

COVID-19 IS THE SPRINT, EQUITY IS THE MARATHON:

Key elements for building a public health and community health workforce

JUNE 2021

EXECUTIVE SUMMARY

For more than a year, the COVID-19 pandemic has revealed the cracks in our health infrastructure and pushed our systems to the breaking point. It has exacerbated underlying inequities and disproportionately impacted communities of color. The United States needs a systemic investment in public and community health jobs focused on serving the most marginalized.

Over the last decade, the nation has lost at least [38,000 public health jobs](#), while state and local public health budgets have dropped by 16% and 18% per capita, respectively. Systemic underfunding since 1980 has [slashed](#) the state and local public health workforce from nearly 500,000 jobs to under 200,000 today. Especially hard hit are poor communities and communities of color, which have been continually passed over and neglected due to entrenched inequities. This undermines health in all communities. As a result, [hospitalization rates](#) of Black people in the U.S. due to COVID-19 are almost three times those of white people in the U.S., while COVID-19 related death rates were twice that of white people in the U.S.

President Biden signed into law the [American Rescue Plan Act](#) (ARP), a \$1.9 trillion relief bill, in March 2021 and issuing the “Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government” (“Equity Executive Order”) on his first day in office. In the ARP, Congress provided \$7.66 billion for a Public Health Workforce (ARP Section 2501).

On March 25, 2021, labor unions, community-and faith-based organizations, public health experts, and advocates gathered for a roundtable discussion on how the ARP might build the public and community health workforce the country desperately needs. The roundtable participants identified the needs of community and public health workforces to address COVID-19 discrepancies and build more equitable public health responses in the U.S. Critical findings about elements necessary for the success of the ARP workforce emerged in four categories: targeted funding, who we hire, the quality of the jobs, and building community capacity.

On May 4, 2021 the Biden administration [announced](#) the first allocation of Section 2501 through investments in grants for community-based organizations (CBOs); this was followed up by a May 13 [announcement](#) investing the rest of Section 2501 funds in local and state public health departments and long-term funding to improve public health systems. [These funds](#) included a distinct focus on hiring from and investing in training programs within communities affected by COVID-19 and minority-serving academic institutions.

The May announcements focused exclusively on funds made available under Section 2501 of the ARP, but the legislation made additional allocations for workforce investments: including \$7.6 billion in funding for vaccines (Section 2301); \$47.8 billion allocated for testing, contact tracing, and mitigation (Section 2401); and \$7.6 billion provided for community health centers and community care (Section 2601). The ARP affirms and has laid the foundation for the Administration's commitment to building an equitable health force of more than [100,000 public health workers and 150,000 community health workers](#) (CHWs) capable of addressing the interlocking crises of health and social inequity.

In this white paper, we highlight recommendations that build on these announcements, and suggest policies for the administration to consider while building the public health and community health workforces.

- **Smart investments can build the community and public health workforce for the long-haul.**
 - Addressing racial inequities in health requires a workforce that can address difficult, deep-set issues. This is more than the work of a single year or a crisis response: it requires building a workforce that can run a marathon.
 - ARP funds should be strategically deployed to fund a large, multi-year commitment to the public and community health workforce.
- **Workers must be hired from the communities they will serve—those hit hard by the COVID-19 pandemic and health inequities.**
 - To achieve this, targeted hiring is critical; a new recruitment plan is a good first step towards actualizing this.
 - Funded training can teach key skills, and ensure that the qualifications that matter most—embeddedness in a community and cultural competence—drive who gets hired.
 - This workforce will be made of a variety of jobs—navigators, CHWs, social support specialists, and more.
- **Ensuring good jobs for public health and community health.**
 - Living wages and benefits will help recruit a talented workforce.
 - With targeted hiring, good benefits will ensure that communities facing both the COVID-19 pandemic and recession get the jobs they need to drive an equitable recovery.
- **Community coordination can drive effective public and community health strategy, hiring, and funding.**
 - The U.S. Department of Health and Human Services (HHS) should structure grants to create an analogue to the Ryan White Act's community planning councils.
 - Grants should be awarded to ensure that small CBOs have the opportunity to grow alongside the public and community health workforce. Two new grant opportunities demonstrate initial efforts.

Together, these recommendations can drive an equitable recovery from this pandemic and advance progress against deep health disparities throughout America.

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I. SMART INVESTMENTS TO BUILD THE PUBLIC AND COMMUNITY HEALTH WORKFORCE

Multiple funding streams in the American Rescue Plan (ARP) are necessary to fund the community and public health workforce that can meet President Biden’s pledges to advance racial equity, combat health disparities, and hire [100,000 public health workers and 150,000 community health workers](#) (CHWs).

The Biden administration began to address this goal when, on May 13, 2021, they announced how the majority of the \$7.6 billion in funding for Section 2501 of the ARP will be allocated.

Recommendations

- The U.S. Department of Health and Human Services (HHS) should use funds throughout the ARP to build the largest and most lasting public and community health workforce possible.
- Smart and transparent funding criteria, timelines, and grant disbursements made in advance are critical for rapid scale up.
- The public and community health workforce needs to be built for the long-haul with targeted hiring to advance equity. While some roles may include AmeriCorps jobs or stipend-based fellowship opportunities, they must also look beyond short-term funding programs to build a sustainable long-term pipeline. ARP funds should continue to focus on recruiting, training, and expanding the public and community health workforce.
- While [\\$250 million](#) is a meaningful start, funding should continue to go directly to community-based organizations (CBOs) to expand long-term capacity and address health inequities in every community.
- HHS should create a centralized tracking tool (like the one provided in 2009 at [recovery.gov](#)) that gives granular information on where ARP funds are going to help ensure funds are used effectively and build long-term support for this critical work.

Long-term funding is essential for equity

The public and community health workforce should be funded with a longer-term (2+ year) time horizon to effectively tackle COVID-19 and other disease burdens. This will create an investment in a workforce that can make progress on [President Biden’s racial equity Executive Order](#).

Long-term jobs are important for attracting a talented and stable public and community health workforce. Guaranteed funding beyond the immediate term will ensure the workforce can grow to become even more effective on the job. The administration’s [announcement](#) includes a \$3 billion investment to modernize the public health workforce and build toward health equity. Funds will be distributed through a new grant program—designed by various federal, state, local, and territorial public health experts—aimed to support health departments in lower-income and under-resourced communities. This grant program may increase hiring of CHWs and provide an opportunity to continue in their role beyond COVID-19.

Nevertheless, the timeline of investing beyond the pandemic is unclear, and should be outlined and clarified—with health equity at its center—to ensure the public health workforce is sustained beyond the pandemic.

Longer-term funding will allow state and local health departments and CBOs the opportunity to build capacity, plan for the future, and strategize together. The public and community health workforce can best “build back better” if they’re recruited and trained with an eye on addressing underlying health inequities, [as called for by the National Community-Based Workforce Alliance](#).

Volunteer Service Corps positions are often antithetical to the goal of building long term jobs due to the temporary nature of the role, as well as the often inequitable support and incentives provided. The CDC has introduced a partnership with AmeriCorps to establish surge capacity and training programs for young people. This program aims to “focus on building a diverse pipeline for the public health workforce and providing direct service to communities across the country.” As the launch of the Public Health AmeriCorps is not the administration’s *only* investment in a public health workforce, this program seems additive to the goals of the ARP, however we caution that it should not take priority over more long-term career pathways.

Smart investments from the ARP can have a large impact

HHS should draw on all relevant funding streams to support the community and public health workforce. President Biden’s historic goal of hiring [100,000 public health workers and 150,000 CHWs](#) is only achievable if different funding streams from ARP are used to build the workforce. This scale is necessary to meet the pandemic moment and President Biden’s goal to “[improve quality of care and reduce hospitalization for low-income and underserved communities](#)” over the long-term.

ARP Section 2501 appropriates \$7.66 billion through HHS to health departments and CBOs for public and community health workforce growth. Sections 2401, 2406 (testing, tracing, and mitigation) and 2601 (community health centers and community care) provide a total of \$53.6 billion which can and must be used, in part, for the public and community health workforce. Section 3041 appropriates \$240 million for workforce development through the Indian Health Service. In addition to the administration’s [announcement](#) of \$500 million from Section 2501 allocated to hiring school nurses,—critical members of the community health workforce—Section 2001 can also be used to fund school nurses.

We estimate that Section 2501 could fund as many as 150,000 public health and community health jobs for one year (assuming \$50,000 annual salaries, and accounting for benefits and overhead). However, Section 2501 falls short of President Biden’s ambitious goal to create [100,000 public health workers and 150,000 CHW](#) jobs. To reach this milestone, HHS must draw on other ARP funding streams, as highlighted above. Because health workers will use the same skills needed to mitigate the pandemic to address longer-term inequities, they should be funded to achieve the Biden Administration’s short-, medium-, and long-term goals. Importantly, these roles will need to be hired at multiple levels, going beyond federal programs or state funding alone. Each funding stream should have a plan and each should require targeted hiring, as is outlined in the [announcement](#) of the Section 2501 funds.

HHS should focus a portion of funds in Sections 2401 and 2406 on funding community and public health workers whose first, essential tasks will be focused on guiding their communities through the COVID-19 pandemic. In a May 2021 [letter](#) to Secretary Xavier Becerra, Senator Elizabeth Warren, along with Representatives Barbara Lee, Judy Chu, Karen Bass, Pramila Jayapal, Robin Kelly, Lisa Blunt Rochester, Kaiali’i Kahele, Nanette Diaz Barragán, Marilyn Strickland, Mark DeSaulnier, Adam Smith, and Earl Blumenauer, calls for these funds, among others, to be directed toward CBOs that work within medically underserved areas.

Smart funding requires flexibility so that states can coordinate funds to local public health departments to expand capacity at every level. Sens. Kirsten Gillibrand, Michael Bennett, Tina Smith, Amy Klobuchar, Chris Van Hollen, and Cory Booker recommended one possible formula in their [letter of intent](#) to Secretary Xavier Becerra and Director Rochelle Walensky.

When thinking about the local level, the National Association of County and City Health Officials (NACCHO) has released a set of guidelines. [NACCHO clarifies](#) that local health departments must be engaged in conversations about how to best resource their communities in the ongoing response, and recovery from, the COVID-19 pandemic. [EO 13996](#) specifically requires “the Secretary of HHS and the Secretary of Labor [to] promptly consult with State, local, Tribal, and territorial leaders to understand the challenges they face in pandemic response efforts, including challenges recruiting and training sufficient personnel to ensure adequate and equitable community-based testing, and testing in schools and high-risk settings.”

Local health departments operate under a variety of governance structures, the majority of which are independent from the state health department. Direct local input is key for developing a tailored strategy, and in some jurisdictions is essential to be included in grant applications due to the lack of county health departments in the governance structure.

NORTH CAROLINA'S APPROACH TO COVID-19 THROUGH COMMUNITY HEALTH

The North Carolina Department of Health and Human Services (NCDHHS) took early advantage of CARES Act funding to provide wraparound care to people infected and affected by COVID, which should serve as a model for other states. With \$14.7 million in CARES Act funding from August-December 2020 and \$16 million in state and CDC funding from January-June 2021, NCDHHS was able to hire and manage over 400 CHWs and pay them living wages. Fulfilling a wide range of roles, CHWs help connect individuals to testing, provide general COVID and vaccine-related education, facilitate vaccination, screen for social determinants of health, and refer to necessary social supports.

Because these CHWs came from the communities they worked in and are employed by CBOs with longstanding local ties, they brought with them existing trusted relationships, and were able to create an “ecosystem” of support in the most vulnerable counties in the

state. This system helped to ensure that referrals for social supports via the CARES Act-funded Support Services Program (financial relief, food assistance, PPE, transportation) and additional state mechanisms (housing support, rent/utility assistance, child care, etc.) were fulfilled by the appropriate funding streams and that technology solutions were accompanied by a person-centered workforce. Of over 39,000 households served from September 2020 through April 2021, almost all referrals via the Support Services Program received food assistance and 70% received financial relief (up to \$800). With all of these efforts, North Carolina has largely avoided becoming one of the U.S. states hardest hit by COVID-19. This is no doubt due to the state’s promotion of safe quarantine and isolation for COVID-19 in marginalized populations, and resource coordination done by the NC CHW and Support Services Programs.



Community health workers at a local food distribution event hosted by La Semilla, a non-profit organization serving Latinx communities and partnering with Spanish-speaking CHW vendor Curamericas Global in Durham, North Carolina and the surrounding area. [Photo courtesy of Curamericas](#)

II. WHO WE HIRE: RECRUITMENT AND TRAINING

For a successful and equitable new public and community health workforce, the recruitment, hiring, and training of people whose experiences and competencies can best serve communities in need are crucial. To hire for lived experience, recruitment and hiring must target those most affected, and accessible training programs must be employed to ensure the long-term sustainability of the program.

The Biden administration [announced](#) that the CDC will use \$3.4 billion of Section 2501 of the ARP towards “new hiring for state and local public health departments to quickly add staff to support critical COVID-19 response efforts.” Coupled with the [announcement](#) of \$250 million to help CBOs hire community outreach workers, including social support specialists, it is clear that the administration is promoting equity as a top priority in the response to COVID-19. This is a great first step, and should not be the last.

Recommendations

- The public and community health workforce should be recruited from the communities they serve—those which have faced the highest rates of COVID-19 due to pre-existing health inequities.
- Recruitment for the expanded public and community health workforce should supplement, not replace, state and local public health funding streams.
- ARP funds should be used to support robust trainings for the public and community health workforce, and capacity building for state and local health departments and CBOs to ensure the workforce has the support and coordination it needs to succeed.
- The workforce should be structured around a variety of different job functions, be embedded in community organizations, and be built around skills that will continue to improve health equity after the COVID-19 pandemic.

Recruit from the communities most affected by COVID-19

To best serve the communities that face the greatest inequities, HHS should ensure that recruitment and hiring empower those very communities. This is critical because the workforce plays two distinct roles: a means of delivering services to communities, and a jobs program for communities grappling with multiple, intersecting crises.

The public health workforce needs workers with the linguistic and cultural competence and lived experience to build trust with most-impacted communities, as they are most representative of the community since they live, pay taxes, raise children, and spend their wages there. This trust, in turn, is essential to delivering effective and racially equitable public health services. Hiring from these communities is essential for the ARP to achieve its ends—a workforce that comes from, and deeply understands, a specific community will be better able to serve it. ARP Section 2501(B)(ii) directs HHS to ensure that needs of these communities are being met, specifying that money for hiring should go to organizations “particularly in medically underserved areas.” This point is also referenced in the aforementioned Sen. Warren and Rep. Lee [letter](#).

Public health workers need to understand and build trust with those they serve. For CHWs to [operate most effectively](#), for instance, they need to learn peoples’ lived experiences and understand the complex interactions of social needs at an individual and community level. For communities that speak languages other than English, the workforce will need linguistic capability. An [HHS report on minority health](#) underscored the importance of workers’ linguistic capability, while other research has found that [language and communication barriers reduce the effectiveness of care](#).

Moreover, this approach is urged by [President Biden’s January 20, 2021 Executive Order on Equity](#). In that Executive Order, President Biden announced that it was the policy of his Administration to pursue a “comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.” Accordingly, the President directed “heads of agencies, study strategies, consistent with applicable law, for allocating Federal resources in a manner that increases investment in underserved communities, as well as individuals from those communities.” HHS can make good on this policy statement by ensuring that ARP grants flow to underserved communities through targeted recruitment and hiring. Such policies will ensure that money goes to those who have too-often been unjustly denied opportunities and benefits.

Targeted hiring helps mitigate the pandemic's economic impact by providing an influx of federal investment in people, places, and communities disproportionately harmed by the ongoing health crisis. The COVID-19 pandemic has exacerbated longstanding social inequalities, [with people of color experiencing a outsized burden of COVID-19 cases, hospitalizations and deaths](#). Moreover, unemployment for Black and Latinx communities is [still increasing](#) to 10% and 8.8%, respectively. Low-wage workers, in general, have faced [both financial and health insecurity](#), and Black workers in particular face [two compounding preexisting conditions, racism and economic inequality](#). The ARP can thereby serve as a vital step in building a better workforce.

Train for a broad set of skills

Public health workers should be recruited and trained to foster a broad skill set, so they can transition from addressing acute COVID-19 concerns to addressing the social determinants of health, which have driven the inequitable impact of COVID-19. The skills that allow the workforce to contain COVID-19 will be critical to advancing health equity over the longer term. Partnerships with public health apprenticeship programs that have strong connections to impacted communities, health departments, and CBOs should be strongly encouraged to enable cross-cutting training.

There are several working models for training a competent public health and community health workforce. For instance, the New Jersey Department of Health has collaborated with the New Jersey Department of Labor and Workforce Development to create the NJ Community Health Worker Institute to increase the number of CHWs in general, with a particular focus on hiring women, people from low-income communities, and communities of color. [SEIU 721 has partnered with the City of Los Angeles](#) for an effective [joint hiring and apprenticeship program](#). These programs offer pathways that enable workers to develop and advance their careers, benefiting the worker, the workforce, and the communities they serve.

As the acute phase of the COVID-19 pandemic subsides, CHWs will go from talking to community members about social supports needed for isolation and COVID-19 vaccines, to helping their neighbors navigate social supports needed to get to school; manage chronic pain, mental health, or diabetes; find a job; and secure better housing. Much of the COVID-19 support system is the same support system our communities need to improve health long-term. This is true for traditional public health jobs as well—the epidemiologist who is now evaluating contact tracing data will not suddenly switch to a different line of work. She will apply the skills that helped track the spread of new variants to addressing outbreaks of HIV, tuberculosis, or the flu, and can adapt these tools to help track and respond to other urgent health needs, such as the opioid epidemic.

The White House's [allocation](#) of Section 2501 funds towards a grant program that “will offer community health workers and others hired for the COVID-19 response an opportunity to continue their careers beyond the pandemic as public health professions,” indicates the administration is beginning to think about the importance of building and investing in the public health workforce past the pandemic. This effort must remain central to the strategy in order to build programs that respond to local needs.

Allow for a wide range of job functions

The ARP allows for a wide range of job functions to be hired under Section 2501¹. This is a feature—not a bug—that ensures that the community and public health workforce can address the social determinants of health from multiple directions. HHS may use the funds to either hire people for the roles enumerated in the ARP or to prevent, prepare for, and respond to COVID-19.

Congress intended for HHS to provide a wide array of jobs because it not only listed many different jobs, but it also enabled HHS to hire “any other positions” related to the pandemic. In other words, HHS has authority to tackle the broad social determinants of health according to this language, and should not be limited to those called out directly in this Section. Due to concurrent impacts of the pandemic on homelessness, jobs programs, and increased need for family care, HHS should consider roles that navigate social support networks, conduct targeted homelessness outreach, and integrate legal support when drafting guidance. This has yet to be outlined in the White House’s [allocation](#) of Section 2501 funds.

HHS should also use this leeway to support the hiring of a broadly defined workforce that is united by its ability to address the health inequities that have made COVID-19 so devastating. While the workforce section of the ARP is broad and has allowed flexibility for many roles, it falls short of explicitly funding legal aid attorneys who can help resolve issues that affect health and drive COVID-19 spread [like eviction](#), [unsafe workplace conditions](#), [incarceration](#), or unresolved immigration issues. This broad mix of skills and roles is critical to ensuring that the overall workforce is effective and built to last.

Health workforce members should be trained with skills that enable them to address both immediate and longer-term health needs

Many of the essential skills and roles needed to finish combatting the COVID-19 pandemic are also essential for addressing the underlying and persistent health inequities that have made the pandemic so deadly for impoverished regions and communities of color. In addition to expanding capacity, leadership, and training in state and local public health departments, the community-facing workforce, such as CHWs and social support specialists, should be structured around key workforce design principles. Their duties should be structured around improving behavioral health, expanding access to preventative screening, immunizations, connections to social support systems, and chronic disease management.

CHWs are the core of the expanded community and public health workforce. During the COVID-19 pandemic, global health leaders, health providers, legislators, policy makers and funders have called for the rapid scale up and integration of CHWs to strengthen public health and local and state COVID-19 response plans. On March 19, 2020, the U.S. Department of Homeland Security Cybersecurity and Infrastructure Security Agency (CISA) demonstrated the urgency to engage CHWs when it issued guidance to states, tribes, and territories that classified CHWs as essential critical infrastructure workers during COVID-19.

The Community Health Worker Consensus project has defined [ten core competencies](#) for effective CHWs, ranging from cultural competence and mediation to patient advocacy and navigation. Building on this work, the National Community-Based Workforce Alliance has created a [playbook for effective CHW COVID-19 response strategies](#) to help design a robust CHW workforce. HHS should require that grantees commit to the [Community-Based Workforce Principals](#) to ensure local recruitment and continuous training and professional development, in line with these thorough and robust recommendations.

¹ Section 2501(b), “use of funds for public health departments,” gives HHS the power to: [Provide funds related to the recruiting, hiring, and training of individuals] to serve as case investigators, contact tracers, social support specialists, community health workers, public health nurses, disease intervention specialists, epidemiologists, program managers, laboratory personnel, informaticians, communication and policy experts, and *any other positions as may be required to prevent, prepare for, and respond to COVID-19*.

Partners In Health estimates that at least [540,000 new CHWs](#) are needed across the country to advance a more equitable approach to care and community engagement. By building on the existing CHW workforce across the country, a portion of Section 2501 funds can be used to the greatest effect. CHWs are best positioned to help consumers navigate [technological gaps](#) in vaccine platforms, serve as trusted messengers for COVID-19 vaccine outreach and case investigation, and guide care and resources for other major health concerns in their communities.

In addition, evidence from the [Contact Tracing Collaborative](#) in Massachusetts, and contact tracing efforts elsewhere, have shown that a focus on *social support specialists* is essential for COVID-19 response. Sometimes called care resource coordinators or navigators, these individuals ensure that a COVID-19 case or contact has the social, material, and other supports they need to safely isolate or quarantine. Connecting individuals and families to these essential resources has been [remarkably effective at helping contain the spread of COVID-19](#).

The CDC defines *social support specialists* 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. 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. Many individuals must take unpaid time off from their jobs 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. Social support specialists can also help people secure housing support or health care enrollment.

TRUSTED MESSENGERS IN CHICAGO

Latinx and Black communities in Chicago, IL have suffered a disproportionate impact from COVID-19. While 29% of Chicago residents identify as Latinx, they account for 44% of COVID cases, based on conservative estimates. Death rates among Black Chicagoans are nearly double than that of white residents. To address the specific mistrust in the Chicago community around the COVID-19 vaccine, a group of dynamic and like-minded organizations are collaborating with CBOs to form a vaccine partnership of credible messengers: individuals indigenous to and respected by the community where they work or live, to support COVID-19 vaccination efforts and related health messaging.

The Chicagoland Vaccine Partnership is utilizing the trusted messenger model to build a public health workforce of tens of thousands of individuals that will educate community members about the value and safety of vaccination, connect them to healthcare sites where they can access the vaccine, and link them to other key socioeconomic supports. These trusted messengers are vital for the immediate COVID-19 response and vaccine rollout, but also in the long-term, given other public health failures that disproportionately affect Latinx and Black communities all over the country.

III. ALL JOBS CREATED THROUGH ARP SHOULD BE GOOD-PAYING JOBS

Consistent with other efforts by the Biden administration to establish a higher minimum wage, as well as meeting the objectives of the ARP, all public and community health jobs should be good jobs, backed by strong labor standards. Building off the [letter of intent](#) from Senators Gillibrand, Bennett, and others, workforce members should be well-compensated and hired to build upon and extend existing public health workforce capabilities.

Recommendations

- Workforce members should be paid not less than the higher of \$15/hr or prevailing wage in accordance with the [McNamara-O'Hara Service Contract Act](#) (SCA).
- Workforce members should receive benefits, including health, retirement, and paid family and medical leave.
- Workforce members should have anti-displacement protections and rights to recall.
- The workforce should be structured in ways that are amenable to labor organizing to help build effective training, retention, and political power to support future funding.

Strong pay and benefits are necessary to advance health equity and build back better

Decent job standards are critical for our essential workers. Public health workers are essential to the well-being of our society during the pandemic, as well as post-pandemic. Too often, however, our policies have [undervalued and devalued](#) their vital work, causing community and public health workers to [earn below living wages](#). Securing good wages, benefits, and working conditions for public health workers is essential for the longevity of this workforce. Moreover, because the workforce members will be recruited from the most-affected communities, investment in a strong, well resourced, and protected workforce is also an investment in those communities.

A strong wages-and-benefits package will enable the community health workforce to more readily achieve the objectives laid out in the ARP. As ARP Section 2501(a) tasks HHS with the responsibility of “establishing, expanding, and sustaining a public health workforce,” the agency should ensure that wages and benefits are at a sufficient level to recruit and retain workers. Failure to provide sufficient labor standards could lead to the deterioration of the workforce for several reasons:

- Hiring entities might find it difficult to recruit people of requisite competence, experience, and background without offering prevailing wages.
- Prevailing wages will create lower turnover, which improves the quality of services. High turnover, by contrast, is [“expensive, results in loss of expertise, and negatively affects organizational performance.”](#)
- Providing for the health of these workers, who must also attend to their own health and wellness, will enable them to be successful in their jobs. Low wages [adversely affect physical and mental health of workers](#) through a variety of mechanisms, ranging from stress and lack of access to goods and services, to the feeling from workers that neither they nor their work is valued. A sufficient wage-and-benefit floor can ensure that workers are economically secure, motivated, and ready and able to do the important work the country needs.

Pathways for advancement create a workforce that can take on large health disparities

Once workers are hired, pathways for career development are critical to recruit, retain, and expand the community health workforce. Accordingly, all funds distributed under Section 2501 should require a strategic plan for developing public health careers. The current language in the [recent allocation of funds](#) is vague.

These provisions can both serve as an effective initial recruitment tool and help retain workers, enabling the workforce to draw on their expertise and experience to best serve communities in need. Before the pandemic, experts warned of supply shortages of CHWs, [a trend that will likely worsen as an aging population places a greater burden on existing systems](#). These career ladders will help retain workers, thereby building a more sustainable workforce and increasing the quality of care it will provide.

HHS should clarify that Section 2501 funds cannot be subgranted to for-profit organizations, used to contract out to for-profit organizations, or used for any purpose other than employment, PPE, and administration by health departments and nonprofit private or public organizations.

In addition, HHS should seek clarity on student loan assistance for public health workers out of other funds in the ARP, executive authority for loan forgiveness/forbearance, or updated guidance for the Federal Student Loan Forgiveness Program. These options would ensure that the public health workforce utilize existing programs, rather than divert funds from Section 2501.

IV. BUILDING CAPACITY IN COMMUNITIES

To address systemic, underlying health inequities, it is critical that the public and community health workforce be driven by priorities set at the community level. Local responses are better able to adapt to the needs of communities, bring linguistic and cultural competency, and build trust. However, local communities are often under-staffed in terms of responsibilities and roles, and smaller CBOs are often under-funded, in part due to a lack of capacity, unclear guidance, or connections with public health systems.

To this end, HRSA has announced [\\$250 million](#) in awards for CBOs. One opportunity lays out up to 10 awards for intermediary organizations to serve as a pass through for CBOs, and another which directly funds up to 121 CBOs. Half of the \$250 million for CBOs to work with those hardest hit by COVID-19 have recently been [allocated to 14 nonprofit organizations](#), with the other half expected to be allocated to [121 smaller CBOs](#) by July 1. These opportunities are a first step toward empowering communities to address COVID-19 and health equity. Here we lay out considerations that build upon this effort.

Recommendations

- Job requirements should focus on skills, shared life experiences (especially for CHWs), and cultural fluency—rather than academic credentials.
- Ensure indirect measures of workforce readiness (criminal legal record, eviction record, credit score, or immigration status) are not primary considerations for roles.
- HHS should allow undocumented persons who serve as CHWs a pathway to citizenship.
- Use community-driven processes, paired with state-led needs assessments, like structures in the [Ryan White Program](#).
- HHS should rely on local intermediaries to ensure that community knowledge informs the development of the public and community health workforce.

HHS can structure grants to build capacity for small, localized CBOs right now

There are a number of actions HHS can take immediately to begin building capacity for small CBOs to ensure a smooth and effective expansion of the public and community health workforce. Capacity development grants similar to those under Ryan White Part C would promote organizational infrastructure development for smaller CBOs. In response to the HIV/AIDS crisis, federal programs aim to strengthen efforts around rapid antiretroviral therapy (ART), CHWs, integration of HIV/AIDS primary care with oral health and/or behavioral health, and transitioning youth into adult HIV/AIDS care.

HHS should also require that grantees not use excessive degree, licensure, or certification requirements that might exclude qualified candidates, particularly for community-based roles. Candidates can be assessed for basic literacy, numeracy, and data collection skills. Where applicable, training programs, as described above, should be paired with state-mandated accreditation. Degree requirements in particular threaten to exclude candidates with the community knowledge and critical people skills needed to reach marginalized communities.

Nearly [one in three](#) American adults have some sort of a criminal legal record. Black men [disproportionately](#) bear the burden of discrimination based on criminal legal involvement. The community and public health workforce is designed to address the underlying health disparities within communities—barring those who have been convicted from meaningful legal employment undermines these goals by excluding people with important lived experience from the workforce. HHS must ensure that legal records, particularly for charges that disproportionately affect communities of color, do not automatically bar candidates from consideration.

The argument for undocumented persons is comparable. HHS should allow undocumented individuals who serve as CHWs to expedite applications for immigration, where applicable. Such action is in line with [calls](#) to reform the existing immigration system and will help undocumented individuals, who are predominantly uninsured and reliant on emergency rooms for medical attention, [to access culturally competent care](#).

Community coordination is essential to combat COVID-19 and address local needs

As grants are allocated, HHS should require states and all grantees to coordinate health strategy and implementation with community voices. As a core condition of funding under ARP Section 2501 grants, states should lead a needs assessment, planning, and community planning council process.

To do this, HHS should help states coordinate a locality- and CBO-involved needs assessment to understand priorities for urgent and long-term workforce positions. State health departments should then develop an implementation plan while they chart a roadmap for communities to create local implementation councils.

We suggest that HHS require a community consultation similar to the [Ryan White planning council model](#). This community-led planning and implementation model can ensure that the funds from the ARP are used in an appropriate and efficient way to address communities' needs. HHS should consider giving priority to grantees that have councils in place, which should be designed to give CBOs, labor organizations, and community members the ability to contribute to plans that implement ARP workforce funds at the local level.

Such a requirement would empower CBOs that know their community well and ensure that their knowledge is shaping state and local health department strategy. Small CBOs are often the most effective in reaching local communities because they have a nuanced understanding of needs in the community. [This advantage helps drive equity in hiring and program goals](#). However, small CBOs tend to be at a disadvantage in gaining funds, and are sometimes entirely excluded from planning processes. A community planning council model would give CBOs a seat at the table, and potentially help smaller CBOs contribute to and serve their communities without the burden of grant reporting and other constraints on capacity.

PLANNING COUNCILS CAN EMPOWER COMMUNITIES

The Ryan White Act is a powerful example of how a federal program can incorporate community-level representation into the funding allocation process and support the work of CBOs by improving their organizational infrastructure. [Part A](#) of Ryan White requires that community-based planning bodies, known as planning councils, conduct a needs assessment and develop a comprehensive plan for the delivery of services in that region based on its findings. These planning councils must reflect the demographics of the local population, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations. Part A further promotes accountability to local communities by requiring that all planning council meetings and minutes are publicly accessible.

Planning Council Needs Assessment [Example](#):

In 2016, the San Francisco HIV Planning Council found disparate rates of PreP utilization in its service area. The needs assessment revealed that mostly college-educated, cisgender white men with private health insurance utilized PreP while other high-risk populations were not accessing PreP at comparable rates. These findings subsequently informed the planning council's comprehensive plan to expand PreP outreach and education campaigns to include different languages and targeted outreach to people of color, transgender persons, injection drug users, and cisgender women over the next 5 years.

While planning councils ensure that federal funding is responsive to community-specific needs, the capacity development grants in [Part C](#) of Ryan White allow CBOs to access the funds necessary to develop the organizational infrastructure to respond to that need. Through the Capacity Development Program, CBOs and other nonprofit entities can apply for grants administered by HRSA to improve organizational capacity in either of two ways: care innovation or infrastructure development projects. In 2020, these grants allowed non-profit entities to [apply for funding to expand](#) their organizational capacity to implement, enhance, or expand CHW services to serve the eligible populations identified in their needs assessment.

V. FOLLOWING UP ON THIS DOWN PAYMENT

The investment afforded by the ARP has provided our health infrastructure with the first seeds of funding it has desperately needed for decades. With billions on the table to start the process of rebuilding, HHS has the opportunity to begin to address both the immediate exigencies of the pandemic and the longer-term challenges of creating sustainable health equity. The principles and recommendations that emerged from the roundtable on March 25, 2021 can serve as vital first steps in ensuring that money flows to communities in need, hires the workers who can best serve those communities, and builds capacity for the short- and long-term.

The Biden Administration's decision to invest [\\$7.4 billion](#) from the ARP towards a public health workforce, and [\\$250 million](#) towards CBOs, is a laudable first step in rebuilding the U.S. health infrastructure.

It is essential to recognize that the funds from the ARP are a down payment on what must be a broader, sustainable investment in our public health infrastructure. Efforts in the American Jobs Plan, American Families Plan, and future priorities of the administration must build on these investments. As the pandemic has underscored, our systems of support and care are insufficient for equitably meeting the needs of our people. While the ARP has provided a vital lifeline, it must be the first of many steps towards building the public health workforce and system we need. This coalition of stakeholders looks forward to the long-term project of making that aspiration a reality.

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