Behavioral Health Workforce Innovations: How Massachusetts and New York Engage Community Health Workers and Peers to Address Racial and Ethnic Disparities

By Jill Rosenthal

Racial and ethnic inequities in health status and quality of care affect individuals’ health outcomes and increase the cost of care. This is especially pronounced for racial and ethnic minorities with behavioral health conditions.1 Racial and ethnic minorities are less likely to receive diagnoses and treatment for mental illnesses, have less access to mental health services, and often receive poorer quality of mental health care.2

There are a variety of ways states are addressing these issues, such as broadening access to and building capacity of, their behavioral health workforce. Cultural and linguistic competency is an important strategy for improving the quality of care provided to people of all backgrounds and there are training tools available to enhance this skill.3

In addition to building the capacity of trained and licensed health care providers, evidence suggests individuals benefit from relationships with people who have similar lived experiences and are members of their community, such as community health workers (CHWs) and peer supports. These professionals include, but are not limited to, promotores, peer support specialists, and natural helpers.4

CHWs may be uniquely positioned to build trust and address barriers traditionally underserved communities face to seeking care.5 Training CHWs to support the delivery of evidence-based practices may help to address mental health disparities.6 CHWs can reduce the stigma associated with receiving mental health care and provide collaborative, patient-centered approaches to care, including understanding and incorporating patient preferences.

As states transform their health systems, they have opportunities to integrate innovative workforce approaches to meet the needs and understand the lived experiences of individuals with behavioral health needs, particularly among racial and ethnic minority populations. Many state programs are enlisting CHWs to address challenging aspects of their health improvement initiatives, such as facilitating care coordination, enhancing access to community-based services, and addressing social determinants of health.7 Massachusetts and New York are incorporating CHWs and credentialed family peer advocates respectively into their redesigned payment and delivery systems in ways that can address these disparities. They are using a range of strategies and working across state agencies and with private partner organizations to ensure that this new workforce is able to address patient needs.

The National Academy for State Health Policy (NASHP) interviewed officials from Massachusetts and New York to learn how they use regulatory levers, such as training and certification requirements, along with payment and delivery reform, to improve behavioral health
care for racial and ethnic minority populations. They also shared their models at the 2019 NASHP annual health policy conference.

**How Massachusetts Builds Community Health Worker Capacity**

The Massachusetts Delivery System Reform Incentive Payment (DSRIP) Program, under the authority of its 1115 Demonstration waiver, provides $1.8 billion over five years (through June 30, 2022) to support MassHealth (Massachusetts Medicaid) providers as they transition to value-based payment. Entities that have signed contracts to be MassHealth accountable care organizations (ACOs) or Community Partners (behavioral health or long-term support and services) are eligible to participate in DSRIP. DSRIP supports the development of infrastructure and the implementation of care coordination activities for ACOs and Community Partners throughout the state, helps providers transition to new care delivery models, improves enrollees’ care and experience, and strengthens provider capacity.

In addition to funding ACOs and Community Partners directly, there is a dedicated funding stream to support statewide investments, which allows the state to scale up statewide infrastructure and workforce capacity to better prepare the workforce for a newly emerging health care environment. Investing in training CHWs, recovery coaches, and peer specialists, along with their supervisors is among the workforce development and training priorities. MassHealth chose this area of focus because ACOs and Community Partners recognized that CHWs and peer specialists have a unique ability to engage and help improve the health of MassHealth enrollees who are most likely to be disconnected from health care, and they expect to increase the size of this workforce. Although MassHealth does not reimburse CHWs, ACOs can spend DSRIP dollars in a variety of ways and many have chosen to hire CHWs as part of their efforts to improve health outcomes and decrease total cost of care.

Cultural competency is woven into the 10 recognized core competencies of CHWs. The Massachusetts Board of Certification of CHWs administers a voluntary CHW certification program designed to help integrate CHWs into the health care and public health systems. The board develops standards for the education and training of CHWs and CHW trainers.

According to a 2016 survey, mental/behavioral health is the second-most frequently cited issue that CHWs report addressing, and the area that CHWs who work within clinical organizations expressed the most interest in receiving training. The Massachusetts Department of Public Health currently funds curriculum development of specialized training for CHWs in behavioral health and substance addiction. In addition to expanding the capacity of existing training programs to accommodate new needs, MassHealth supported the design and implementation of a new training curriculum for CHW supervisors, as well as the design of a nine-month learning community to provide peer support, mentorship, and professional development for CHWs and peer specialists and to promote primary care/behavioral health integration. MassHealth plans to share data and knowledge gained from these programs with ACO and Community Partner leaders to better equip them to create workplaces that support CHWs and peer specialists.

**Levers Massachusetts Uses to Support CHW Capacity to Address Health Disparities**

**State and public health agency partners:**
• MassHealth (Medicaid program)
• Department of Health
• Office of Community Health Workers, Bureau of Community Health and Prevention
• Board of Certification of CHWs, Bureau of Health Professions Licensure
• Boston Public Health Commission, Cambridge Public Health (CHW core competency training programs)


Regulation and guidance: Core Competencies for Community Health Workers

Federal authority: Massachusetts’ Delivery System Reform Incentive Payment (DSRIP) Program, under the authority of its 1115 demonstration waiver.

How New York Expands Family Peer Support for Child Health

New York is in the process of transitioning its Medicaid-funded behavioral health services into Medicaid managed care and is using this opportunity to build on its experience using family peer supports. New York has a long history of including family peers in its state programs, engaging families in accessing services, and in policy development. The state has provided peer support services as an integral component of children’s behavioral health system for many years. Family peers have:

- Engaged families and addressed concerns about the mental health system;
- Explained how services can help their children;
- Alleviated stigma; and
- Addressed cultural barriers to services.

New York’s Children and Family Treatment and Support Services (CFTSS) program was developed under a State Plan Amendment (SPA)16 as part of the Children’s Medicaid Redesign. The program is available to children and youth up to and including age 20 who are Medicaid-eligible under the Medicaid EPSDT benefit. Family peer services, previously only accessible to a subset of children under a Home and Community Based Services (HCBS) waiver, will be more universally available to all children who meet medical necessity criteria. The expanded access to the new CFTSS, including family peer support services as a reimbursable service, became available in January 2019.17 Provider agencies that employ peer advocates bill Medicaid using a specified set of rate codes.

According to the state plan, CFTSS, including family peer supports, can be provided by those with a state-recognized Family Peer Advocates (FPA) credential18 for children with mental health needs and Certified Peer Recovery Specialist certification with a family parenthetic (CRPA-F) for children with substance use needs. Families Together in New York State (FTNYS) administers the two levels of the FPA credential, which includes parent empowerment training. FTNYS also provides training for certification on the Family Needs and Strengths19 assessment and awareness tool to help FPAs ensure their work is family-driven and youth-guided. The
Community Technical Assistance Center (CTAC),20 in partnership with the state and FTNYS, offers Family Peer Support Services training including how to provide the services within a Medicaid managed care environment.

Eligibility for the FPA credential includes, among other criteria, demonstrating “lived experience” as a parent or primary caregiver who has navigated multiple child-serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral health care needs and adherence to cultural competency guidelines. Cultural awareness and competence are among the requirements to complete the credential. A component of the curriculum incorporates the impact of structural and cultural factors that may shape families’ tendencies to care for their health in certain ways.21 It is intended to facilitate understanding of how structural factors determine beliefs, attitudes, values, and behaviors.22

Formal and informal services and supports are provided through a structured, strength-based relationship between an FPA and the parent or caregiver, based on goals and objectives that a licensed practitioner recommends in the child’s treatment plan.23 All SPA services can be delivered in the community where the child/youth lives, attends school, and/or engages in services.

Levers New York Uses to Help Family Peer Advocates Address Health Disparities

**State agency partners:**
- Department of Health (Medicaid program)
- Office of Mental Health
- Office of Alcoholism and Substance Abuse Services
- Office of Children and Family Services
- Office for People with Developmental Disabilities

**Legislation and guidance:** Children and Family Treatment and Support Services

**Federal authority:** New York SPA and 1115 Waiver

**Lessons and Considerations**

Massachusetts and New York offer examples of ways that states can work to develop and deploy unique workforces to meet the behavioral health needs of racial and ethnic minority populations. Other states may consider the following early lessons:

**Incorporate peer supports and CHWs during transitions to new payment and delivery approaches.** Both Massachusetts and New York are redesigning their delivery systems to improve their quality of care and control Medicaid costs. As they do, they are expanding and adapting this workforce with the recognition that CHWs and peer supports may be uniquely positioned to address barriers to care and address mental health disparities. They are making these workforce investments through the federal authority of 1115 waivers and state plan amendments.
Partner across state agencies to maximize state resources and opportunities to engage CHWs and peer supports most effectively. Medicaid agencies can be critical to transforming payment and delivery systems. Departments of health, mental health, and other state agencies with responsibilities and expertise can support efforts through training, certification, and unique approaches to behavioral health and health equity. Massachusetts is drawing on its national leadership in CHW training and credentialing, and New York is building on its strong history of employing family peer supports.

Provide capacity-building support to employ and supervise the workforce. Massachusetts and New York offer training for supervisors and organizations that employ CHWs and peer supports. Massachusetts provides technical support to employers and sister agencies, such as the departments of Mental Health and Corrections and MassHealth, so they are prepared to meet CHW workforce needs. Knowing that managed care organizations want to ensure that the family peer support providers with whom they contract are effective in the delivery of services that they provide to families, New York provides toolkits to help organizations support and integrate peers and CHWs and online self-assessments to evaluate organizational readiness.

Embrace the cultural shift needed to employ CHWs and peer supports as equal partners within treatment teams. Massachusetts and New York recognize that providers must collaborate on care teams and with communities, and must value the lived experiences of CHWs and peer supports. Their criteria for CHWs and peer supports, including cultural competency, reflect these values. Massachusetts requires ACOs to partner with community partners in order to qualify for DSRIP funding. New York includes family peer support among an array of professionals serving children.

Recognize the unique needs of racial and ethnic minority populations with behavioral health needs. Engaging CHWs and peer supports can build trust, reduce stigma, and address barriers to care. Massachusetts and New York are expanding the reach of this workforce in innovative ways that can address care inequities. They are using a range of patient-centered approaches to facilitate care coordination, enhance access to community-based services, and address social determinants of health to meet patient needs.

As states transform their health systems, they have opportunities to integrate innovative workforce approaches that acknowledge the lived experiences of individuals with behavioral health needs in order to better meet their needs. CHWs and family peer advocates hold promise for improving health outcomes and reducing costs, particularly for racial and ethnic minority populations. States can use their purchasing and regulatory levers to advance innovative strategies and improve behavioral health.

Notes

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3 The HHS OMH has developed a free and accredited e-learning program: Improving Cultural Competency for Behavioral Health Professionals.


10 Although the Massachusetts focus in this case study is on CHWs, the state is also investing in Certified Peer Specialists and Recovery Coaches. For a comparison of roles, see Commonwealth of Massachusetts Peer Support Worker Comparison Chart: Adult Services Department of Public Health Bureau of Substance Addiction Services (DPH/BSAS), February 27, 2019, https://www.mass.gov/files/documents/2019/03/20/Peer%20Support%20Worker%20Comparison%20Chart%203.14.pdf.


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