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Helping Leaders Advance Child Health Care Transformation

A FRAMEWORK FOR FOCUSING UPON CHILDREN AND NEIGHBORHOODS IN FEDERAL POLICIES ESTABLISH A COMMUNITY-BASED HEALTH WORKFORCE

Charles Bruner, May, 2021

Many investments to "build back better" through the American Rescue Plan Act and proposed in the American Jobs and the American Families Plans regarding infrastructure are designed to be targeted by place – to communities with the greatest need. Such targeted investments are key to addressing inequities and disparities.

How place is defined and what is then done by place, however, will impact the degree to which these investments achieve their goals. *The Geography of Vulnerability, Opportunity, and Resilience* is but one analysis showing the importance of recognizing the following in developing place-based strategies:

1. Defining place by neighborhood and not county or state is essential to identifying places of greatest vulnerability and opportunity;
2. The demographics of high vulnerability/opportunity neighborhoods show the need for focus on children (and their families) as a priority population for response; and
3. These neighborhoods are deeply segregated by race and ethnicity and working with their residents and members is key to reducing inequities by race and ethnicity as well as income and socio-economic status.

Currently, however, the emphasis in proposed federal actions and investments – particularly in creating an expanded and enriched community-based or community-health workforce – do not have this focus. **The Appendix provides possible language to incorporate into legislation to develop such a workforce. It does so by providing specific amendments to three pieces of legislation introduced in this area:**

- **The Health Force and Resiliency Force Act and Jobs to Fight COVID-10 Act of 2021 … page 3**
- **The Building a Sustainable Workforce for Healthy Communities Act of 2021… p 13**
- **The Social Determinants of Health Act of 2021… page 21.**

TALKING POINTS

1. If we are going to focus upon reducing disparities through place-based strategies and investments, we must go down to the neighborhood/census tract level and not stay at the state, county, or municipal level. This is essential because:
    a. Variations within county on a range of indicators of vulnerability (income, wealth, education, housing, and family structure) are much greater than variations across county. We will miss a major part, if not most, of the vulnerable population if we categorize risk and direct resources by county, municipality, or state.
    b. We will fail to fashion culturally, linguistically, and ethnically responsive strategies if we do not recognize and reflect the make-up of the particular places being served.
    c. Place matters, and particularly for children, neighborhoods are the places where they learn, play, spend their time and grow.

2. In doing so, children and their development and well-being are the biggest key to making an impact. This is essential because:
    a. Children are the most diverse part of our population and, for the first time in our country's history, at risk of not growing up as healthy, living as long lives, or being as equipped to compete and lead in a world economy, as their parents.
    b. There are the longest-term impacts and highest returns on societal investments in children.
    c. Poor and marginalized neighborhoods are rich in children, with much higher proportions of children in their neighborhoods and a very large share of the children most vulnerable to compromised health and development.

Both Congress and the Administration need to draw upon this knowledge base as they further enact legislation and set regulatory guidance for federal investments directed to where they can have the most impact.

APPENDIX 1: Health Force, Resilience Force, and Jobs To Fight COVID–19 Act of 2021

This and other Congressional bills are produced in their entirety, with strike-inset and comment functions used to show recommended changes.

Section 1: SHORT TITLE
The title of the bill is the "Health Force, Resilience Force, and Jobs To Fight COVID–19 Act of 2021"

Section 2: HEALTH FORCE

Subsection (a): Purpose.—

It is the purpose of the Health Force to recruit, train, and employ a standing workforce of Americans to respond to the COVID–19 pandemic in their communities, provide capacity for ongoing and future public health care needs, and build skills for new workers to enter the public health and health care workforce.

Subsection (b): Establishment.—

The Centers for Disease Control and Prevention (CDC) through its State, local, territorial, and tribal partners, shall establish a Health Force composed of community members dedicated to: a) responding to public health emergencies; and b) providing increased capacity to address ongoing and future public health needs.

Subsection (c): Organization and Administration.—

The CDC will award grants, contracts, or enter into cooperative agreements for the recruitment, hiring, training, managing, administration, and organization of the Force to States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, health service providers to Tribes, or Native Hawaiian health organizations (referred to in this section as the "Funded Entities"). The CDC will ensure that State, county, and local health departments, agencies, including community health centers and clinics, receive funding from Funded Entities or directly from the CDC. The CDC will provide assistance for expenses incurred by Funded Entities prior to award to facilitate implementation, including planning and recruitment activities.
The CDC will award funds as soon as possible.

Subsection (d): Funding Allocations.—

Of the funding awarded, not less than 5% shall be awarded to Tribes and not less than 80% shall be awarded to States and territories. Of funding awarded to Tribes, 80% will be awarded proportional to population size and 20% will be awarded according to burden of preventable disease and disability. Of funding awarded to States and territories, 60% shall be awarded proportional to population size, 20% will be awarded according to burden of disease and disability, and 20% will be awarded based on the number of jobs lost over the preceding 12 months in each State or territory as a proportion of all jobs lost nationally during that timeframe.

Of funding awarded to States and territories, at least 40% shall be allocated for State health departments and at least 40% shall be allocated for county and other local health departments within the State. Funds appropriated under this section shall be used to supplement, not supplant any existing funding for Indian Tribes, Tribal organizations, urban Indian health organizations, health service providers to Tribes, Native Hawaiian health organizations, States, territories, State health departments, county and other local health departments.
Based on bill text of January 21, 2021

Subsection (e): Service.—

Minimum Requirements: The Force will be composed of individuals chosen by Funded Entities who will ensure that that a membership in the Force is not restricted based on education or citizenship status. Eligible individuals will include those who are at least 18 years of age and authorized to work in the United States.

Recruitment: Funded Entities will support recruitment efforts for personnel who are from or reside in the locality in which they will serve, including efforts to recruit among focal communities described in subsection (h), as well as dislocated workers, individuals with barriers to employment, veterans, new entrants in the workforce, underemployed or furloughed workers, graduates and students from Historically Black Colleges and Universities, Tribal Colleges and Universities, Hispanic Serving Institutions, and historically marginalized populations. State labor offices will share information about Force opportunities with individuals applying for or receiving unemployment benefits.

Selection: Personnel will be selected based upon their aptitude and skills in engaging community members and providing support, drawing upon evidence from effective community health workforce projects and evidenced-based guidelines for recruitment and selection of community-based workers.

Commented [CB1]: These positions require certain aptitudes and skills and then support within the organizations who employ them.

Preference: Hiring preference will be given to individuals who are dislocated workers, individuals with barriers to employment, veterans, new entrants in the workforce, underemployed or furloughed workers, or community-based nonprofit or public health or health care professionals, from focal communities as described in subsection (h), or

unemployed or underemployed individuals. First priority will be given to previous employees of Funded Entities or subawardees who were recently furloughed, laid off, subject to a reduction in force, on leave, or have recall rights.

Placement: To the extent feasible, Force members will be recruited from and serve in their home communities. Force members will be physically co-located with health departments or other eligible organizations. According to local needs, Force members may be physically co-located with local public health, health care, and community-based organizations, including community health centers, as determined appropriate by Funded Entities.

Training:

- Contact Tracer Training: The Director of CDC will provide guidance and resources for Force members to successfully conduct contact tracing activities. Funded Entities will determine which recruits will be provided with contact tracer training. Funded Entities may provide Contact Tracing Training using CDC's materials or other evidence-informed programs.
- Additional Training: Within 90 days, the Director of CDC will identify and, as necessary, develop additional evidence-informed training resource packages to provide Force members the knowledge and skills necessary to conduct the full complement of activities described in subsections (f) and (g). Funded Entities will determine which members will be provided with additional training.
- Specialized Training: The Director of CDC may elect to establish divisions of Force members who receive specialized, comprehensive training.
- Requirements: The training program under this subparagraph will:

o Be adaptable by Funded Entities to meet local needs;
o Be implemented as quickly as possible;
o Be distance-based eLearning accessible by smartphone and other devices;
Based on bill text of January 21, 2021
o Include refresher training and regular and frequent intervals;
o Incorporate components on personal safety and health privacy and ethics;
o Leverage existing training and certification programs.

- Miscellaneous: Where deemed necessary, the Director of CDC may:

o Recommend training that includes face-to-face interaction;
o Collaborate with a variety of organizations to develop and implement training;
o Develop training and communications materials in multiple languages.

- Payment: Individuals will be paid for each hour they spend in training.
- Career Growth: Funded entities will support Force members' career growth, including by providing disaster relief employment and training activities and opportunities for Force members to maintain employment after the COVID–19 public health emergency has concluded.

Force Member Compensation: Members of the Force will be full-time and paid directly by Funded Entities and their subawardees using funds provided by the CDC. All Force members, including supervisors, shall be paid a wage and fringe benefits not less than the minimum wage and fringe benefits established in accordance with the Service Contract Act. The Secretary of Labor, or the Secretary's authorized representative, shall have the authority and functions set forth in the Service Contract Act and shall issue a nonstandard wage determination, subject to periodic revision, establishing minimum wages and fringe benefits for each class of Force members in accordance with the prevailing rates for those positions or, where a collective bargaining agreement is in effect, in accordance with the rates provided for in the agreement. It is the sense of Congress that Force member compensation shall include health, retirement, and paid family and medical leave benefits.

Supervisory Structures: Force members will receive ongoing supportive supervision from staff members of Funded Entities or their subawardees, which may use awarded funds to pay for such supervisory staff and structures. Force members may be promoted into supervisory roles and supervision may also be provided by Disease Intervention Specialists.

Supplies and Equipment: Funded Entities will provide all necessary supplies and equipment to Force Members. Funded Entities may use awarded funds to pay for such supplies and equipment.

Subawards: As authorized by the CDC, Funded Entities may make subawards to local partners, including community health centers, labor organizations, labor-management partnerships, and other community-based and nonprofit organizations, in order to facilitate recruitment, training, management, supervision, and retention as well as to facilitate Force integration into existing public health, health care, and community-based services.

Service in Public Health Emergency: Funded Entities will assign Force members to respond to a public health emergency in the area served. Such Force members will be supervised and managed by Funded Entities.

Service Post-Emergency: Funded Entities may retain Force members after a public health emergency has ended in order to:

- Prevent and respond to future public health emergencies; and
- Respond to ongoing and future public health and health care needs.

Limitation: A Force member may not be assigned for international deployment on behalf of Health Force.

Funding: All costs associated with the service and functions of Force members under this section, including salary and employment benefits as well as associated direct and indirect costs, will be paid by the Federal Government through grants, contracts, or cooperative agreements to Funded Entities.

Nondisplacement: Funded entities and subawardees will not displace or partially displace any employee as a result of the use of Force members.

Subsection (f): Activities to Respond to the COVID–19 Pandemic.—
For the duration of the COVID-19 Public Health Emergency, Force members will be trained and employed to:

- Conduct contact tracing, including the identification of cases of COVID-19 and their contacts in a culturally competent, multilingual manner;
- When available, support the administration of diagnostic, serologic, or other COVID–19 tests and vaccinations;
- Provide support that addresses social, economic, behavioral and preventive health needs for individuals affected by COVID-19, including those who are asked to voluntarily isolate or quarantine; and
- Carry out or assist with other activities as determined appropriate by Funded Entities.

Subsection (g): Activities Post-Emergency.—

After the COVID-19 Public Health Emergency concludes, Force members will be trained and employed to:

- Carry out or assist with activities described in subsection (f);
- Provide support services, including but not limited to:

o Expanding public health information sharing, including by sharing public health messages with community members and organizations;
o Helping community members address social, economic, behavioral health, and preventive health needs using evidence-informed models and in accordance with existing standards, and, where children are involved, addressing their specific health and development needs in the context of their families, schools, and communities;
o Sharing community-based information with State, local, and Tribal health departments to inform and improve health programming, especially for hard-toreach communities; and
o Promote linkages to other Federal, State, and local health and social programs.

- Carry out or assist with other activities as determined appropriate by the Director of CDC and/or Funded Entities.

Subsection (h): Focal Communities.—

Funded Entities will dedicate a substantial proportion of Force members to addressing the needs of focal communities. To be designated as a focal community, a community will:

Commented [CB2]: Children are not "little adults" and require approaches that are holistic and developmental, with particular emphasis on family stability and nurturing at the start of life. Children easily can be lost in responses which stress people with existing health/medical conditions.

・Bear a disproportionate burden of disease; or

・Be identified as a "most vulnerable" community according to the CDC's Social Vulnerability Index; or

・Be identified as a "high poverty" area, which includes census tracts with poverty rates of 25 percent or higher, as defined by the Workforce Innovation and Opportunity Act; or

・Be identified as a "high unemployment" area, which includes census tracts with unemployment 150 percent or higher than the national unemployment rate, as determined by the Bureau of Labor Statistics based on the most recent data on the total unemployed, the U-6 unemployment measure or similar measure, available on the date of enactment of this Act; or

・Be designated as a Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population.

As focal communities are identified, they shall be assessed in terms of their racial and ethnic composition, their prevalence of young children and school-aged children, and the resources currently available to them.

Commented [CB3]: Poor neighborhoods (particularly ones with poverty rates over 30 percent), are often very racially and ethnically segregated and have very high proportions of very young children, while at the same time not having playgrounds, parks, family-friendly gathering places, and other parts of a built-community for young children to be safe and grow. Building these require more than individual services and this workforce can be a locus for building that public health infrastructure.

Subsection (i): Coordination and Collaboration.—

Facilitation by CDC: The Director of CDC will facilitate coordination and collaboration between the Force and other national public health services programs, including the Bureau of Maternal and Child Health, the Public Health Service and Medical Reserve Corps, as well as the Federal Emergency Management Agency's Resilience Force.

Commented [CB4]: A lot of the current community health work and outreach, particularly for children, comes from MCHB and needs to be built upon.

・Within 6 months after enactment of this Act, the Director will convene a stakeholder advisory group comprised of the leadership of: other national health service programs; other relevant Federal offices and agencies; leaders representing Funded Entities, leaders in developing and implementing evidenced-based programs employing community-based workers as a core component of their strategies, and persons representing the consumers and users of those services. The group will meet yearly to provide guidance for the programmatic success and longevity of the Force. Such guidance will be codified in an annual report of recommendations and
evidence-informed practices to be shared publicly.

Commented [CB5]: Three is quite a base of knowledge on effective practice in this area but it mostly comes from innovators and those who study them. These should be incorporated into the Advisory Group.

Facilitation by Funded Entities: Funded Entities will ensure coordination and, as appropriate, collaboration between the Force and local public health, health care, and community-based organizations, to ensure complementarity and further strengthen the local public health response. Funded entities must demonstrate a commitment to valuing the role of community health workers as part of their overall planning and implementation strategies and as part of their own teams and in informing coordination across other community services.

Commented [CB6]: This is one of the key findings from research – that unless such workers are truly valued and supported within their organizations, their effectiveness is severely compromised and burn-out/turnover high, which works directly against their building relationships in communities.

・Within 3 months after the date of enactment of this Act, each Funded Entity will convene a stakeholder advisory group comprised of community leaders and other key stakeholders

to meet on a regular, recurring basis to provide formal guidance, including priority setting and funding guidance, for the programmatic success and longevity of the Force.

- Funded Entities may enter into agreements or compacts for cooperative effort and mutual assistance.

Subsection (j): Monitoring.—

The Director will develop a performance monitoring template for Funded Entities to adapt and use. The template will require the reporting of the number of Force members hired, the role hired into, and the demographic characteristics of Force members. Funded Entities will share these data with CDC on a regular, recurring basis and these data will be made publicly available.

Subsection (k): Learning and Adaptation.—

The Director of CDC, in consultation with the Advisory Group and local advisory groups, will develop a learning and evaluation component to identify successful components of local activities that may be replicated, to identify opportunities for continuing education and career advancement for Force members, to evaluate the degree to which the Force created a pathway to longer-term public health and health care careers among Force members, and to identify how the Force impacted the health knowledge, behaviors, and outcomes of the community members served. Results of this learning will be made publicly available.

The Director of CDC shall consult with and draw upon the expertise of researchers, practitioner innovators, and frontline health and community-based practitioners in further development of this workforce as a core part of the overall health system, with commensurate attention to the skills, qualities, working conditions, supervisory support, professional development, time and intensity of contact with members of the community, and authority and standing within their organizations in which they are located and the communities they serve that maximize their impact and produce population gains in health. In doing so, the CDC shall place special emphasis upon the role of community health workers in ensuring the healthy development of children across physical, cognitive, social, and emotional elements through strengthening and ensuring the support from the environments in which they live and grow.

Commented [CB7]:

Commented [CB8R7]: Building a robust workforce across the country will require a lot of intentionality and continuous learning and improvement. There needs to be a strong infrastructure for this, and those who have the most knowledge and passion about ensuring success need to be engages and inform development.

Subsection (l): Reporting.—
Within 180 days after the end of each fiscal year, the Director will submit to the Congress a report which shall contain—

- A description of the progress made in accomplishing the objectives of the Force;
- A summary of the use of funds during the preceding fiscal year;
- A description of the application of the funding formula;
- The number of individuals recruited, hired, and retained;
- The number of Force members who transition to other public health roles;

・The number of Force member who were unemployed prior to being hired;

・The number of Force members who continue to be employed within 6 months and 1 year of hire and within 6 months and 1 year of the conclusion of the COVID-19 public health emergency;

・Any information on the outcomes and impact of Health Force on health and employment.

Subsection (m): Financial Reporting.—

Within 45 days after enactment, and every 60 days thereafter for the first 12 months after such date of enactment, the Director shall submit to Congress a report describing awards made, funding obligated, and expenditures to date. The report will provide details on the application of the funding formula specified in subsection (d), including the amount awarded to each Funded Entity.

Subsection (n): Labor and Workplace-related Guidance.—
Within 14 days after the date of enactment of this Act, the Secretary of Labor will provide guidance and technical assistance regarding how to provide individuals in contact tracing and pandemic response positions with healthy and safe working conditions.

Subsection (o): Tribal Data Sovereignty.—
The Director shall consult with Indian Tribes and Tribal organizations and coordinate with Tribal health organizations to ensure that any reporting process under this section honors and preserves the data sovereignty of individuals who are members of Indian Tribes or Tribal organizations.

Subsection (p): Requirements for Transition Back to Unemployment Compensation.—

As a condition of a State receiving funds under this section, the law of the State shall, in the case of an individual who is receiving unemployment compensation at the time the individual is hired as a Force member, provide for the following:

・Such individual shall be eligible to resume receiving unemployment compensation after leaving the Force if the individual returns to unemployment.

・The amount of the weekly benefit for such individual shall be the greater of the weekly benefit amount such individual was receiving when such individual entered the program; or a weekly benefit amount that is determined based on such individual's earnings from employment under the Health Force program.

Subsection (q) Authorization of Appropriations.—

There is authorized to be appropriated, and there is appropriated, $40,000,000,000 for each of fiscal years 2021 and 2022.

・These funds are will remain available until expended.

・Additional funding beyond 2022 for continuation of Health Force will be determined in 2022 based on identified staffing needs.

・Health Force is intended to be implemented for at least 10 years.

The amounts appropriated are designated as an emergency requirement pursuant to the Statutory Pay-As-You-Go Act of 2010. In the Senate, this section is designated as an emergency requirement pursuant to section 4112(a) of H. Con. Res. 71 (115th Congress), the concurrent resolution on the budget for fiscal year 2018.

Section 3: RESILIENCE FORCE

Subsection (a): Purpose.—
It is the purpose of the Resilience Force established under this section to recruit, train, and augment the existing cadre of first responders at the Federal Emergency Management Agency to assist in the immediate COVID–19 pandemic response, to provide a surge capacity to address other national emergencies, and to strengthen America's public health infrastructure.

Subsection (b): In General.—
For fiscal years 2021 through 2023, the Administrator of the Federal Emergency Management Agency (FEMA) will appoint, administer, and expedite the training of additional 62,000 Cadre of On-Call Response/Recovery Employees (referred to as a "CORE employee") to address the coronavirus public health emergency and other disasters and public emergencies.

Subsection (c): Detail of CORE Employees.—
A CORE employee may be detailed to any Federal agency or State, Local, or Tribal Government to fulfill an assignment, including but not limited to:

・Providing logistical support for the supply chain of medical equipment and other goods involved in COVID–19 response efforts;

・Supporting COVID–19 testing, tracing, vaccination, vaccination education, and related surveillance activities;

・Providing nutritional assistance to vulnerable populations; and

・Carrying out other disaster preparedness and response functions for other emergencies and natural disasters.

Subsection (d): FEMA Responsibility.—
The costs associated with detailing CORE employees will be borne by FEMA.

Subsection (e): Requirement.—
As soon as practicable, the Administrator of FEMA will make public job announcements to fill the CORE employee positions. Hiring will be prioritized from among:

・Unemployed veterans of the Armed Forces;

・Individuals who live in a “high unemployment” area, which includes census tracts with unemployment 150 percent or higher than the national unemployment rate, as determined by the Bureau of Labor Statistics based on the most recent data on the total unemployed, the U-3 unemployment measure or similar measure, available at the time of the enactment of this act;

・Unemployed individuals who served in the AmeriCorps, Peace Corps, or as United States Fulbright Scholars, particularly those whose service terms ended as a result of the coronavirus public health emergency;

・Recent graduates of public health, medical, nursing, social work or related health-services programs.

・Members of communities who have experienced a disproportionately high number of COVID–19 cases.

Subsection (f): Hiring.—
FEMA will hire CORE employees pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, and use existing statutory authorities that permit regional offices and site managers to advertise for and hire CORE employees.

Subsection (g): Training.—
The Administrator of FEMA may make appropriate adjustments to the standard training course curriculum for CORE employees to include on-site trainings at FEMA regional offices, virtual trainings, or trainings conducted by other Federal, State, local or Tribal agencies, or eligible institutions defined in subsection (i).

Subsection (h): Clarification.—
For the purpose of employing CORE employees:

・No individual who is authorized to work in the United States will be disqualified because of citizenship or immigration status;

・No individual will be disqualified because of bankruptcy or a poor credit rating resulting from the coronavirus public health emergency.

Subsection (i): Eligible Institution Defined.—
For the purposes of this act “eligible institution” means a public 2-year institution of higher education, as defined under section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

Subsection (j): Authorization of Appropriations.—
There are authorized to be appropriated $6,500,000,000 for each of fiscal years 2021 through 2023, not less than $1,500,000,000 of which will be made available each fiscal year for the associated administrative costs.

APPENDIX 2: BUILDING A SUSTAINABLE WORKFORCE FOR HEALTHY COMMUNITIES ACT OF 2021

To implement a nationwide community health workforce program to ensure a sustainable workforce capable of preventing, preparing for, and responding to, public health crises and reducing longstanding health disparities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Building a Sustainable Workforce for Healthy Communities Act of 2021''.

SEC. 2. PURPOSE.

The purpose of this Act is to establish, fund, and implement a nationwide community health workforce program to employ approximately 150,000 community health workers in the United States. Workforce members would serve 23,000,000 individuals so that the Nation's communities in highest need have a sustainable workforce capable of preventing, preparing for, and responding to public health crises, including the COVID–19 pandemic, and reducing longstanding health disparities.

SEC. 3. DEFINITIONS.

In this Act:

(1) COMMUNITY HEALTH WORKER.—The term ''community health worker'' means a frontline health worker who is a trusted member of the community, who has an unusually close understanding of the community in which the individual serves that enables the worker to promote health and provide tailored and holistic social support by—

(A) conducting individual and community needs assessment;

(B) serving as a liaison between communities and health care agencies;

(C) providing social support to community members;

(D) enhancing the ability of community members to effectively communicate with health care providers;

(E) providing culturally and linguistically appropriate health education or support services;

(F) advocating for individual and community health;

(G) promoting healthy behaviors through individual or community outreach;

(H) providing case management, system navigation, or referral and follow-up services, or otherwise coordinating care;

(I) proactively identifying and enrolling eligible individuals in Federal, State, local, and private health and human services programs; and

(J) providing preventive services.

(2) COMMUNITY HEALTH WORKER STANDARDS.—The term ''community health worker standards'' means evidence-informed guidelines for—

(A) recruiting community health workers through community-based organizations and networks;

(B) employing community health workers who share life experience with the community served and have interpersonal skills;

(C) minimizing barriers to employment, including formal educational requirements, where appropriate;

(D) compensating community health workers and fostering career development;

(E) training community health workers on core competencies such as those established by the Community Health Worker Core Consensus Project;

(F) ensuring that community health workers have manageable caseloads that allow them sufficient time to build relationships and trust;

(G) enabling community health workers to provide tailored, holistic, person-centered support based on client needs and preferences and, in the case of children, family-centered support based upon both child and family needs and developmental appropriate for the child;

(H) ensuring community health worker safety and access to needed personal protective equipment;

(I) providing adequate supervision for coaching, performance assessment, and support, with integration of community health workers with other care team members; and

(J) allowing community health workers to apply the full range of roles and capabilities for which they are qualified, and supporting such workers in so doing.

(3) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity described in section 399V(k)(3) of the Public Health Service Act (42 U.S.C. 280g–11(k)(3)).

(4) INDIAN TRIBE AND TRIBAL ORGANIZATION.—The terms ''Indian Tribe'' or ''Tribal organization'' have the meanings given the terms ''Indian tribe'' and ''tribal organization'', respectively, in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(5) PREVENTIVE SERVICES.—The term ''preventive services'' means diagnostic, screening, preventive and rehabilitative services to prevent illness, disease (including chronic illness), injury (including suicide), or any other physical or mental health condition, reduce physical or mental disability, and restore an individual to the best possible functional level. **For children, preventive services include habilitative services and services that strengthen the safety, stability, and**

nurturing in the home environment to elevate child health trajectories across physical, cognitive, social, and emotional dimensions of health. Such services include the following:

(A) Services described in section 1905(a)(13) of the Social Security Act (4225 U.S.C. 1396d(a)(13)).

(B) Assessment of individual and community needs.

(C) Containment of infectious disease outbreaks, including providing in-language, culturally specific, and trusted support services, such as public health outreach and contact tracing to enable self-isolation.

(D) Provision of social support to combat stress, anxiety, depression, and social isolation.

(**E) For children, provision of family-centered services and services to advance the child's education and development.**

(E) Case management and linkage to resources to alleviate financial strain, including food, housing, health care coverage, and medical care.

(F) Care coordination and connection to preventive care services, including for chronic conditions, such as diabetes, asthma, chronic obstructive pulmonary disease, congestive heart disease, autoimmune disease, or behavioral health **conditions and for children, for hazardous environments related to lead, airborne contaminants and asthma triggers, and other toxins**.

(G) Promotion of healthy behaviors, such as hand-washing, wearing face masks (when recommended by public health officials), physical activity, and smoking cessation.

(H) Advocacy on behalf of individuals, families, and communities.

(I) Other services, as the Secretary determines appropriate to preserve and improve the public health **and the optimal development of children**.

(6) COMMUNITIES OF HIGHEST NEED. — The term "communities of highest need" mean geographic areas that states have determined to have high levels of need through an analysis conducted by the state or its counties that examines geographic areas in comparison with the state and includes analysis at the subcounty and census tract level as well as the county level. Such analysis shall include the following:

(A) Use of data available through the American Community Survey at the county and the census tract level, including but not limited to the Social Vulnerability Index produced by the Centers for Disease Control and Prevention.

(B) Involvement of representatives from and organizations serving people in high poverty neighborhoods and communities, representative of the racial and ethnic compositions of those neighborhoods and communities in determining geographic areas.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) SERVICE PRIORITIES.—The term ''service priorities'' means services for—

(A) low-income populations, including medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)));

(B) populations residing in health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)));

(C) populations residing in racially, ethnically, or geographically diverse areas, as determined by the Secretary; and

(D) populations that may have difficulty accessing health care, social, **educational**, or other community-based support services due to age or disability.

(8) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, and any territory of the United States.

SEC. 4. NATIONAL COMMUNITY HEALTH WORKFORCE FOR COVID–19 CONTAINMENT AND RECOVERY.

(a) ESTABLISHMENT OF GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary, in consultation with the Director of the Centers for Disease Prevention and Control, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Indian Health Service, the Administrator of the Health Resources and Services Administration, and State, local, Tribal, and territorial health departments, shall establish a grant program that expands and supports the community health workforce that addresses both public health emergencies, including the public health emergency declared by the Secretary under section 319 of the Public Health Service Act (42 U.S.C. 247d) on January 31, 2020, with respect to COVID–19, and longer-term and ongoing community health needs.

(2) OTHER CONSULTATION.—In establishing the grant program under paragraph (1), the Secretary may consult with other relevant stakeholders, as appropriate, including public or private nonprofit entities (or consortia of entities), community-based organizations, such as organizations led by community health workers, institutions of higher education (including minority institutions of higher education, such as historically Black colleges and universities and Hispanic institutions), medical centers, research institutions and organizations, professional organizations, third party payors, and other governmental agencies.

(b) COMPETITIVE GRANT.—

(1) IN GENERAL.—Using not less than 90 percent of the funds appropriated under subsection (g), the Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and the Director of the Indian Health Service, shall make competitive awards to eligible entities for the purposes described in subsection (a).

(2) TECHNICAL ASSISTANCE.—In addition to awarding competitive grants under subparagraph (1), the Secretary may provide technical assistance to grantees to develop capacity and provide evidence-informed programs and services according to community health worker standards, and may do so through the awarding of grants, contracts, or cooperative agreements. The Secretary may, when awarding such a grant or entering into such a contract or

collaborative agreement, take into consideration whether the eligible entity is community-based or led by community health workers.

(3) GRANT AMOUNTS.—The Secretary shall award grants under this subsection in amounts the Secretary determines appropriate, taking into account population need and strength of the recipient's proposal with respect to alignment with community health worker standards.

(4) GRANT PROCESS.—The Secretary shall ensure that the grant application process under this section is streamlined to ensure high quality programs.

(c) REQUIREMENTS.—Each entity receiving an award under this section shall implement a program that—

(1) aligns with community health worker standards for hiring, training, supervision, and work practice;

(2) ensures that members of the community health workforce provide preventive services in accordance with the service priorities; and

(3) outlines efforts that will be taken by the grantee to secure long-term, sustainable funding to support the community health workforce.

(d) REVIEW.—The Secretary shall conduct periodic reviews of the programs funded under this section to ensure that such programs align with the community health worker standards.

(e) GUIDANCE.—

(1) DRAFT GUIDANCE.—The Secretary shall, not later than 60 days after the date of enactment of this Act, issue draft guidance regarding recruiting, hiring, compensating, training (including continuing education and training), managing, and evaluating members of the community health workforce using evidence-informed tools and templates in order to respond to the COVID–19 pandemic, as well as for longer-term, ongoing, and future community health needs. The Secretary shall request public comment on such draft guidance.

(2) FINAL GUIDANCE.—Not later than 180 days after the date of enactment of this Act, the Secretary shall finalize guidance described in paragraph (1). Such guidance shall inform States, localities, territories, Indian Tribes, and Tribal organizations on how to sustain a community health workforce beyond the COVID–19 pandemic, to address ongoing public health needs, and to prepare for, and respond to, future public health emergencies. The Secretary shall update the guidance under this subsection in 2022 and every 4 years thereafter.

(f) NATIONAL HEALTH SECURITY STRATEGY.—Section 2802(a)(3) of the Public Health Service Act U.S.C. 42 U.S.C. 300hh–1(a)(3)) is amended by striking 'environmental health'' and inserting ''community health, environmental health,''.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section (other than subsection (f)), there are authorized to be appropriated, and there are hereby appropriated out of amounts in the

Treasury not otherwise appropriated, $8,000,000,000 for each of fiscal years 2020 and 2021, to remain available until expended.

(2) EMERGENCY DESIGNATION.—

(A) IN GENERAL.—The amounts appropriated under paragraph (1) are designated as an emergency requirement pursuant to section 4(g) of the Statutory Pay-As-You-Go Act of 2010 (2 U.S.C. 933(g)).

(B) DESIGNATION IN SENATE.—In the Senate, paragraph (1) is designated as an emergency requirement pursuant to section 4112(a) of H. Con. Res. 71 (115th Congress), the concurrent resolution on the budget for fiscal year 2018.

(3) SUPPLEMENT NOT SUPPLANT.—Amounts appropriated under this subsection shall be in addition to any other amounts otherwise appropriated pursuant to any other provision of law.

SEC. 5. STATE MEDICAID OPTION TO SUPPORT COMMUNITY HEALTH WORKFORCE FOR COVID–19 CONTAINMENT AND PUBLIC HEALTH RECOVERY.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

‘‘(cc) COMMUNITY HEALTH WORKFORCE SUPPORT.—

‘‘(1) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title that the Secretary determines is necessary to waive in order to implement this subsection, beginning January 1, 2021, a State, at its option as a State plan amendment, may provide for medical assistance for diagnostic, screening, preventive and rehabilitative services furnished by a community health worker.

‘‘(2) REQUIREMENTS.—The Secretary shall not approve a State plan amendment under this subsection unless the State meets the following requirements:

‘‘(A) The State limits the provision of medical assistance for preventive services that are furnished by community health workers to providers that implement evidence-informed community health worker standards for recruiting, hiring, training, and managing community health workers.

‘(B) The State makes medical assistance available for each category of preventive services.

‘‘(C) If a State plan amendment is submitted under this subsection during the public health emergency described in section 1135(g)(1)(B), the amendment includes a description of how—

‘‘(i) the State will ensure that the preventive services furnished by community health workers under the amendment will respond to such public health emergency; and

''(ii) following the public health emergency, the preventive services furnished by community health workers under the amendment will transition to sustainable community health supports.

''(3) DEFINITIONS.— The terms 'community health worker', 'community health worker standards', and 'preventive services' have the meaning given such terms in section 3 of the Building a Sustainable Workforce for Healthy Communities Act of 2021.''.

SEC. 6. REPORTING.

(a) IN GENERAL.—The Secretary shall report annually to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives on the impacts of the community health workforce on the public health, during the previous fiscal year, including the following relevant metrics:

(1) The number of members of the community health workforce nationally for the previous fiscal year.

(2) Federal funds expended to establish, implement, and maintain the community health workforce for the previous fiscal year.

(3) Mortality rates.

(4) Hospitalizations.

(5) Patient-reported outcomes, including quality of life, mental and physical health self-assessments, adverse event surveys, and other evidence-based tools.

(6) Adherence to community health worker standards.

(7) Unmet social needs, including housing instability and food insecurity.

(8) With respect to any reporting period during the period that begins on the effective date of the public health emergency declared by the Secretary under section 319 of the Public Health Service Act (42 U.S.C. 247d) on January 31, 2020, with respect to COVID–19, and ends one year after the end of such public health emergency—

(A) the number of COVID–19 cases, as determined by molecular diagnostic tests;

(B) the number of deaths due to COVID 19; and

(C) the number of hospitalizations due to COVID–19.

(9) Other metrics, as the Secretary determines appropriate for assessing the effectiveness of the community health workforce by the Secretary, **including metrics related to child health and development**.

(b) REPORTS TO THE SECRETARY.—Each entity receiving an award under section 4 and each State with a State plan amendment approved under subsection (bb) of section 1903 of the Social Security Act (42

U.S.C. 1396b) shall provide to the Secretary, on an annual basis during the period of the award and once not later than one year after such award has expired, a report on the impacts of the community health workforce on the public health during the previous fiscal year, in the applicable jurisdiction, including, at minimum—

(1) the number of members of the community health workforce in the previous fiscal year;

(2) Federal funds expended to establish, implement, and maintain the community health workforce for the previous fiscal year; and

(3) other metrics, as the Secretary determines appropriate for assessing the effectiveness of the community health workforce, such as—

(A) mortality rates;

(B) hospitalizations;

(C) metrics related to child health and development;

(C) patient-reported outcomes, including quality of life, mental and physical health self-assessments, adverse event surveys, and other evidence-based tools;

(D) adherence to community health worker standards;

(E) unmet social needs including housing instability and food insecurity; and

(F) with respect to any reporting period during the period that begins on the effective date of the public health emergency declared by the Secretary under section 319 of the Public Health Service Act (42 U.S.C. 247d) on January 31, 2020, with respect to COVID–19, and ends one year after the end of such public health emergency—

(i) the number of COVID–19 cases as determined by molecular diagnostic tests;

(ii) the number of deaths due to COVID–19; and

(iii) the number of hospitalizations due to COVID–19.

(c) DISAGGREGATION OF DATA.—The reports under subsections (a) and (b) shall provide data disaggregated by demographics, including age, race, ethnicity, income, gender identity, sexual orientation, and geographic location.

Appendix 3: Improving Social Determinants of Health Act of 2021

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Social Determinants of Health Act of 2021".

SEC. 2. FINDINGS.

Congress finds the following:

(1) Healthy People 2030 defines social determinants of health as conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

(2) One of the overarching goals of Healthy People 2030 is to "create social, physical, and economic environments that promote attaining the full potential for health and well-being for all".

(3) Healthy People 2030 developed a "place-based" organizing framework, reflecting five key areas of social determinants of health namely—

(A) economic stability;

(B) education access and quality;

(C) social and community context;

(D) health care access and quality; and

(E) neighborhood and built environment.

(4) It is estimated that medical care accounts for only 10 to 20 percent of the modifiable contributors to healthy outcomes for a population.

(5) The Centers for Medicare & Medicaid Services has indicated the importance of the social determinants in its work stating that, "As we seek to foster innovation, rethink rural health, find solutions to the opioid epidemic, and continue to put patients first, we need to take into account social determinants of health and recognize their importance.".

(6) The Department of Health and Human Services' Public Health 3.0 initiative recognizes the role of public health in working across sectors on social determinants of health, as well as the role of public health as chief health strategist in communities.

(7) Through its Health Impact in 5 Years initiative, the Centers for Disease Control and Prevention has highlighted nonclinical, community-wide approaches that show positive health impacts, results within five years, and cost-effectiveness or cost-savings over the lifetime of the population or earlier.

(8) Through its Social Vulnerability Index (SVI), the Centers for Disease Control and Prevention has established a tool for identifying geographic areas with the greatest vulnerability to natural disasters, and this SVI can be the basis for establishing a data base providing information on social determinants of health across the social determinant areas at both the county and census tract levels.

(8) Health departments and the Centers for Disease Control and Prevention are not funded for such cross-cutting work.

SEC. 3. SOCIAL DETERMINANTS OF HEALTH PROGRAM.

(a) PROGRAM.—To the extent and in the amounts made available in advance in appropriations Acts, the Director of the Centers for Disease Control and Prevention (in this Act referred to as the “Director”) shall carry out a program, to be known as the Social Determinants of Health Program (in this Act referred to as the “Program”), to achieve the following goals:

(1) Improve health outcomes and reduce health inequities by coordinating social determinants of health activities across the Centers for Disease Control and Prevention.

(2) Improve the capacity of public health agencies and community organizations to address social determinants of health in communities.

(3) Increase the knowledge and understanding of how social determinants affect different age groups and synthesize the knowledge and research base on effective programs and strategies to respond to social determinants of health for different age groups.

(b) ACTIVITIES.—To achieve the goals listed in subsection (a), the Director shall carry out activities including the following:

(1) Coordinating across the Centers for Disease Control and Prevention to ensure that relevant programs consider and incorporate social determinants of health in grant awards and other activities.

(2) Awarding grants under section 4 to State, local, territorial, and Tribal health agencies and organizations, and to other eligible entities, to address social determinants of health in target communities.

(3) Awarding grants under section 5 to nonprofit organizations and public or other nonprofit institutions of higher education—

(A) to conduct research on best practices to improve social determinants of health;

(B) to provide technical assistance, training, and evaluation assistance to grantees under section 4; and

(C) to disseminate best practices to grantees under section 4.

(4) Coordinating, supporting, and aligning activities of the Centers for Disease Control and Prevention related to social determinants of health with activities of other Federal agencies related to social determinants of health, including such activities of agencies in the Department of Health and Human Services such as the Centers for Medicare & Medicaid Services.

(5) Collecting and analyzing data related to the social determinants of health**, including data for different age groups and by geographic areas, including use of the CDC Social Vulnerability Index and additions to that Index that relate to social determinants and are available through the Current Population Survey.**

SEC. 4. GRANTS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH.

(a) IN GENERAL.—The Director, as part of the Program, shall award grants to eligible entities to address social determinants of health in their communities.

(b) ELIGIBILITY.—To be eligible to apply for a grant under this section, an entity shall be—

(1) a State, local, territorial, or Tribal health agency or organization;

(2) a qualified nongovernmental entity, as defined by the Director; or

(3) a consortium of entities that includes a State, local, territorial, or Tribal health agency or organization.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grant under this section shall be used to address social determinants of health in a target community by designing and implementing innovative, evidence-based, cross-sector strategies.

(2) TARGET COMMUNITY.—For purposes of this section, a target community shall be a State, county, city, or other municipality **or a geographic area within a state, city, or other municipality that is underserved or shown to have a high SVI or high vulnerability from a social determinants of health perspective.**

(d) PRIORITY.—In awarding grants under this section, the Director shall prioritize applicants proposing to serve target communities with significant unmet health and social needs, as defined by the Director.

(e) APPLICATION.—To seek a grant under this section, an eligible entity shall—

(1) submit an application at such time, in such manner, and containing such information as the Director may require;

(2) propose a set of activities to address social determinants of health through evidence-based, cross-sector strategies, which activities may include—

(A) collecting quantifiable data from health care, social services, education, and other entities regarding the most significant gaps in health-promoting social, economic, and environmental needs;

(B) identifying evidence-based approaches to meeting the nonmedical, social needs of populations identified by data collection described in subparagraph (A), such as unstable housing or food insecurity;

(C) developing scalable methods to meet patients' social needs identified in clinical settings or other sites;

(D) convening entities such as local and State governmental and nongovernmental organizations, health systems, payors, and community-based organizations to review, plan, and implement community-wide interventions and strategies to advance health-promoting social conditions;

(E) monitoring and evaluating the impact of activities funded through the grant on the health and well-being of the residents of the target community and on the cost of health care; and

(F) such other activities as may be specified by the Director;

(3) demonstrate how the eligible entity will collaborate with—

(A) health systems;

(B) payors, including, as appropriate, medicaid managed care organizations (as defined in section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. 1396b(m)(1)(A))), Medicare Advantage plans under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq**.), state CHIP programs**, and health insurance issuers and group health plans (as such terms are defined in section 2791 of the Public Health Service Act);

(C) other relevant stakeholders and initiatives in areas of need, such as the Accountable Health Communities Model of the Centers for Medicare & Medicaid Services, health homes under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), community-based organizations, and human services organizations;

(D) other non-health care sector organizations, including organizations focusing on transportation, housing, **education, child and family services,** or food access; and

(E) local employers; and

(4) identify key health inequities in the target community and demonstrate how the proposed efforts of the eligible entity would address such inequities.

(f) MONITORING AND EVALUATION.—As a condition of receipt of a grant under this section, a grantee shall agree to submit an annual report to the Director describing the activities carried out through the grant and the outcomes of such activities.

(g) INDEPENDENT NATIONAL EVALUATION.—

(1) IN GENERAL.—Not later than 5 years after the first grants are awarded under this section, the Director shall provide for the commencement of an independent national evaluation of the program under this section.

(2) REPORT TO CONGRESS.—Not later than 60 days after receiving the results of such independent national evaluation, the Director shall report such results to the Congress.

SEC. 5. RESEARCH AND TRAINING.

The Director, as part of the Program—

(1) shall award grants to nonprofit organizations and public or other nonprofit institutions of higher education—

(A) to conduct research on best practices to improve social determinants of health;

(B) to provide technical assistance, training, and evaluation assistance to grantees under section 4; and

(C) to disseminate best practices to grantees under section 4; and

(2) may require a grantee under paragraph (1) to provide technical assistance and capacity building to entities that are eligible entities under section 4 but not receiving funds through such section.

SEC. 6. FUNDING.

(a) IN GENERAL.—There is authorized to be appropriated to carry out this Act, $50,000,000 for each of fiscal years 2022 through 2027.

(b) ALLOCATION.—Of the amount made available to carry out this Act for a fiscal year, not less than 75 percent shall be used for grants under sections 4 and 5.