- Documentation
- Confidentiality and guidelines

04 Chronic Disease and Social Determinants of Health

- Overview of chronic disease and comorbidities
- Social determinants of health
- Self-management

05 Cultural Competence

- Recognizing patients' families' cultural needs/ factors that may affect their choices or engagement
- Communicating with patients and families in a culturally competent manner

06 Ethics and Professional Boundaries

- Ethical and responsible decision-making
- Professional boundaries

07 Quality Improvement

- The quality improvement process
- Quality improvement methods and processes

08 Community Orientation

- Connecting patients and families to community resources
- Supporting families as they seek resources in the community

09 Health Information Technology, Documentation and Confidentiality

- Basic technology skills and the electronic health record
- Documentation
- Confidentiality and guidelines

Case Studies in Workforce Innovation

Since 2011, NYACH has developed several workforce innovations built on our understanding of how healthcare work was changing—or needed to change—on the ground. Leveraging research, our foundational Core Competencies, ongoing industry insights, and our understanding of overall healthcare reform strategies and goals, this collaborative, evidence-based approach led to meaningful interventions in a range of healthcare subsectors.

The following section includes six case studies from NYACH's 10 years of work since our founding. The first three describe examples of how NYACH helped build new training and staffing models for enhanced roles and emerging care management occupations. The last three describe innovative initiatives to improve the workforce pipeline.

The success of the collaborative work detailed in these case studies provided NYACH with foundational experience and stakeholder relationships that would later prove essential during the COVID-19 pandemic, detailed in the following section of this report.

If you would like to learn more about any of these projects, programs, or initiatives, or would like to discuss ways to work with NYACH in the future, please do not hesitate to contact us.

CASE STUDIES

Homecare Jobs **p.27**

Certified Recovery Peer Advocate **p.31**

Health Coach **p.34**

Bilingual Medical Assistant **p.37**

Nursing **p.40**

Tomorrow's Healthcare Workforce **p.46**

WORKFORCE INNOVATION CASE STUDY:

Homecare Jobs

Overview

Both working a homecare job and running a homecare business are incredibly challenging. Homecare represents one of the fastest growing occupations in the country,[15] due to a rapidly aging baby boomer population and a declining family caregiver-to-elder ratio. According to New York State (NYS) Department of Labor, New York City (NYC) already has over 300,000 Home Health Aides (HHA) and Personal Care Aides (PCA)[16] who work at hundreds of long-term care businesses and nonprofits. According to a 2020 analysis released by NYACH Partners Council member PHI, 93% of direct-care workers (which include HHAs and PCAs as well as Certified Nurse Assistants (CNA) and Direct Support Professionals (DSP)) are women and 90% are people of color (75% of workers are Black or Hispanic), with a median age of 49, yet the median personal annual earnings amount to only $20,700, resulting in 56% who rely on public assistance[17].

At a business level, homecare agencies are under enormous financial strain, with costs rising faster than increased revenue, which, in many cases, is dependent on the state Medicaid program. This means that even well-meaning employers, who especially struggle to keep their doors open as they work to pay better wages and otherwise support workers, find it difficult to make or sustain investments necessary to improve job quality for homecare workers. Further, while more recent labor policies (such as wage parity) have improved wages, benefits, and working standards for homecare workers, it also pulls financial resources away from other job or patient care improvement programs, such as enhanced job training.

15 U.S. Bureau of Labor Statistics. (2021). (rep.). *Occupational Outlook Handbook: Home Health and Personal Care Aides*. Retrieved from https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm.

16 Occupational Wages. (n.d.). Retrieved from https://statistics.labor.ny.gov/lswage2.asp#31-0000.

17 PHI. (2020). (rep.). *New York City's Direct Care Workforce*. Retrieved from https://www.phinational.org/resource/new-york-citys-direct-care-workforce/

Based on expert industry feedback from our Partners Council and employer stakeholders, NYACH has identified four principal factors that drive home care job quality and worker retention challenges:

- low pay
- lack of full-time hours availability & unpredictable schedules
- insufficient training and job preparation
- poor supervision and support

Homecare workers are often unsung heroes of the healthcare system, ensuring that New Yorkers experiencing illness or disability can live full and independent lives from the comfort of their own homes. Despite the growing demand for these workers, homecare jobs continue to be underpaid, emotionally and physically taxing, and in general are undervalued both within the healthcare system and in society at large. As a result, the subsector is plagued by high turnover and chronic labor shortages that can threaten continuity of care for the most vulnerable and neediest New Yorkers, forcing them into unsafe and undesirable circumstances.

After the 2010 passage of the Affordable Care Act and election of Governor Andrew Cuomo, NYS regulators began examining the Medicaid

What is a Homecare Worker?

Common Titles:
Home Health Aide (HHA), Personal Care Aide (PCA). Similar roles also include Certified Nurse Assistants (CNA) who work predominantly in nursing homes, and Direct Support Professionals (DSP) who work with individuals living with disabilities.

Responsibilities:
Care for individuals in their homes under the supervision of nursing staff. They provide personal care to patients including supporting them with activities of daily living, such as general housekeeping, meal preparation, bathing, dressing and grooming. Homecare workers may also perform routine health tasks, such as checking vital signs, changing bandages, and dressing wounds.

Required Educational Background:

- High school degree or equivalency
- Standard NYS-approved training. Courses are usually 75-120 hours.

Average NYC Wages:
$15/hour, though homecare workers often have a difficult time piecing together full time hours.

Common Career Next Steps:
Certified Nurse Assistant, Medical Assistant, Licensed Practical Nurse, Registered Nurse

How is the Job Changing?:
With the onset of population health and the NYS Medicaid payment shift to Managed Long Term Care (MLTC), homecare workers are increasingly playing a more active role with chronic disease management, care transitions (e.g. when a patient moves from one setting to another such as from the hospital back to the home), and communication with the wider care team (e.g. the patient's Primary Care Provider, Social Worker, and others). In addition to historically-required skills, the job now requires enhanced English literacy and technology proficiency, teamwork, and knowledge of chronic disease management.

Learn More:
Home Health Aide Advancement Map

program and implementing far-reaching structural changes to reduce costs and improve care.[18] It was in this context in 2012 that NYS began encouraging long-term care services to migrate from a traditional fee-for-service model to a managed care model. This migration involved, among other things, homecare agencies contracting with Managed Long Term Care (MLTC) insurance plans/organizations and the introduction of new value-based payment incentives and revenue streams.

The move to MLTCs (and to value-based care more broadly) was an attempt to change 'how we work with patients' on the theory that changing the financial incentive structure would produce better outcomes. What an exclusive focus on financial incentives misses, however, is that the workers themselves need to be aware of the change and need to have the skills to perform differently. While requiring the change to MLTC, unfortunately, NYS did not simultaneously update the required minimum training requirements for homecare workers.

Hearing a clear need from partners about both the changing healthcare landscape and the need for homecare workers to have new skills, NYACH became an early investor in enhanced homecare worker training. NYACH also hoped that an enhanced homecare worker training would not only help with performance against new models of care, but would also improve the homecare worker's feelings of preparation and experience of the job, and in turn improve job retention and its associated impact on business operations.

18 This was the same context as the NYS DSRIP program was implemented. Of note, DSRIP was largely anchored by hospitals and only peripherally involved long-term care providers. The two additional mechanisms besides DSRIP that NYS used to encourage long-term care's adoption of population health and value-based care models were through the move to Managed Long Term Care (MLTC) beginning in 2012 and later through workforce development with the 2018 creation and funding of Managed Long Term Care Workforce Investment Organizations (a program also established under the 2014 1115 waiver amendment).

Home Health Aide Training using Enhanced Curriculum

With both systemic challenges and business model changes in mind as context, NYACH sought an enhanced training program with three goals: 1) Prepare workers to perform in new population health-based models of care, thereby improving both care quality and business financials, 2) help businesses maintain a stable workforce, and 3) improve the job experience for workers.

In 2012, NYACH began working with PHI, a leading national authority on the direct care workforce and a member of NYACH's Partner Council, to deploy an enhanced training model.

The PHI Enhanced HHA training model consisted of the following:

- an improved recruitment and screening process that ensured a good fit between the candidate and job
- 120 hours of curriculum (45 hours beyond the state minimum) that focused on core competencies for the role including communication, patient-centered care, and cultural competence
- better accommodation of low-literacy levels in trainees
- adult-learner centered teaching methods, including participatory activities, like role-play and skill demonstrations
- an assistant trainer who is a home health aide
- a peer mentor

In some cases, additional training for a "Specialty Aide" was included, which covered topics such as dementia care, fall prevention, palliative care, and others.

Beginning in 2013, NYACH invested in this enhanced training, working with PHI to deploy and test the model in two different settings–locally at participating employer sites and separately in partnership with CUNY, the city's community college system.

Overall, the program was successful in making an impact on workers, their clients, and their employers. As one employer-based trainer at Sunnyside Community Services shared, "our home health aides just love the training–it's just better for them...." It also demonstrated a better way to improve recruitment and screening for home health aides and train a better prepared workforce. Nearly 1,200 home health aides became certified through a high quality, learner-centered training model, 77% of whom went directly to employment. That said, given the enormous size of the workforce and scale of economic challenges facing the sector, there is much more work to do.

Learn more about the program by reading our 2019 industry brief.

How else is NYACH involved with Homecare?

NYACH has made a sustained commitment to support the homecare subsector, beginning with this training program in 2013, working to improve both the job quality of homecare workers and the economic viability of their employers. To do this, NYACH has worked at the center of a multi-stakeholder approach that involves leading industry advocates, employers, training providers, and philanthropy to develop solutions that are innovative, industry-informed, expertly-evaluated, and scaled to help bring about real systems change.

In partnership with its Long-term Services and Support (LTSS) Advisory Group, NYACH has led diverse, collaborative work in this effort, working with leaders in the industry on a range of initiatives that have included labor market research, the development of new curricula and worker training models, English language bridge programs and homecare supervisory training, COVID-19 emergency work (see Pandemic Response section on page 50), public advocacy, and a new initiative in 2021-22 designed to provide business support services in a way that encourages high road employment practices.

WORKFORCE INNOVATION CASE STUDY:

Certified Recovery Peer Advocate

Overview

As a broad definition, a peer support worker is a non-clinical worker who is trained and employed to use their personal lived experience with a particular health condition to support others living with the same health condition on their treatment journey. Though peers have been part of care models in New York and across the country for many years, peer work has traditionally been left out of the wider healthcare delivery system, both in terms of integration into care teams and into healthcare financing models (as historically peer work is largely funded or subsidized by grants).

In 2015, new statewide certification and educational criteria were announced by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) to qualify peer support workers who work with those with a substance use diagnosis—known as Certified Recovery Peer Advocates (CRPA)—and shortly thereafter CRPA services became reimbursable by NYS Medicaid at an increased rate. This move towards the professionalization of CRPAs and increased funding enabled providers to begin employing them at greater scale and through more sustainable payment mechanisms.

Shortly after these regulatory and policy changes, NYACH began hearing from industry partners that, while there was growing interest in hiring CRPAs, there were several challenges to doing so, including finding a workforce pipeline of qualified CRPAs, the lack of clear evidence making the business case for using CRPAs, and uncertainty around how to best integrate this workforce into care delivery models. To meet this need and projected workforce growth, NYACH embarked on a collaborative effort to develop the workforce pipeline and to document and share integration evidence and best practices with industry.

What Is a Certified Recovery Peer Advocate (CRPA)?

Common Titles:
Certified Recovery Peer Advocate (CRPA). The position is similar to other jobs that require lived experience, such as Peer Specialist, who work in mental health, and other peer workers who work with specialty populations, such as diabetes, HIV, and criminal justice involvement.

Responsibilities:
Provide patient engagement and outreach services to individuals struggling with substance use disorders (SUD). CRPAs use their lived experience of substance use and specialized training to act as a non-clinical social and emotional support for patients/clients. CRPAs can work in a variety of healthcare settings, including substance use clinics, hospital emergency rooms and inpatient units, community outreach, among others.

Required Educational Background:

- High school degree or equivalency
- Specialized training, work/volunteer experience, and completion of a certification exam (often completed in 3-12 months

Average NYC Wages:
$17-$19 per hour

Common Career Next Steps:
Many CRPAs find that the role is a good fit for them, especially as they continue to manage their own recovery, and are not interested in pursuing further career advancement. For those interested, CRPA is a great first step into a career in Social Work.

How is the job changing?:
While the role of a peer worker helping those with substance use is not new, CRPAs are newly becoming integrated into regular healthcare staffing models and becoming an essential member of the team when working with SUD patients. CRPAs need to have excellent communication skills, both for working with patients and care team members, and must be able to clearly document activities in electronic health records and other care management systems.

Learn More:
NYS OASAS CRPA Occupational Overview

Curriculum Development and a New Workforce Pipeline

NYACH, working with the NYC Department of Small Business Services, collaborated with a wide array of experts to ensure the CRPA training program model was authentic to the peer role, was high quality, and met the needs of industry.

These partners included:

- NYS OASAS;
- the NYC Department of Health and Mental Hygiene;
- the Peer Network of New York, a network of peers which provided insights into the challenges and opportunities of working in this capacity;
- Queensborough Community College (QCC), which worked with their faculty, a peer expert, and employers (as facilitated through NYACH) to develop and deliver the new curriculum;

- and behavioral health experts at NYC Health + Hospitals (NYC H+H), Community Care of Brooklyn (CCB, the Maimonides Medical Center-led DSRIP network), and a dozen additional behavioral health providers, to share real-time input and feedback on the newly developed curriculum and program model.

The result of that collaborative effort was the creation of the first comprehensive training model for the CRPA role in New York State, which fully prepared participants for the new certification exam and the nuanced role of working as a peer. Key aspects of the three-month, 80-hour training model include:

- an employer-driven screening process to ensure the right students are selected for the program;
- evening classes to accommodate student schedules;
- credit-bearing for three credits towards an Associate's Degree at CUNY;
- intensive case management support for the students;
- a curriculum focused on need-to-know topics such as peer advocacy, ethical responsibilities, mentoring, wellness, boundaries, self-care, and patient-centered communication;
- certification exam test prep; and
- close employer partners who interview all candidates upon completion of the program.

The program model is unique in that it connects individuals with nontraditional employment histories, many with a personal history of substance use and/or former interactions with the criminal justice system, with a chance to earn college credits and pursue careers in the growing field of behavioral health.

Program participants were primarily hired at NYC H+H and CCB as both institutions were looking to incorporate CRPAs into population health-based staffing models and workflows. As Dr. Kishor Malavade, Associate Medical Director for the Department of Population Health at CCB, shared: "Recovery peers do so much to transform our workforce and the way that we care for individuals and our communities. Peers tangibly improve the experience of individuals engaged with the health care system, but they are also a living embodiment of the principle of recovery and every individual's aspiration to be a meaningful contributor in our workforce. As such, they are powerful symbols of healing not only for a patient, but for staff as well."

Sharing Best Practices

NYACH and the partners that collaborated on the workforce pipeline efforts have spoken at many convenings, conferences, and policy-related meetings since the creation of the program to share the experience and learnings with the field.

NYACH also held its own conference about behavioral health and the CRPA role in December 2018. The conference brought together over 70 behavioral health providers, peers, educators, and government representatives to learn from industry leaders about their workforce and integration models, and the challenges and opportunities they have provided. Specific conference topics included: building a business case for peer integration through academic research on the efficacy of peer services, billing appropriately for peer services, effectively supervising recovery peers, and pipeline development and training model for the emerging CRPA role.

Learn more about the learnings and best practices shared at the NYACH 2019 behavioral health conference by reading our industry brief.

NYACH also partnered with NYC H+H as they integrated CRPAs into emergency department patient care workflows to evaluate the effectiveness of this new staffing model. This evaluation proved that CRPAs are a valuable and effective member of the care team for certain populations and provides lessons learned for other employers interested in adopting this new title and staffing model.

Learn more about the NYC Health + Hospitals implementation and the NYACH-sponsored evaluation on page 21.

WORKFORCE INNOVATION CASE STUDY:

Health Coach

Overview

Primary Care Providers (PCP), including doctors, physician assistants, and nurse practitioners, have been under tremendous financial pressure to maintain two competing priorities at once: 1) to increase the number of patients they can see with limited time, and 2) to provide "value," which requires extra time and staff to help patients through their health challenges, particularly those requiring more demanding levels of care. As much as PCPs would like to spend extra time with these patients, there is simply no viable way in the current healthcare delivery and financing model for them to do so at the kind of scale needed to improve the population health challenges faced by so many New Yorkers.

It was in this context that NYACH and Community Care of Brooklyn (CCB), the Maimonides Medical Center-led DSRIP network, began to look for creative workforce solutions to this primary care delivery challenge. To do this, NYACH and CCB looked at primary care staffing in the CCB network and determined that medical assistant staff would be best positioned to take on the extra requisite relationship-building, engagement, and follow-up for patients with chronic medical conditions if provided with appropriate skill development and wage increases. This collaboration between NYACH and CCB led to the implementation of a customized Health Coach Model, beginning in 2016. The Health Coach model is an effective operationalization of person-centered, team-based care. It introduces a new role—the Health Coach—into the primary care team and changes how care team members work with each other and with targeted patients.

Training Program

The curriculum for this initiative was the product of a multi-stakeholder collaboration. The curriculum itself was created by Kingsborough Community College (KCC), which is part of the City University of New York (CUNY) system, and Audrey Lum, a clinical leader and expert from Union Health Center. In addition, CCB provided ongoing feedback from an employer/on-the-ground health system perspective, NYC SBS provided feedback as a government workforce development agency, and NYACH provided feedback related to NYC's macro-level healthcare environment and system transformation goals. The resulting curriculum was dynamic in its approach to adult learning and specific to what the Health Coaches do on the ground from day one.

What is a Health Coach?

Common Titles:
Health Coach. Titles in healthcare emerging occupations are not standardized. Depending on how the healthcare employer writes the job description, similar roles might include Community Health Worker, Patient Navigator, Care Coordinator, and Care Manager.

Responsibilities:
The Health Coach works directly with patients to develop patient-driven self-management goals, reinforces education provided by a primary care provider or nurse, coordinates care for a defined panel of patients, connects patients to other health and social resources, and is a key member of the primary care care team.

Required Educational Background:

- High school degree or equivalency
- Prerequisite: Medical Assistant or equivalent level staff training
- Health Coach specialized training

Average NYC Wages:
$24-$26 per hour

Common Career Next Steps:
Health Coach is a 'next step' position after Medical Assistant and provides the worker with more advanced care management-type experience. Next steps without further education might include Care Coordinator or Care Manager depending on the responsibilities and wages of the job. With additional education, the Health Coach might be interested in pursuing a career in Nursing or in Social Work.

How is the job changing?:
Health Coach is considered an "emerging occupation" in healthcare and is not a common title. The job serves as an anchor for patient engagement and performance in value-based care models.

The comprehensive training is comprised of two 45-hour modules and a practicum. The didactic training focuses on new models of care, communication and patient engagement techniques, cultural competency, stages of behavior change, patient education, in addition to chronic disease, wellness, and prevention. The practicum involves direct participation from CCB supervisors, who join the class and conduct observations and provide participants with feedback on role play activities. Upon completion of the training, participants receive a certificate in Health Coaching and six CUNY undergraduate credits.

Since January 2016, 260 individuals have completed the training program, which represents 16 cohorts, and CCB Health Coaches have engaged 40,000+ Medicaid patients at 100+ primary care practice sites. Of note, NYACH funded the start-up costs and the first two cohorts of training, and CCB took up the mantle afterwards by funding the next 14 cohorts. In this way, this program is a great example of not only creating a model that works, but in creating a model that has staying power beyond NYACH's direct intervention.

CCB Implementation & Change Management

Health Coach is a fairly new occupation in healthcare, designed to participate in primary care to advance specific patient engagement and population health goals. While the training of the Health Coaches themselves was important in order to have a skilled workforce, the model would not have worked without careful consideration of how the role would be integrated into existing primary care staffing models and workflows. CCB, with NYACH's expert support and consultation, implemented a robust change management strategy to roll out the Health Coach model.

Key change strategies used during implementation included:

- Comprehensive workforce development, including selective recruitment, training, and ongoing professional development
- Support and incentives for broad adoption at the employer-level, including wage subsidies and incentive payments for both process and performance outcomes
- Rigorous change management practices and follow-through, including creating a guiding coalition, empowering executive sponsors and on-the-ground advocates, supporting great supervisors, and celebrating small wins
- Support for enabling technology infrastructure, including for both care planning and analytics
- Embedding the change into the work culture and standard operating practices
- Planning for financial sustainability and advocating for long-term structural changes to funds flow with policy makers and insurance plans to sustain the model and workforce in the long-term

Importantly, these steps allowed for not only successful patient care, but have also changed the minds and behavior of participating doctors, nurses, social workers, and other care team members. As one doctor shared, "there's a kind of a follow-up in the care, the attention seems to personalize the care and make [the patient] feel that they are getting something a little bit extra. It's going to really bring their health forward. They see the importance of [the Health Coach] and they don't feel like they're being necessarily pushed and commanded, but they feel like they're being embraced. So they have a chance to actually participate and even make a suggestion."

Learn more about the program, its recommendations for successful implementation and patient impact, by reading our upcoming 2022 industry brief.

WORKFORCE INNOVATION CASE STUDY:

Bilingual Medical Assistant

Overview

Shortly after the 2016 release of the NYACH Core Competencies for Today's Healthcare Workforce, NYACH began hearing from its partners about how employers were expecting to need more Medical Assistants in the coming years and how the role was changing as a result of healthcare reform. Medical Assistants were beginning to take on additional administrative tasks on top of their traditional clinical support responsibilities, and were increasingly being asked to participate in efforts to engage patients. As one employer partner described, "Medical assistants are no longer just rooming patients and taking vitals. We're moving toward care coordination, reducing avoidable hospitalizations by looking at the social determinants of health, quality over quantity, and team-based care. Medical Assistants play a huge role in that effort." As a result, the workforce development system needed to revise the existing Medical Assistant curriculum to make sure that participants completing the training were prepared for the expanded responsibilities of the job.

NYACH also knew two other things about the Medical Assistant role. First, Medical Assistant is one of the rare healthcare occupations that require a middle-level of educational attainment (six months to two years of specialized education) and is well-suited to serve as a jumping off point for individuals interested in later advancing their career in healthcare. Second, healthcare employers looking to improve patient experience and perform against value-based quality measures were eager to hire Medical Assistants who reflected the diversity of their patient population, especially those who speak languages other than English. Putting all of this together, NYACH saw an opportunity to create a pipeline for bilingual New Yorkers to get their start in healthcare at a decent wage and to create standardized learning requirements that match the new skills employers need at the same time.

What is a Medical Assistant?

Common Titles:
Certified Medical Assistant, Patient Care Associate, Medical Office Specialist, Administrative Medical Assistant.

Responsibilities:
Perform administrative and certain clinical duties under the direction of a physician. These tasks can include taking vital signs and medical histories, preparing patients for exams, drawing blood, scheduling appointments, and maintaining medical records.

Required Educational Background:

- High school degree or equivalency
- Medical assistant-specific training
- One of the two nationally-recognized certifications (American Association of Medical Assistants or National Healthcareer Association)
- EKG, Phlebotomy, and CPR certification

Average NYC Wages:
$19/hour

Common Career Next Steps:
Medical Assistant is a great starting place for a career in healthcare. Medical Assistants interested in pursuing careers in clinical roles often return to education for degrees in nursing or specialized training in a technical field. Alternatively, many Medical Assistants go on to pursue administrative careers helping healthcare facilities manage their operations in caring for patients.

How is the job changing?:
With the onset of population health and value-based care models, Medical Assistants are increasingly taking up patient engagement and care coordination responsibilities. In addition to historically-required clinical skills, the job now requires skills in administrative support, teamwork, and patient-centered communication especially around chronic disease management.

Learn More:
Read the NYACH-authored Medical Assistant Occupational Profile.

Creating an Occupational Profile

NYACH began this work by convening partners and conducting a literature review to understand what skills and competencies employers valued most in this role. This work culminated in the creation of a Medical Assistant Occupational Profile, which articulates trends, skills, background, wages, and other occupation-specific information. This resource was designed to be used by job seekers considering starting a career in healthcare, educators who needed to revise their curricular offerings, and employers looking for an easy reference tool when creating new job descriptions or revising staffing models to adapt to new models of care.

Bilingual Medical Assistant Training

NYACH built on its work authoring the occupational profile and turned its attention to the creation of a redesigned training program that incorporated new, needed competencies, while also providing a targeted on-ramp for immigrant New Yorkers, who can bring linguistic and cultural competence to medical assistant work, but who often struggle to find higher-wage,

entry-level positions with longer-term career advancement opportunities. With these goals in mind, NYACH and the New York City (NYC) Department of Small Business Services (SBS) partnered with LaGuardia Community College to design and implement a revamped bilingual medical assistant training program.

This revamped training model includes:

- Targeted recruitment for low-wage or unemployed English language learners with intermediate levels of English proficiency
- Rigorous assessment process to ensure participants are a good fit for the program
- Flexible, part-time evening and weekend schedule
- Contextualized 200-hour ESOL (English as a second or other language) bridge
- Enhanced 368-hour Clinical Medical Assistant Training with integrated ESOL support
- Medical vocabulary modules in participants native language for Spanish, Mandarin Chinese, and French speakers
- 100-hour paid internships at participating healthcare employers, many of whom participated in the training program's design
- Tutoring and vouchers for the National Healthcareer Association EKG Technician, Phlebotomy Technician, and Certified Clinical Medical Assistant exams
- Case management and wrap-around services to help participants through the educational and job seeking process

Training during the COVID-19 Pandemic

Like all workforce programs, the Bilingual Medical Assistant Training faced serious disruption during the pandemic. In response, NYACH, SBS, and LaGuardia Community College took key steps to ensure trainee safety and participant completion while maintaining the enhanced value of the training model. In particular, the course shifted to a hybrid model of learning, where didactic lessons were conducted virtually and clinical lab lessons for EKG, Phlebotomy and other technical skills were hosted in-person with physical distancing. In addition, all students and staff were provided appropriate PPE. Now more than ever, as the healthcare workforce is facing profound burnout and shortages, it is important that we reinforce effective pipelines for diverse New Yorkers into healthcare careers that can be adaptive enough to weather ongoing operational challenges.

The Bilingual Medical Assistant Training has graduated over 100 students in seven cohorts since beginning in 2017. Learn more about the program by reading our 2019 industry brief.

WORKFORCE INNOVATION CASE STUDY:

Nursing

Overview

As part of its work to strengthen pipelines for essential healthcare occupations, NYACH has increasingly made investments to support New York City (NYC) nurses at different points in their career trajectories to reduce attrition among incumbent nurses while also increasing the number of diverse and foreign-trained nurses qualified to serve in the five boroughs. Nursing is one of the fastest-growing professions in the healthcare sector, as nurses are critical members of healthcare delivery teams that provide essential bedside care to patients in hospitals, nursing homes, and increasingly in primary care, home- and community-based settings. It is also an occupation that has long faced shortages and early-career retention challenges, and which now more than ever demands coordinated attention and strategic investments to support this workforce as nurses continue to face considerable professional and emotional strain serving New Yorkers through the COVID-19 pandemic.

According to May 2020 NYS Bureau of Labor Statistics, the NYC metropolitan area is home to more than 300,000 nursing professionals on the frontlines of patient care, which includes Registered Nurses (RNs), Licensed Practical and Licensed Vocational Nurses (LPN & LVNs), and Advanced Practice RNs (APRNs) like Nurse Practitioners (NPs). And while the NYC metropolitan area's RN workforce represents about 6% of all RNs nationwide, the local rate of growth in this profession is expected to increase at more than twice the rate of national projections over the next decade, with statewide RN employment projected to grow 25% before 2028, versus 9% nationally. In other words, nearly 9% of all projected national RN openings are expected to be here in New York State (NYS) over a decade.[19]

However, these data and projections predate the pandemic, and we are only now getting a clearer picture of the toll the past two years has taken on nursing employment citywide. The pandemic's effects—which include burnout, moral distress, and unresolved grief on the front lines, early retirements among older nurses, and extreme nationwide competition for talent—are compounding long-known trends about the city's nurse population at a time when new NYS regulations are expected to dictate increased nurse staffing levels in nursing homes and likely in hospitals. In short, both insights from industry partners and emerging data paint a picture of record demand and profound

19 NYACH analysis of 2021 New York State Department of Labor data.

workforce challenge that will only be solved via a coordinated effort across the sector to increase the size and effectiveness of the pipeline.

NYACH is working to bring this coordinated effort to bear in 2022, building upon its successes of the past decade to expand its support for new graduate nurses transitioning to practice, increasing efforts to qualify foreign-trained nurses for in-state certification exams, and finding new ways to support this essential pipeline.

Helping New Nurses

About 9,000 students graduate from nursing schools in NYS each year, and based on pre-pandemic projections NYC alone will average more than 6,600 RN job openings each year over a decade.[20] While job opportunities for

20 Martiniano R, Goodwin N, Cleaves M, Stiegler K, Khalid T, Moore J. (2019). (rep.). *Trends in New York Registered Nurse Graduations, 2002-2018.* Center for Health Workforce Studies. Retrieved from https://www.chwsny.org/wp-content/uploads/2019/10/Trends_NY_Nurse_Grads_2018.pdf

What is a Registered Nurse?

Responsibilities:
Registered nurses (RNs) provide and coordinate patient care and educate patients and the public about various health conditions. They perform a variety of critical tasks, including assessing and recording patient health, monitoring and administering medication, and navigating care with the medical team. Registered nurses work in all types of healthcare settings, including at the bedside in hospitals, in ambulatory and primary care, in skilled nursing facilities and in homecare, as well as in non-healthcare settings such as schools and employee health.

Required Educational Background:

Registered Nurses usually take one of three education paths: a bachelor's degree in nursing, an associate's degree in nursing (which is increasingly less common in New York State), or a diploma from an approved nursing program. Registered nurses must be licensed and maintain their license and registration over time.

Average NYC Wages:
$103,290 annually

Common Career Next Steps:
A registered nurse has many potential career paths available to them. Career options that do not require substantial additional education include moving into specialty care, changing settings (e.g. moving from inpatient to ambulatory care), or moving into employee health. Experienced nurses can also move into management, or can return to education for an advanced practice degree (such as becoming a Nurse Practitioner) or by supporting other nurses through a career in nursing education.

How is the job changing?:
With the onset of population health and value-based care models, Registered Nurses are increasingly working with new team members and technologies to support care coordination and care transitions. In general, this requires enhanced skills in teamwork, patient-centered communication, and greater familiarity with new technology.

Learn More:
The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity published by the National Academies of Sciences in 2021.

new graduates are projected to be abundant nationally, one's first job in nursing can be incredibly difficult and many nurses end up leaving their employer or nursing practice altogether before the end of their first year on the job. The attrition rate for nurses in their first year of practice is conservatively estimated to be 17.5% nationally,[21] which only further strains the sector by decreasing supply in the face of incredible demand.

Beyond the ordinary challenges of starting a new job–meeting new colleagues, learning expectations, getting a feel for the facilities–new inpatient nurses have the added pressures of managing patient flow, adapting to 12-hour work shifts, and, importantly, developing a profound sense of responsibility as their actions impact the health and livelihood of real patients. Due to these and many other stresses, transitioning from education to practice is much more difficult than simply graduating, taking a certification exam, and getting hired. From the perspective of employers, it is also challenging to work with new graduate nurses. As compared with their more experienced colleagues, first-time nurses need more support and mentoring, which can be difficult to find time for on a busy patient unit. Nursing turnover is also bad business and can be particularly costly: according to NYACH hospital partners, losing even one nurse in NYC can cost up to $100,000 in recruitment and associated costs.

To address these challenges, NYACH and its partners have worked since 2012 to ease the transition to practice for newly graduated nurses and to help bridge this experience gap and ensure that nurses newly entering the workforce have the best opportunity for success, with the hopes of improving retention across the field.

NYACH's work with nurse transitions began in 2012 with a collaboration with Lehman College's School

of Continuing and Professional Studies and the Greater New York Hospital Association (GNYHA) to provide unemployed, newly licensed, nurses an opportunity to participate in a six-month RN Transition-To-Practice (RN TTP) program. The RN TTP program supported participants with both a hands-on practicum experience and a monetary stipend. Over the course of the program, the participants received six hours of didactic classroom instruction at Lehman College and twenty-four hours of clinical training at one of six participating hospitals under the guidance of a nurse preceptor each week.

Though NYACH would ultimately adopt a different model to support new graduate nurses, the RN TTP program provided valuable learnings for NYACH and our partners. The program itself was a success with over 83% of participants finding employment as registered nurses and was foundational to the launch of the subsequent City-wide Nurse Residency.

City-wide Nurse Residency

NYACH set out to improve its support for new graduate nurses, building upon the lessons learned from the RN Transition to Practice Program. In dialogue with hospital leaders, workforce experts, and leading academics, and as recommended in the Institute of Medicine's 2010 *Future of Nursing* report, it was clear that a nurse residency model had become industry

21 Kovner, C. T., Brewer, C. S., Fatehi, F., & Jun, J. (2014). What does nurse turnover rate mean and what is the rate? Policy, Politics, & Nursing Practice, 15(3-4), 64–71. https://doi.org/10.1177/1527154414547953

best practice for building nurse confidence and competence, improving recruitment and nursing culture, and reducing first-year turnover.

As such, in late 2018 NYACH launched the City-wide Nurse Residency, the nation's first City-led nurse residency program with a consortium of 28 participating local hospitals.

Offered in partnership with the GNYHA and with hospital mentorship from NYU Langone Health and New York-Presbyterian Hospital, the City-wide Nurse Residency uses a standardized, best-in-class curriculum developed by Vizient and the American Association of Colleges of Nursing (AACN),[22] which is implemented by individual hospital nursing education teams, and led by on-site program coordinators and nurse preceptors. The program is designed to last one year and generally involves four to eight hours of seminar once-per-month for a small cohort of first-time nurses from the same hospital with structured flexibility that allows hospitals to make customizations based on their unique operational and cultural needs. For example, a hospital may want to contextualize how a specific topic is covered to emphasize and align with a major institutional quality improvement initiative. In intimate settings over the course of

22 Vizient/AACN Nurse Residency Program. Vizient. (n.d.). Retrieved from https://www.vizientinc.com/Our-solutions/Clinical-Solutions/Vizient-AACN-Nurse-Residency-Program

As of January 2022, 28 New York City hospitals participate in the Citywide Nurse Residency Program:

BronxCare Health System

The Brooklyn Hospital Center

Maimonides Medical Center

MediSys Health Network
- Flushing Hospital Medical Center
- Jamaica Hospital Medical Center

Mount Sinai Health System
- Mount Sinai Hospital
- Mount Sinai Morningside
- Mount Sinai West
- Mount Sinai Brooklyn
- Mount Sinai Queens
- Mount Sinai Beth Israel

New York-Presbyterian
- New York-Presbyterian Brooklyn Methodist
- New York-Presbyterian Queens

NYC Health + Hospitals
- NYC Health + Hospitals – Bellevue
- NYC Health + Hospitals – Coney Island
- NYC Health + Hospitals – Elmhurst
- NYC Health + Hospital – Harlem
- NYC Health + Hospitals – Jacobi
- NYC Health + Hospitals – Kings County
- NYC Health + Hospitals – Lincoln
- NYC Health + Hospitals – Metropolitan
- NYC Health + Hospitals – North Central Bronx
- NYC Health + Hospitals – Queens
- NYC Health + Hospitals – Woodhull

One Brooklyn Health System
- Brookdale University Hospital
- Interfaith Medical Center

St. Barnabas Hospital

Wyckoff Heights Medical Center

the year, nurse residents have an opportunity to learn from hospital subject matter experts, develop confidence in their clinical abilities and judgement, build a supportive network of colleagues, and explore evidence-based practice through group design and implementation projects.

NYACH funds the curriculum costs for the consortium and supports data gathering with our partners about the nurse residencies to help participating hospitals make the financial case for internal adoption of the program as part of baseline orientation for first year nurses. The citywide consortium model builds upon the best practices of other state and regional nurse residency collaboratives, in the hopes that near-universal adoption of nurse residency in the city improves professional standards and creates opportunities for networking and peer learnings across hospital systems, to increase retention and continue to attract new nursing talent to the five boroughs.[23]

Licensing Internationally Trained Nurses

As a city of immigrants where one in three New Yorkers are foreign-born and another third are the children of immigrants, cultural competence in the health workforce is fundamental to improving overall population health. While NYACH recognizes that need in its Core Competencies and related work, NYC's immigrant community is also home to a large population of healthcare workers who can be called upon to serve their own communities. While more than 10% of nurses practicing in NYS are trained outside of the United States,[24] according to analyses from the Migration Policy Institute, NYS is home to some 22,000 underutilized healthcare professionals, with nursing being the most common degree held by immigrants and refugees. Instead of doing valuable nursing work, they end up working in lower-paying jobs such as nursing assistants, home health aides, personal care aides, or as domestic help.[25] Educated and trained abroad, these workers are often underemployed due to barriers such as lack of language proficiency or professional networks and because they do not have the correct New York credentials or licensure.

Given the demand for registered nurses in NYC and this underutilized talent pool, beginning in 2011 NYACH sponsored the NCLEX-RN Preparation for Foreign-Trained Nurses training program in collaboration with NYC SBS and the NYC Welcome Back Center at LaGuardia Community College—a CUNY school. This program provides an eight-month National Council Licensure Examination (NCLEX-RN exam) preparation course for internationally trained nurses, focusing on both the English-language skills and nursing skills needed to pass the NCLEX-RN exam and to become a registered nurse in NYS.

23 Davis, K., Warren, J., Nusbaum, S., Rhoades, J., Liss, D., Ricords, A., & Cadmus, E. (2021). Expanding nurse residency programs through regional and statewide collaborative partnerships. *Nurse Leader*, 19(5), 521–524. https://doi.org/10.1016/j.mnl.2021.01.006

24 Center for Health Workforce Studies. (2015). (issue brief). *A Profile of Active Registered Nurses in New York*. Retrieved from https://www.chwsny.org/wp-content/uploads/2016/07/Nursing_Profile_2015.pdf.

25 Batalova, J., & Fix, M. (2020, April). As U.S. Health-Care System Buckles under Pandemic, Immigrant & Refugee Professionals Could Represent a Critical Resource. Retrieved from https://www.migrationpolicy.org/news/us-health-care-system-coronavirus-immigrant-professionals-untapped-resource.

Impact of COVID-19 Pandemic on Nursing

As depicted in countless news stories from the spring of 2020, the impact of the COVID-19 pandemic took an especially devastating toll on the nursing workforce, as nurses continued to fill their critical role in hospitals, clinics, and long-term care settings despite at times inadequate personal protective equipment and incredible illness and stress. Their efforts were and are heroic, and now the NYC nursing workforce faces profound challenges and shortages caused by the compound effects of burnout from being on the frontlines of the COVID-19 pandemic's first epicenter, an aging workforce retiring earlier than expected, resistance to healthcare worker vaccine mandates, new New York State regulations dictating increased nurse staffing levels, and unprecedented pandemic-driven demand and compensation for nurses in competing markets across the United States. This shortage is causing increased workloads and further stress for current nurses, negatively impacting the quality of care available to NYC patients and communities and diminishing our preparedness for future healthcare crises, including subsequent waves of COVID-19. NYACH has heard these details from across our partner network and from nursing executives throughout the city.

When nursing students were graduating months early to support hospital surge staffing in spring 2020, the City-wide Nurse Residency Program (NRP) continued to provide ongoing education and training, research opportunities, and perhaps most importantly a peer support infrastructure for new registered nurses who were transitioning to their first inpatient nursing job under the most dire circumstances imaginable working in "the epicenter of the epicenter" of the COVID-19 emergency. The pandemic underscored NRPs' intrinsic value as it supported some of our most overburdened healthcare personnel while continuing to produce good performance outcomes.

Read more about NYACH's work during the COVID-19 public health emergency on page 50.

WORKFORCE INNOVATION CASE STUDY:

Tomorrow's Healthcare Workforce

Overview

The transformation taking place in the healthcare industry to new models of care means that we need a workforce equipped with skills and experience to take on these new challenges. While many of NYACH's historical workforce efforts have been focused on the healthcare workforce of today—both incumbent workers and new entrants—the NYACH Ready for Healthcare initiative took a step even further back in the pipeline to work with high school students who will be the health professionals of the future.

Throughout the course of this initiative, which began in 2017 and concluded in 2021, NYACH worked with our employer partners to understand the skills they need young professionals to have developed as well as what real and perceived barriers employers have in engaging with students directly to support their learning, such as being a guest speaker or hosting a student intern. NYACH also heard from school leaders about their experiences collaborating with healthcare employers and youth development experts on how to structure learning activities to be effective for high school students.

Over the course of this initiative, NYACH assessed the relevant landscape, built a new work-based learning model that worked for employers, educators, and students, designed a supportive toolkit to help with implementation, and then tested the model through direct implementation and evaluation.

Building and Testing a New Work-based Learning Model

The NYACH Ready for Healthcare work-based learning model and supporting toolkit were explicitly designed with both employers and educators in mind, structuring learning activities to be relevant to the skills employers need, ensuring they are developmentally appropriate for students, and creating easily modifiable tools to support the full range of work-based learning activities. In particular, the model was designed to be implemented as a four-year, scaffolded high school program, with the first year focused on an updated foundational curriculum based heavily on the NYACH Core Competencies (see page 24), the second on career exploration (which included guest speakers, job tours, career expos, and mentorship), the third on building professional skills through a project-based internship, and the last on building technical skills through a clinical internship.

NYACH developed and tested this model through three different phases. First, we went through a learning phase to listen to employer needs and to clarify the challenges they faced in engaging with high school students. Second, we designed the work-based learning model, created a supportive toolkit, and selected a local youth development nonprofit to be an implementation partner in piloting the model. Lastly, NYACH piloted the new work-based learning model in partnership with four Department of Education (DOE) Career and Technical Education (CTE) healthcare high schools and 79 local healthcare employers.

By the numbers

Four Department of Education (DOE) Career and Technical Education (CTE) healthcare high schools representing students across the city.

79 local New York City healthcare employers, including ~20 that directly informed the creation of the work-based learning model

Student Participation:

- 781 students benefited from at least one aspect of programming
- 321 students completed at least three career-exposure activities
- 75 students participated in mentorship
- 193 students participated in paid ($15 per hour) professional skills internships
- 22 students participated in paid ($15 per hour) clinical technical skills internships (interrupted by COVID-19)

Internship Demographics:

- 82% identified as female
- 87% identified as Black/African American, Hispanic/Latina/Latino, or Asian/Pacific Islander
- 76% from households with an income less than $50,000; 52% less than $30,000

90+ supportive tools created with implementation support in mind, validated by healthcare human resources leaders and youth development experts, and tested in the field. The fully editable toolkit will be public and available on NYACH's website in early 2022.

FIGURE 16. A Continuum for Improving Work-Based Learning in Healthcare for High-School Students

Our approach for improving work-based learning in healthcare was designed in partnership with industry and has mobilized healthcare employers to engage with students in a progressive sequence of experiences.

1 FOUNDATION

Enhanced Healthcare Core Curriculum

Objective

Learn industry-identified core skills needed to succeed in today's changing healthcare landscape

Our Approach

Robust curriculum focusing on the nine competencies critical to employer consideration in taking on students in work-based learning opportunities

2 EXPOSURE

Career Exploration Models

Objective

Understand the variety of occupations and types of employers in the healthcare sector

Our Approach

A diverse menu of experiences designed for seamless employer participation and aligned to emerging occupations and anticipated growth

3 PROFESSIONAL SKILLS

Professional Skills Internship Model

Objective

Develop the key professional skills fundamental to excelling in a healthcare setting

Our Approach

Project-based internships driven by employer need that generate meaningful opportunities for student interns

4 TECHNICAL SKILLS

Technical Skills Internship Model

Objective

Develop clinical skills and technical experience for a specific and in-demand occupational track

Our Approach

Advanced internship opportunities structured around employer-identified skills needed to secure employment in a competitive job market

Key Learnings

On the whole, the program was successful at delivering quality preparation for students and creating a model in which healthcare employers engaged meaningfully in work-based learning.

In particular, the model proved to be effective at addressing employers' perceived and actual barriers. Employers identified five main areas of concern: (1) student preparedness, (2) time constraints for supervisors, (3) physical space constraints, (4) union relations, and (5) liability. After we implemented the model, employers reported being impressed by students' professionalism, with 94% reporting they found students either "professional" or "very professional." Employers also reported that supervision time and space constraints were less challenging than anticipated. Lastly, neither union nor liability concerns were raised by employers during the actual implementation of the model, leading us to conclude that these barriers are more about employer perceptions than practical roadblocks.

97% of employers who worked with us on implementing this model indicated they would likely work with high school students again and would recommend doing so to their peers. Students also reported positive impacts from the sequenced learning model: 96% stated that they benefited from the progressive nature of the model and 89% reported they had better knowledge of what to expect in their first healthcare job after graduation.

Furthermore, while the COVID-19 pandemic was incredibly disruptive, including requiring the suspension of in-person clinical internships to ensure student and patient safety, the program still provided excellent support to students, educators, and employers, and provided ample learnings for the field. In particular, the program provided financial and educational resources to students while much of their normal learning and—for some—family income was disrupted, and provided employers with the opportunity to experiment with virtual internships and guest speaking. A further discussion of COVID-19's impact on this program and NYACH's work more generally during this time is included in the pandemic response section of this report (see page 50).

Implementation Toolkit

The NYACH Ready for Healthcare work-based learning implementation toolkit is a collection of resources (such as sample internship projects, worksheets, teaching guides, and planning documents) intended to serve as an open-source roadmap and curriculum guide to introduce high schoolers to the diversity of careers available in healthcare and the skills they need to succeed in those careers. Together, the model and toolkit make it easier for employers and educators to engage with meaningful work-based learning activities and support students through their professional journey.

Though this toolkit was specifically designed to support our four-year, scaffolded, learning model, these tools are modular, easy-to-use, and highly adaptable, intended to be of use to anyone interested in introducing young people to the potential of working in the healthcare sector. The toolkit includes resources for employers, mentors (health professionals who want to engage with students on their own), educators, and students themselves.

The fully editable toolkit resources will be made public and available on NYACH's website in early 2022 with easy navigation to allow interested stakeholders to filter and customize tools for any activity type or audience.

NYACH's COVID-19 Pandemic Response

The sudden and severe beginning of the COVID-19 pandemic was a fearful time for everyone in New York City (NYC), and while the intensity of the emergency presented an obvious crisis for the operational logistics of our healthcare system, it was an especially daunting experience on a human level for the thousands of frontline healthcare workers whose professional dedication and human care continued uninterrupted, despite tremendous personal risk and emotional stress. NYACH had the privilege and responsibility to continue its work in support of these workers throughout the public health emergency as an intermediary for the system, a meeting place for stakeholders across the industry and workforce development ecosystems, and as a direct crisis operations manager.

NYACH was committed to helping the sector and its people in any way it could. We built upon our track record of being an effective convener and innovator in the NYC healthcare economic and workforce development ecosystem, while also trying to make sense of the immense emotional toll the pandemic was taking on the workforce and the city. As an intermediary straddling both government and the private sector, NYACH quickly became a go-to translator and force multiplier for government and industry partners alike–directly running workgroups and initiatives, serving as subject matter expert and translator, and frequently bringing the urgent voice of exhausted workers and businesses to government and the wider public.

Long-Term Care in Crisis

In March 2020, it quickly became apparent that the lion's share of attention and government resources were going towards hospital surge capacity and supply chain issues–which was certainly very much needed–with little support being given to the long-term services and supports (LTSS) healthcare subsector, including nursing homes, homecare, and care for those with disabilities, which was nevertheless in need of government attention and intervention. NYACH immediately launched an emergency response group for LTSS, using its track record of relationship-building and investment in the subsector to bring a diverse group of government and industry stakeholders together to address the crisis. This weekly workgroup, which began the first week of lockdown, brought local government, long-term care employers, industry associations, employers, labor unions, and educational institutions together to identify, escalate, and problem-solve pressing challenges for the subsector.

NYC's LTSS subsector has long suffered underinvestment, with much of its business operations being funded through the New York State (NYS) Medicaid program at incredibly low reimbursement rates. To give an example, one homecare agency leader and NYACH partner has described the business situation "as if you are running a consulting firm and all of your revenue comes from billable hours but where you can only bill $22 per service hour." Given these circumstances, it is no wonder that LTSS employers who struggle to stay afloat in normal times, further struggled profoundly to procure the bare minimum of PPE and other supportive resources for their workers at the beginning of the pandemic.

Direct care workers, including home health aides, personal care aides, nurse assistants, direct support professionals and related titles, include more than 350,000 New Yorkers. These hard-working, mostly low-income women of color had to show up on the frontlines of the pandemic just the same way other health professionals did. What they did not get—at least not early on—was the visible support of the broader community paid to hospital workers and EMS professionals, either through the symbolic nightly applause at 7pm, or in much more tangibly important ways, such as the ability to isolate at a hotel or being equipped with sufficient protective equipment, as their work took them on public transit sometimes multiple times in the course of one workday to serve patients across the five boroughs.

Pandemic Impacts on LTSS

The pandemic didn't create any of these problems in the LTSS system, but the problems made the existing fragility of the business model and its worker equity challenges that much harder. The primary impacts of the pandemic on LTSS include:

- Increased costs (e.g. PPE)
- Reduced revenue (e.g. fewer patients/clients wanting services)
- Workers getting sick or calling out sick; and corresponding increased competition for new workers
- Collapse of in-person training pipeline (especially for homecare workers)
- Direct care workers continue to be unseen by society and policy makers–or worse, blamed for bad outcomes

The NYACH LTSS emergency workgroup offered an essential, real-time, vantage point on the state of the long-term care sector city-wide, and led to many fruitful collaborations, shared resources, and innovative programmatic

solutions. These included brokering a successful relationship between 1199SEIU United Healthcare Workers East and the NYC Department of Health and Mental Hygiene (DOHMH) to ensure PPE got into the hands of direct care workers, the launch of a new COVID-19 resource page on the NYACH website, a print and social media campaign promoting worker visibility and recognition,[26] a program connecting administrative volunteers to homecare agencies, and a successful advocacy effort to designate homecare workers as essential healthcare workers in the NYS-determined vaccine eligibility criteria, followed by cross-sector work to inform vaccine distribution and outreach strategies. Finally, building on its historical work with homecare training, NYACH also partnered with NYC Department of Small Business Services (SBS) and the City University of New York (CUNY) to launch the state's first-ever hybrid-virtual Home Health Aide training program after the collapse of the in-person training pipeline (see case study on next page).

Above all, the emergency workgroup served as one of the only places where LTSS stakeholders felt seen and respected by the government, and felt like they had a safe place to build cooperative solutions to common problems.

Read more about our emergency work in the subsector in NYACH's 2020 industry brief, NYC COVID-19 Emergency Response in Long Term Services and Supports (2020).

26 Thompson, J. P., & Salerno, J. (2020, May 18). Let's Thank All Caregivers, Not Just the Most Visible. *Gotham Gazette*. Retrieved from https://www.gothamgazette.com/opinion/9397-thank-all-caregivers-not-just-most-visible-coronavirus-new-york-city.

Members of the Long-Term Services and Supports Workgroup

Government Stakeholders

Office of the Deputy Mayor for Strategic Policy Initiatives • Mayor's Office of Workforce Development • NYC Office of Emergency Management • NYC Service • NYC Department of Health and Mental Hygiene • Mayor's Office of Immigrant Affairs • Mayor's Office of Policy and Planning • Mayor's Office for People with Disabilities • NYC Department of Small Business Services • NYC Department for the Aging • NYC Department of Consumer and Worker Protection • City University of New York (CUNY)

Non-Government Stakeholders

1199SEIU Training and Employment Funds • 1199SEIU United Healthcare Workers East • AHRC NYC • Caring Majority • Continuing Care Leadership Coalition • Cooperative Home Care Associates • LeadingAge New York • PHI • RiseBoro Community Partnership • Southern New York Association • Sunnyside Community Services • The New Jewish Home • The New York Academy of Medicine • Visiting Nurse Service of New York

Case Study: **Hybrid-Virtual Home Health Aide Training**

Overview

The need for home health aides (HHAs) in New York City (NYC) skyrocketed during the COVID-19 public health crisis, a stark challenge from the pandemic's onset due to 1) increased HHA absenteeism and attrition out of fear of infection; 2) quarantine policies that kept HHAs out of the field after an exposure to COVID-19; and 3) the halt of in-person, employer-based training during government mandated lockdowns that ordinarily allows for a steady pipeline of HHAs.

To respond to this crisis, in June 2020 NYACH and the NYC Department of Small Business Services (SBS), in partnership with the City University of New York (CUNY) and the NYACH LTSS COVID-19 Emergency Response Workgroup, launched an emergency hybrid-virtual HHA training program to help meet this sudden increase in demand in the healthcare workforce.

Piloting a Hybrid-Virtual Home Health Aide Training

NYACH and its training partners designed and implemented the hybrid-virtual training with three objectives in mind. First, it was intended to address the acute workforce shortage resulting from the pandemic by directly training workers. Second, the program was designed as a pilot to determine whether hybrid-virtual training could be used during the pandemic as an emergency measure to support the pull-back of in-person training. Lastly, the pilot was forward looking, designed to inform if a virtual modality could hold additional value for the training pipeline after the pandemic.

NYACH and SBS leveraged pre-existing relationships with two CUNY training providers–The City College of New York and New York City College of Technology (City Tech)–and led collaboration to adapt staffing, curriculum, and equipment to a hybrid-virtual model, to secure State regulatory approval, and to recruit and screen candidates for four pilot cohorts within an expedited emergency timeline.

The training program launched in mid-June 2020 with the final cohort concluding in late-November 2020, training a total of 112 individuals. Successful training participants were entered in the New York State (NYS) Home Care Registry and began work with one of three NYC-based homecare employers who partnered on this initiative.

In December 2020, NYACH published an industry brief on the pilot to share the hybrid-virtual training model, its outcomes, and lessons learned as widely as possible in the midst of the ongoing staffing crisis. To accompany its publication, NYACH hosted an informational webinar where employers and other homecare stakeholders in New York City and beyond asked additional questions about the pilot in the interest of their own plans to implement new hybrid-virtual trainings. Following the implementation of the training pilot, New York State created a new regulatory pathway for industry-based training to allow for hybrid-virtual modalities in HHA training during the ongoing pandemic.

Learn more about the Hybrid-Virtual HHA training by reading our Industry Brief released in 2020.

Emergency Operations

Beyond its work with long-term care, NYACH was involved in a range of crisis management projects since the early days of the pandemic. In the face of severely overwhelmed hospitals and nursing homes, NYACH supported surge staffing planning alongside the NYC Office of Emergency Management (NYCEM) and Greater New York Hospital Association (GNYHA). This work ensured local institutions, recruiters, and government partners could access talent via emergency staffing mechanisms, including through getting the Workforce1 Center System access to the NYS Department of Health volunteer portal. NYACH would revisit some of this work later in 2020 working with NYCEM on emergency table-top surge planning exercises, as they sought to memorialize hard-learned lessons from the spring and plan for an anticipated winter 2021 surge in cases.

NYACH also worked to secure and distribute much needed personal protective equipment (PPE) and other supplies to healthcare institutions, connecting City and manufacturing industry colleagues who were creating new supply chains for hospitals, community health centers, nursing homes, and homecare agencies.

NYACH also lent its workforce development and training expertise to the preliminary design of the NYC contact tracing program, prior to its transfer to NYC Health + Hospitals, and subsequently supported the Mayor's Office of Workforce Development in the design and launch of the Resource Navigator program, working alongside the NYC Department of Small Business Services (SBS) to stand up worker recruitment and onboarding training. Working with 15 community-based organizations throughout the five boroughs, the Resource Navigator program ensures that any New Yorker isolating or quarantining due to COVID-19 can access government-enabled resources to safely separate at home.

Moving past the early days of the pandemic into 2021, when the Mayor committed to hiring 2,000 New Yorkers from the neighborhoods hit hardest by COVID-19 to work in vaccine distribution through the Vaccine for All Corps, NYACH was enlisted by the City's Vaccine Command Center (VCC) to design and help run an operation to recruit and train workers, and to design downstream pipeline programs where this newly hired workforce could continue caring for their communities beyond the short-term need for vaccine distribution staff. Alongside the other members of the VCC Staffing Branch and partners from SBS, NYCEM, and the NYC Department of Health and Mental Hygiene (DOHMH), NYACH created the design and preliminary operational structure of the jobs program, designed equity-based recruitment and screening processes, supported the orchestration of onboarding training, led initial communications and community outreach efforts for the VCC Staffing Branch, and supported ongoing operations throughout 2021. This infrastructure delivered a new, essential, well-paid, community-sourced workforce of clinical and non-clinical workers to administer thousands of vaccine doses to New Yorkers each day.

As vaccine distribution work shifted from throughput volume to enhancing community trust in the vaccine, NYACH shifted from supporting the operations of the Vaccine for All Corps to working with DOHMH to design a Community Health Worker (CHW) apprenticeship program, building on our expertise working in emerging healthcare occupations. CHWs "are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community they serve. It is through their trusting relationship with community members that CHWs are able to assist individuals in accessing services while also advocating for improvement in the quality and cultural humility of service delivery."[27] CHWs have been proven to improve health outcomes for historically disadvantaged communities, such as those New York City (NYC) neighborhoods hardest hit by COVID-19.

Working with DOHMH and CUNY, NYACH consulted to the design of the program structure and led competency-based curriculum development for this new initiative. The CHW Apprenticeship trained 250 Vaccine for All Corps members as Community Health Workers over the course of 10 weeks: one week of orientation, three weeks of virtual training, followed by six weeks of on the job learning at one of 40 community-based organizations citywide. These CHWs are foundational to the City's newly-created Public Health Corps,[28] an initiative to create a knowledgeable community-based workforce to meet a broad spectrum of public health needs—from accessing vaccination to counseling services—to strengthen community health across NYC.

27 *Community Health Workers*. American Public Health Association. (n.d.). Retrieved from https://apha.org/apha-communities/member-sections/community-health-workers

28 Office of the Mayor. (2021, September 29). Mayor de Blasio Launches the NYC Public Health Corps. T*he Official Website of the City of New York*. Retrieved from https://www1.nyc.gov/office-of-the-mayor/news/658-21/mayor-de-blasio-launches-nyc-public-health-corps#/0

Adding Value through Existing Programs

In addition to a host of new emergency management efforts, NYACH also doubled down on its pre-existing programs, whose value took on a new importance in the face of the public health emergency.

When nursing students were graduating months early to support hospital surge staffing in spring 2020, the City-wide Nurse Residency Program (NRP) continued to provide ongoing education and training, research opportunities, and perhaps most importantly a peer support infrastructure for new registered nurses (RNs) who were transitioning to their first inpatient nursing job under the most dire circumstances imaginable working in "the epicenter of the epicenter" of the COVID-19 emergency. The pandemic underscored NRP's intrinsic value as it supported some of our most overburdened healthcare personnel while continuing to produce good performance outcomes.

Read more about the City-wide Nurse Residency Program on page 42.

NYACH's Ready for Healthcare program—which introduce young people at NYC Career and Technical Education (CTE) high schools to potential healthcare careers—likewise took on added importance during the pandemic, adding value beyond its intended objectives as the demand for healthcare workers reached all-time highs. Though its components had to be modified and made virtual as all education in the city was, the structured curriculum was well suited for the pivot to online learning, and in some cases was improved by the online format: for example, asynchronous virtual guest speakers were logistically easier to coordinate than live, in-person, events while enabling wider student access to speakers as all schools could participate and/or watch recordings.

Similarly, virtual internships eliminated employer concerns about office space constraints while still encouraging meaningful project-based work. For example, one group of students at Mount Sinai Beth Israel worked on a project sharing COVID-19 vaccine information with patient networks through social media. One student shared, "...in the end, my group and I were able to get around 30 people vaccinated at Mount Sinai Beth Israel. This was such a great accomplishment for me." The project was also a real value-add for the employer, commenting that the students developed a "sophisticated" project with "remarkable outcomes." We also heard from students that in some cases the wages they earned from their internships offered an opportunity to bring in income when faced with a family member's loss of a job. On the employer side, even with pandemic burdens placed on healthcare facilities, many of the 79 participating healthcare employers still offered internships in 2020 and 2021.

Importantly, NYACH was able to both complete its testing of the new work-based learning model despite the pandemic's disruption and help equip young people along the way with the industry-informed skills they need to succeed in healthcare careers—where they are needed now more than ever.

Read more about the NYACH Ready for Healthcare initiative on page 46.

Conclusion

The COVID-19 pandemic is the worst health crisis in 100 years, and the worst economic downturn New York City has faced since the Great Depression. Throughout the crisis, NYACH worked tirelessly to support its constituent businesses and workers. NYACH also recognized the potential of the pandemic to develop new ways of working with partners within the sector—albeit often out of urgent necessity—and to advance new projects that built upon and scaled former work.

While there were no silver linings in the emergency, it did force NYC's diverse coalition of healthcare stakeholders to think outside of the box. In many ways, the healthcare system in NYC was frozen in its historical ways of working, and, in some places, we were able to break through the ice, working with new government partners, capitalizing on the opportunities to scale innovative work rapidly, and demonstrating NYACH's value-add as an intermediary, as none of this work would have been possible without a collaborative approach. Although faced with rapidly compressed timelines, NYACH and its partners old and new rose to the occasion to innovate and scale solutions.

It is no understatement to say that the healthcare sector—and NYACH—was irreversibly changed by the pandemic. NYACH continues to listen to the industry, through its Partners Council, Advisory Groups, and in myriad other ways to ensure that the many lessons learned throughout the sector are elevated, well-articulated, and amplified to the broader healthcare and workforce ecosystem, in the hopes that we are better prepared for the next public health emergency to come.

Our Priorities Today

As the urgency of the pandemic subsides and NYACH reflects upon a decade of accomplishment, it is not nearly enough to celebrate our successes or to document lessons learned, as the healthcare sector–both its businesses and workers–continues to be in serious need of support. NYACH is steadfast in its commitment to the sector at this current moment, bringing our relationships, expertise, and capabilities to today's acute challenges while investing for the long-term needs of tomorrow.

NYC's healthcare sector has gone through tremendous transformation in the past 20 years, beginning with new technologies, accelerating through the passage and implementation of the Affordable Care Act, and now undergoing urgent, seismic shifts due to the COVID-19 pandemic. While many trends–such as the move to value-based care–continue at full force, the continuation of some trends driven by healthcare reform that seemed obvious and inevitable before the pandemic are now unclear. For example, the city spent 20 years reducing its hospital footprint, migrating care to lower cost community and home-based settings. The demands of the pandemic, however, caused panic about the reduced number of hospital beds in the five boroughs and we are now seeing some shifts in institutional planning. Similarly, technology adoption had been painfully slow, with many providers still using paper records, let alone implementing effective virtual care. When faced with the need to physically distance to reduce the spread of a highly infectious respiratory disease, however, the city suddenly saw an almost overnight adoption of telehealth care modalities.

As the industry continues to operate under serious strain, it is unclear what its future will look like. What does remain unchanged, however, is that the healthcare sector must continue to deliver care today to more than 8.8 million New Yorkers and our neighbors in the region, while building sufficient capacity to respond to the health crises of the future. This means making sure that businesses across the spectrum of care delivery have solid financial footing, that care is accessible to all NYC communities, and that we have a robust and flexible workforce.

The pandemic highlighted the gravity of pre-existing workforce shortages (like those in long-term care) while causing a spate of new ones (such as in nursing), that must be addressed both in the immediate term and systemically for the sector's long-term health. While filling labor shortages is incredibly important, the process and outcomes also matter. The pandemic brought new and urgent attention to issues of

equity and the realities of systemic racism, above all the profound unfairness of living in a society that forces a disproportionate disease burden and health risk onto communities of color while failing to notice–let alone attempting to rectify–that hardship.[29] Addressing workforce shortages gives us an opportunity to employ New Yorkers to care for their own communities and to empower people with meaningful work and a living wage.

In taking on this challenge, we find promise in NYC's wealth of healthcare resources: everything from world-renowned academic medical systems to hundreds of community and home-based care organizations, to strong industry associations, advocacy groups, and unions. Similarly, NYC has a robust healthcare workforce development ecosystem with strong private and government funding supporting community-based bridge programs, academic degree and continuing education programs, union-sponsored programs, and programs run directly by employers. Yet, even with these resources, disparities in health outcomes have continued to plague our city[30] and ensuring a well-equipped workforce that reflects the diversity of the city has been slow progress.

29 Thompson, C. N., Baumgartner, J., Pichardo, C., Toro, B., Li, L., Arciuolo, R., Chan, P. Y., Chen, J., Culp, G., Davidson, A., Devinney, K., Dorsinville, A., Eddy, M., English, M., Fireteanu, A. M., Graf, L., Geevarughese, A., Greene, S. K., Guerra, K., ... Fine, A. (2020). Covid-19 outbreak — New York City, February 29–June 1, 2020. *MMWR. Morbidity and Mortality Weekly Report*, 69(46), 1725–1729. https://doi.org/10.15585/mmwr.mm6946a2

30 New York City Health Department. (n.d.). Health Disparities. New York City Health Department. Retrieved from https://www1.nyc.gov/site/doh/data/data-sets/health-disparities.page

Minority Health Data and Statistics. (2019, November). Retrieved from https://www.health.ny.gov/statistics/community/minority/.

During the pandemic we have seen historically siloed stakeholders newly willing to work together and to work differently than they had previously, and there is increasing alignment in identifying the challenges facing the system. Equity and workforce issues have been universally called out as priorities from health departments at every level of government, whether in New York City's declaration of racism as a public health crisis,[31] or in the goals articulated in the Federal Department of Health and Human Services' recently released *Health Workforce Strategic Plan*.[32] Similarly, employers, industry groups, and unions have been ringing alarm bells about injustices and their intersections with staff shortages and the lack of fair compensation or recognition for overburdened and burnt-out healthcare staff. These unified calls for action are timely, as NYC welcomes new political leadership in Mayor Eric Adams, as well as anticipated new investments in Medicaid reform and other healthcare economic and workforce development initiatives from State and Federal governments, which are likewise under new executive leadership since the pandemic's onset. We see this as an opportunity for renewed commitment to and action towards systems change goals that are more clearly necessary than ever, which require important investments not only in businesses and workers, but also in the public sector's capacity to support the healthcare industry and consequently public health.

In short, the pandemic has given the system more urgency, more open-mindedness, more focus, and potentially more investment. The challenges the healthcare sector and workforce ecosystem face are daunting, but 2022 is also a moment of tremendous opportunity.

With all this in mind, NYACH embraces **five priority areas** of work for 2022 to serve NYC and capitalize on this opportunity:

PRIORITY

Build a comprehensive pipeline for shortage and resiliency-needed titles, with a focus on growing a diverse workforce with family-sustaining careers.

The New York City (NYC) healthcare workforce is facing profound challenges and shortages caused by the compound effects of burnout from being on the frontlines of the COVID-19 pandemic's first epicenter, an aging workforce retiring earlier than expected, resistance to healthcare worker vaccine mandates, new New York State regulations dictating increased nurse staffing levels, and unprecedented pandemic-driven demand and compensation for contract clinical staff in competing markets across the United States. This shortage is causing increased workloads and stress for current staff, diminishing NYC's preparedness and resiliency to face any potential future healthcare crisis, and, importantly, negatively impacting the quality of care available to NYC patients, particularly historically-disadvantaged communities with less access to resource-rich providers.

While NYC's healthcare workforce was able to respond effectively to the early months of the pandemic, this was largely due to the city's ability to attract out-of-state clinical staff at a time when the pandemic had not yet surged across the country. Therefore, it is not only important to alleviate the immediate strain on workers and employers by buttressing the workforce as quickly as possible, but NYC must also create long-term changes to the healthcare workforce pipeline to ensure that we are not faced with this level of regional shortage in the event of another health emergency.

31 New York City Health Department. (2021, October 18). Board of Health Passes Resolution Declaring Racism a Public Health Crisis. New York City Health Department. Retrieved from https://www1.nyc.gov/site/doh/about/press/pr2021/board-of-health-declares-racism-public-health-crisis.page

32 U.S. Department of Health and Human Services, Health Workforce Strategic Plan (2021). Retrieved from https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/about-us/hhs-health-workforce-strategic-plan-2021.pdf

We need to look specifically at healthcare shortage and resiliency-necessary occupations (such as in nursing, respiratory therapy, and skilled technologist jobs), identify places where people are getting stuck in the pipeline (especially in in-need populations/communities), and implement targeted interventions for those specific areas. Successful projects under this work will demonstrate to the NYC healthcare workforce development ecosystem–including employers, educational institutions, union training funds, and CBOs–more effective ways of working, with the intention of becoming the new standard operating practice for these and other relevant areas of the pipeline.

Specifically, in 2022 NYACH will build on its track record of successful multi-stakeholder career pathway programs, such as the hospital-based Citywide Nurse Residency Program, the NCLEX Exam Preparation Course for Foreign-Trained Nurses, and the Bilingual Medical Assistant program, to create innovative accelerated career advancement and education-to-practice transitional programs in shortage and resiliency-needed occupations, starting with nursing. These new program models will ensure businesses have the workers they need in both the short- and long-term and that effective and efficient pathways to high paying jobs exist for systemically disadvantaged communities.

PRIORITY:

Use healthcare reform to expand the number, pay, and stability of middle-wage jobs through the creation of new business and staffing models

NYACH estimates total Medicaid spending in New York City (NYC) to be at more than $51 billion annually[33], which allows New York State (NYS) regulators outsized influence in the investment and future direction of NYC's healthcare system. While this has been true for many years, NYACH anticipates a renewed intensity and focus on the Medicaid program in 2022 and new flexibility with a new governor.

NYC Medicaid enrollment grew by 22% during the pandemic (3,384,225 in February 2020; 4,133,720 in January 2022), which means that ~47% of NYC residents are now covered under Medicaid.[34] This highlights two things: first, that almost half of NYC residents are living in or near poverty significant enough to be eligible for Medicaid coverage (in addition to the more than half a million people who are uninsured the city),[35] and second, that the system must be responsive to the needs of the Medicaid population.

On top of changes resulting from recent Medicaid enrollment growth, NYS government is in the middle of negotiating a $17 billion, five-year, new 1115 Waiver Demonstration project.[36] This

33 At a February 23rd 2022 Executive Budget webinar, NYS Department of Health indicated that total Medicaid spending state-wide is currently $84 billion in FY22 and that it expects it to increase to $92 billion in FY23. The webinar can be found on NYS DOH's website: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm

NYS's Medicaid program is jointly funded by federal, state, and local governments, and NYC specific spend information is not readily available. NYACH instead examined the percent of state government spending allocated to NYC through the Medicaid Global Cap (~61% as per Appendix C of the final FY21 Medicaid Global Cap report: https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2020-2021/docs/mar_2021_report.pdf) and applied that percentage to the total state-wide spending to estimate total spending in NYC at more than $51 billion annually. Of note, the Medicaid Global Cap does not include all categories of State spending, and it is fair to assume that, due to NYC's high concentration of NYS's healthcare resources, a higher percentage of federal, capital, and other dollars are allocated to NYC than the percentage reflected in the Global Cap.

34 NYS Medicaid Enrollment Databook. (2022, February 7). Retrieved from https://www.health.ny.gov/health_care/medicaid/enrollment/historical/all_months.htm.

35 Robinson, S., & Willyard, K. (2021). (publication). *Small Area Health Insurance Estimates*: 2019. United States Census Bureau. Retrieved from https://www.census.gov/library/publications/2021/demo/p30-09.html.

36 Office of Health Insurance Programs, 1115 Waiver Demonstration: Conceptual Framework A Federal-State Partnership to Address Health Disparities Exacerbated by the COVID-19 Pandemic (2021). New York State Department of Health. Retrieved from https://health.ny.gov/health_care/medicaid/redesign/2021/docs/2021-08_1115_waiver_concept_paper.pdf

new program, if approved, would be a spiritual successor to the 2014-2020 DSRIP program, with the same population health and collaboration goals of the earlier program. The current proposal from NYS, however, is larger in both scope and ambition from the earlier DSRIP program, this time aimed in an even more targeted way at creating a more equitable health system.

There are many priorities in NYS's proposal that, if implemented, would have an impact on the economic and workforce systems in NYC, including plans around health coordination, addressing social determinants of health including housing and jobs programs, reinforcing home and community-based services, and expanded telehealth infrastructure. The NYS proposal also explicitly calls out workforce development repeatedly throughout the document, including a broad commitment to "Develop a Strong, Representative and Well-Trained Workforce."

Assuming that this next round of NYS Medicaid redesign is similar in payment structure to DSRIP, it is likely that much if not all funding will flow through performance payment arrangements. This means it is important city stakeholders act quickly to influence the total dollar allocation to NYC projects once the program is approved by the federal government, and then follow up to ensure that participating organizations are equipped with the tools they need to make the largest, most efficient impact with those dollars. We also need to ensure that philanthropic organizations are aware of these government investments and highlight where private investment can compound the positive effects.

In 2022, NYACH will convene its partners to organize and influence Medicaid redesign investments and equip the ecosystem for maximal innovation and community impact, especially in business and staffing models that utilize locally-hired workers with middle-educational attainment. To do this, NYACH will build on its experience of workforce development during the 2014-2020 DSRIP program and other Medicaid redesign efforts, and its track record of successful programs promoting emerging occupations, including the Health Coach model, Certified Peer Recovery Advocate training, and two different Community Health Worker Apprenticeships.

PRIORITY:

Improve job quality for low-wage homecare workers

The Long-term Services and Supports (LTSS) healthcare subsector, especially homecare, was particularly vulnerable to the challenges of the pandemic due to long-standing systemic challenges, in addition to the acute, disproportionate health impacts on its essential frontline workforce, overwhelmingly composed of women of color.

Read more about the LTSS sector and homecare workforce in the Emergency Operations Section starting on page 50.

New York City also has an aging population[37] with roughly 1.1 million New Yorkers already age 65 or older.[38] Many of these seniors are hoping to be able to age at home, which, from a system perspective, is a hope backed by a wealth of evidence indicating it is better for both health and cost outcomes. Looking toward the future, New York State Department of Labor projects that the city's Home Health Aide (HHA) and Personal Care Aide (PCA) workforce will increase by ~70% by 2028 (from 292,530 to 495,390 jobs in those two titles alone) an increase of more than 200,000

37 As described in the NYC Department of City Planning report on the 2020 census, "while the overall population of New York City grew by 7.7 percent, the population under 18 years old declined (-1.6 percent) by 27,969, a reflection of declining births and an aging population." The full report can be found here: https://www1.nyc.gov/assets/planning/download/pdf/planning-level/nyc-population/census2020/dcp_2020-census-briefing-booklet-1.pdf?r=3

38 Greer S, Adams L, Toprani A, Hinterland K, Dongchung TY, Brahmbhatt D, Miranda T, Guan QX, Kaye K, Gould LH. (2019). (rep.). *Health of Older Adults in New York City*. NYC Department of Health and Mental Hygiene. Retrieved from https://www1.nyc.gov/assets/doh/downloads/pdf/episrv/2019-older-adult-health.pdf

jobs.[39] Thus, New Yorkers' future health is dependent on a robust homecare workforce, and these jobs will require both good employment practices and a living wage to ensure the future economic prosperity of the majority low-income women of color who currently hold these jobs.

NYACH has prioritized improving homecare job quality since its founding in 2011, with initiatives targeted towards innovations in training, supervision, and staffing models. The pandemic highlighted just how essential these workers are and just how incapable the system is to appropriately compensate them or recognize the tremendous value they provide to society. Looking forward to 2022 and beyond, NYACH will continue to prioritize work with the LTSS subsector and for homecare specifically, supporting high-road business and employment practices, and advocating for increased funding and recognition for its workers.

39 Employment Projections. New York State Department of Labor. (n.d.). Retrieved from https://statistics.labor.ny.gov/lsproj.shtm

PRIORITY:

Drive efficient utilization of workforce investment resources through the creation of a centralized dashboard and analytics infrastructure.

The COVID-19 pandemic demonstrated that understanding the labor market at a macro level is insufficient for both emergency response and future planning. Instead, New York City (NYC) requires a robust workforce analytics apparatus that captures data for key industries and occupations at a level of granularity that does not currently exist, in order to produce insights that are timely and actionable, and to share those insights with policy makers, workforce development organizations, and industry. In particular, NYC needs analytics that enable accurate forecasting for the labor needs of the future-of-work as well as those that are determined by resiliency scenario-planning. This kind of analytics capability will focus NYC's workforce development engine on the jobs of the future, and will enable it to pipeline diverse and economically disadvantaged communities into these critical jobs.

Nowhere is this analytics capability needed more than the healthcare sector. In NYACH's conversations with industry and in its participation in Office of Emergency Management (NYCEM) planning exercises for subsequent waves of COVID-19 infection, it became apparent that the city did not have a sufficient local supply of talent in critical occupations (e.g. nursing, respiratory therapists). These occupations, however, all require a minimum of two years of clinical education and/or apprenticeship experience, much too long for an emergency response operation. A robust analytics engine would help identify shortages or growth as they occur, predict shortages in likely future scenarios (such as future health emergencies or technological advances), and direct workforce development investment towards high need occupations before it is too late.

As of writing, there is extremely limited availability of NYC healthcare workforce data. The only New York-based organization that puts out consistent analytics is the Center for Health Workforce Studies, which is affiliated with SUNY Albany. Some local NYC analysis happens through CUNY LMIS and other local academic institutions, however this work tends to be sporadic and contingent on the demands of particular grants and other funding sources.

In 2022, leveraging the need highlighted by the pandemic, NYACH will push to align public and private funding to support the buildout of a robust, local healthcare workforce analytics mechanism. NYACH will also prioritize developing a sustainability model for this analytics capability that does not rely on short-term funding sources.

PRIORITY:

Enhance career mobility through the development and scaling of foundational curricula, such as NYACH's Telehealth curriculum and Young Adult Work-Based Learning model

In addition to the other targeted priorities articulated in this document, it is also important that we equip current and future healthcare workers with the basic skills and competencies they need to be successful in any healthcare job, regardless of educational attainment or specialty. Doing so ensures that we have a fundamentally competent workforce throughout the city and in different types of healthcare settings, while also ensuring that healthcare workers have transferrable skills when they want to move to a new way of caring for patients, thus incentivizing these in-demand workers to stay in the sector.

To that end, in 2016 NYACH and its Partners Council identified and built a consensus around the Core Competencies required for working in today's healthcare environment. This core curriculum outlines nine Core Competencies with accompanying topics and learning objectives and serves as an industry-designed framework to be used by educators and trainers to build curricula that are ultimately tailored to specific occupations, student populations, and geographic and institutional settings. Towards the end of 2021, NYACH began work with its partner network to identify the competencies necessary to work with telehealth care models. Skills in telehealth became an overnight necessity as a result of the COVID-19 pandemic, and it is clear that telehealth is here to stay as an effective and cost-efficient way to deliver certain types of care. Once articulated, NYACH will share learning materials with the workforce development ecosystem and embed them in future trainings, working to ensure that the whole workforce is equipped with telehealth skills.

Learn more about the NYACH Core Competencies for Today's Healthcare Workforce on page 24.

Further building on the work of the Core Competencies, NYACH partnered with the NYC Department of Education (DOE) in 2017 to update the healthcare core curriculum used in Career and Technical Education (CTE) healthcare high schools, which help prepare the next generation of New York City health professionals. The partnership continued beyond curricular updates when NYACH developed and piloted a new work-based learning (WBL) model called Ready for Healthcare, which is explicitly designed with both employers and educators in mind. In developing this model, NYACH worked with partners to structure learning activities to be relevant to the skills employers actually need, ensure that they are developmentally appropriate for students, and create an open-source implementation toolkit for employers and educators. This four-year, four-part, model includes the teaching of foundational curriculum in 9th grade, exposing students to the wide range of healthcare careers via guest speakers, mentorship, and other activities in 10th grade, a required professional skills internship in 11th grade, and a subsequent technical/clinical skills internship in 12th grade. NYACH will make the implementation toolkit public and available in early 2022, and will share lessons learned from the initiative broadly to advocate for wider adoption of this now proven work-based learning model as an evidence-based way to prepare high school students for careers in healthcare.

Learn more about the NYACH Ready for Healthcare initiative on page 46.

Looking Ahead

NYACH imagines a better future for New York City (NYC), one that is now more clearly than ever tied to the viability of the healthcare ecosystem and its role in sustaining public health. The immediate challenges of the COVID-19 pandemic aside, the future will necessitate better integrated social services, a commitment to living wage employment with career mobility, and smart, direct financial investments in innovative business models and underserved communities to create a healthier and more resilient city and healthcare system.

We must begin working toward this future now, as decisive, short-term interventions are urgently needed to help heal a damaged industry, particularly for individual healthcare workers whose frontline experience of the pandemic and its ongoing burdens is unquantifiable. It is critically important that we work to ease these burdens immediately, and be cognizant of their disproportionate current and future impact on marginalized communities. NYACH is committed to supporting the entirety of the healthcare workforce pipeline, helping employers provide good-paying, high-quality jobs, and ensuring that these jobs and the skills they require are accessible to all New Yorkers.

Ten years ago, NYACH was founded on a belief that the best way to make this kind of future a reality is through the cooperative efforts of an inclusive range of relevant stakeholders. NYACH's success as an intermediary is entirely contingent on the participation of our colleagues in the healthcare industry and workforce development ecosystem, as well as the funding and empowerment of philanthropy and local government. We want to take this opportunity to thank our partners for the work we've been able to do together since 2011.

While there are plenty of incredibly effective organizations that focus on improving community health or serving a particular constituency, NYACH is the only NYC healthcare-sector intermediary focused solely on economic and workforce development that serves all businesses regardless of size or type of healthcare service, and all New Yorkers regardless of race or ethnicity, income, neighborhood, immigration status, or union membership. Since its founding in 2011, NYACH has worked to strengthen vulnerabilities in the healthcare economy—which the pandemic pushed to the point of failure—and there is now more work to do than ever to heal the sector and make it more resilient.

The shock to the system of 2020-21 created new ways of working to address the emergency and NYACH is optimistic that the current moment presents a unique opportunity to bring that same innovative collaboration to bear on the big challenges facing our city. For the sake of our city and healthcare sector—for its businesses, workers, and the New Yorkers they serve—we look forward to a better 2022 and to your continued partnership.

March 2022

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