BRIEFING

COVID is the sprint; equity is the marathon

Building a community-based workforce to stop COVID and lay the foundations for health equity

PROBLEM

The uncontrolled COVID-19 pandemic has exacerbated existing health and economic inequities, disproportionately impacting impoverished people and communities of color. Black, Hispanic, and American Indian & Alaska Native (AIAN) people are more likely to be exposed to the virus and suffer five times the rate of hospitalization from COVID than white people, with Black Americans dying from COVID at twice the rate of white Americans.[i] Furthermore, these vulnerable communities are also disproportionately suffering from the unemployment crisis precipitated by the pandemic.[ii,iii] At the same time, as President Biden has correctly stated, the United States still lacks the caregiving and public health workforce and infrastructure required to end its twinned health and economic crises.[iv]

SOLUTION

The administration can simultaneously address the health inequities, unemployment disparities, and public health workforce shortages related to the COVID pandemic by using funding authorized by the *American Rescue Act* (H.R. 1319) to build a **community-based public health workforce**, paid a living wage plus benefits, to fill key COVID-19 control roles, including vaccine outreach, social support for patients isolating or quarantining, case investigation, and contact tracing. This workforce should be linguistically diverse and recruited directly from communities most impacted by poverty, structural racism, the unemployment crisis, and high rates of COVID-19.

Addressing short-term needs: Workers from vulnerable communities are *precisely who are needed* to most effectively fill the necessary roles of test-trace-isolate programs to control COVID, as demonstrated across diverse settings such as San Francisco, San Diego, Nashville, Baltimore, the Navajo Nation, and the state of Massachusetts.[v,vi,vii,viii] Because they have personal experience with inequity and a deep understanding of the communities they serve, these workers, when integrated into comprehensive epidemic control programs, have proven to bolster trust in the public health system,[v,viii] increase contact tracing yields,[v,vi,vii] ensure infected people and their contacts successfully isolate and quarantine,[v,vii,viii] and improve infection control in public spaces,[ix] among other essential functions. For the same reasons, it is workers from vulnerable communities who should be hired to perform community-based vaccine outreach functions, such as answering questions about vaccine safety, coordinating sign-ups for vaccinations, facilitating transport to vaccination events, and conducting follow-up to ensure completion of second doses.

Transitioning to a permanent, equity-focused workforce: This workforce will be sustainable if the administration and Congress include funding in a future spending package to make these jobs permanent. While it is critical to also permanently hire other kinds of public health workers, such as epidemiologists and public health nurses, addressing a vast range of health inequities after COVID will require the same kind of community-based workforce that can serve a broad range of social, economic, behavioral, and health needs.[x,xi] As long as inequity persists, hiring a health equity-focused workforce from poor and marginalized communities will continue to be not only a smart public health program, but also an effective jobs program, training program, and fiscal stimulus program for those communities.

Current funding for this workforce: The *American Rescue Act* (H.R. 1319) contains multiple sources of funding that the administration should consider for use in hiring this community-based workforce. While section 3021 appropriates $7.66 billion to HHS, which can be distributed as grants to health departments explicitly for public health workforce development, sections 3011 (testing, tracing, and mitigation) and 3031 (community health centers and community care) appropriate a total of $53.6 billion, which can also be used for public health workforce development through local, state and territorial health departments and federally qualified health centers, respectively. Section 3041 appropriates $240 million for workforce development through the Indian Health Service.

WHAT THE ADMINISTRATION MUST DO NOW

If the administration desires to stop COVID and address ongoing and future public health catastrophes, then the administration, with the Department of Health and Human Services, must do the following:

Establish a financing formula: Based on Partners In Health (PIH)'s experience assisting departments of health in implementing COVID-19 control programs in 17 jurisdictions across the country, we recommend that HHS establish a formula for the amount of new workforce funding from H.R. 1319 allocated to each state and local health department. Such a formula would ease the necessary transfer of funds to local health departments, bypassing any internal politics or bottlenecks at the state level. Allocations suggested in section 2(d)(1)(B) of the *Health Force, Resilience Force, and Jobs To Fight COVID-19 Act of 2021* (S.32) may serve as a model for the allocations guided by HHS under Section 3021 of H.R. 1319. Section 2(h) of S.32 could also serve as a model for targeting funds to vulnerable communities most affected by the crisis, including the use of the Center for Disease Control and Prevention's Social Vulnerability Index.[xii]

Develop guidelines for nonprofit partnerships: Section 3021 of H.R. 1319 stipulates that the $7.66 billion in workforce funding, if granted to health departments, can be used to hire workers either to the department or to nonprofits who have experience in public health and a relationship with health departments. The administration must develop guidelines to assist state and local health departments to navigate partnerships with those nonprofits, including guidelines on: issuing grants, rather than reimbursements for activities; specific desired outcomes for those partnerships; and streamlined reporting to ensure local health departments and their nonprofit partners are not given the burden of a cumbersome reporting process.

Develop guidance for public health workforce roles: Throughout the development of guidance, rules, and regulation to implement public health workforce provisions of H.R. 1319, we suggest that the administration delineate multiple, distinct public health roles, appropriate to serve in a community-based workforce. Necessary materials and technical assistance activities for implementation, from job descriptions to training programs, must also be designed for each role. The administration can draw on work and materials developed by Partners In Health during our extensive work with 17 state and local health departments to respond to COVID-19. Beyond contact tracing and case investigation, two roles the administration should delineate and help implement from the legislation are *social support specialists* and *community health workers*:

1) ***Social support specialists*** are individuals who ensure a COVID case or contact has the social, material, and other supports they need to safely isolate or quarantine. The CDC defines this role as essential for COVID epidemic control because contact tracing's efficacy in decreasing disease spread relies on the ability of cases and their contacts to safely isolate and quarantine to avoid infecting others.[xiii] Unfortunately, many families with limited resources struggle to isolate and quarantine effectively. In Massachusetts, 15-20% of new cases report needing support to isolate and quarantine.[xiv] Many individuals must take unpaid time off from their jobs during this time or may live in situations where safe isolation or quarantine is difficult or even impossible without assistance. Individuals sometimes need deliveries of food, cleaning supplies, or medication, assistance with child or elder care, or support with communicating with their employers so they do not lose their jobs.

2) ***Community health workers*** and/or ***promotores*** **(CHWs)** are an essential part of the COVID response, as they have linguistic and cultural competency for their communities, have existing trust in their communities, and serve a role designed to address health equity. If incorporated correctly into the COVID response, CHWs can be an incredibly effective partner for addressing vaccine hesitancy, COVID care, and other key components of the response. Community-based organizations and national partners have developed a playbook on implementation tools for health departments aiming to integrate CHWs into their COVID response.[xv] The administration should issue guidance that mirrors these best practices. CHW programs must also include several core tenets, and hiring should follow guidelines as laid out by the Community Health Worker Core Consensus Project. Although we model a need for a much larger cohort of 540,000 new CHWs to advance a more equitable approach to care and community engagement,[xvi] the administration should utilize funds from the *American Rescue Act* to hire and empower a cadre of CHWs to work on vaccine outreach and other COVID response activities. CHWs are best positioned to help consumers navigate technological gaps in vaccine platforms, deploy already trusted messengers for COVID vaccine outreach and case investigation, and guide care and resources for other major health concerns in their communities.

Prepare for deep and ongoing technical assistance: An equitable COVID-19 response requires both top-down and bottom-up approaches, where federal guidelines build on the best practices in states across the country, while local needs are met through decisions made by local and state health departments, guided by the data and voices of the communities they serve. While state and local health departments may be able to establish protocols for hiring professional public health staff, community-based workforce roles, especially the community health worker and social support specialist roles, will take additional scrutiny and guidance to be deployed in an effective and equitable way.

PIH stands ready to convene expert implementers, public health officials, community-based organizations, and academic advisors to help the administration with the technical details necessary to build this workforce.

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