



February 4, 2022

The Honorable Patty Murray
United States Senate
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Richard Burr
United States Senate
428 Dirksen Senate Office Building
Washington, DC 20150

Dear Chairwoman Murray and Ranking Member Burr,

We deeply appreciate your inclusion of community health workers as a critical investment as we think about our nation's best prevention efforts for pandemics. To that end, we want to offer feedback on Section 222, *Awards to support community health workers and community health*. We strongly support retaining this section in the final legislation.

1. Prioritize community-led eligible entities.

The language in the legislation includes a number of organizations as eligible for receiving funds, including states, public health departments, and federally qualified health centers, as well as community-based organizations. Most of the eligible entities included have a number of funding opportunities across the government, which can be leveraged to hire and partner with CHWs. These well-resourced organizations have vast administrative capacity, placing community-based organizations at a disadvantage in grant competition. Therefore, we encourage the Committee to focus this opportunity for community-based and community-led organizations, and we recommend adding an explicit focus on those organizations in the legislative language.

EDIT: Page 105, line 1, add: **“(5), is a community-based organization.”**

2. Include alternative data sources.

We commend the Committee for focusing community health worker resources on medically underserved areas, using a reference to the definition in the Public Health Service Act 799B. Unfortunately, we have found through our work on the ground that this data set is not always accurate or up to date. Therefore, we recommend adding as an alternative measure the Center for Disease Control's Social Vulnerability Index and the Equitable Distribution Index.

EDIT: Page 101, lines 9-12: “...health conditions prevalent in – (i) medically underserved communities (as defined in section 799B, ***or through Social Vulnerability Index and Equitable Distribution Index measures maintained by the Centers for Disease Control and Prevention***), particularly racial and ethnic minority populations

3. Align program goals with the best practices report.

We agree that others should learn from the outcomes of this grant program and support the development of a best practices assessment. However, in order to ensure that organizations are focused on recruitment and retention, those concepts should be included as priorities of the program from the outset.

EDIT: Page 101, line 5, add: “recruit, hire, ~~and~~ train **and retain** community health workers that reflect the needs of the community”

4. Acknowledge the systemic failures against which community health workers are striving every day.

Despite community health workers’ invaluable skills, talents, resourcefulness, and expertise, they cannot undo the generational systemic harms that have befallen communities due to racism, structural injustice, and poverty. When reporting back on this program to Congress, programs should be judged on the criteria that acknowledge and incorporate these daily realities.

EDIT: Page 106, line 11-13: “a report concerning the effectiveness of the program under this section in addressing ongoing public health and community health needs, *including an assessment of the political, public health, and community needs that must be addressed through additional structural reforms.*”

5. Define community health worker.

We feel it is imperative that the bill acknowledge the unique personal and professional identity of community health workers as acknowledged in the 2010 Department of Labor SOC 21-1094, their self-determination and leadership capabilities in workforce development codified in APHA policy statements adopted in 2001 (200115), 2009 (20091) and 2014 (201414), but we acknowledge that with the acceleration of the workforce and the increased recognition of their scope of work, this can be a challenging task in statute. We recommend that you empower HHS to issue a regulatory definition either using the APHA policies and definitions or through a process with diverse community health worker stakeholders that are comprised of a majority of community health workers. From the first U.S. medical society in 1766 and in nursing, medical and social work professional board since, work definitions and standards for a given occupation are overseen by boards comprised primarily of the workforce to lead the development of all the priority concerns for that profession including a code of ethics, fees, training requirements, practice, etc.

EDIT: Page 105, line 21, insert new subsection “(g) COMMUNITY HEALTH WORKER DEFINITION – The Secretary shall, with reference to the American Public Health Association’s definition, and through a co-development process with community health worker stakeholders and public notice and comment, issue a definition of community health worker that shall guide the work of eligible entities under this section.”

6. Focus on sustainability.

The challenge inherent to grant funded programs is their time-limited nature. Therefore, we think it is imperative to build in a focus on sustainability within the use of funds. Encouraging and supporting a process of collaboration on the local level will have a dramatic positive impact on the field at large.

EDIT: Page 103, line 9, add an additional subsection, “(7), develop plans for workforce development, financial and career sustainability of community health workers, including through collaboration with private and public stakeholders at the state and local level in the grantee’s region.”

7. Align community health worker services with best practices in the field.

The Community Health Worker Core Consensus Project (C3) has worked to provide a greater understanding of the full potential of community health workers to improve health, community development, and access to systems of care. The C3 Project offers a single set of CHW roles and competencies for reference by those both inside and outside the field as they work to build greater support for and sustainability among CHWs in all settings. C3 recommends 10 roles and 11 skills and endorsed existing knowledge about qualities, with emphasis on “connection to the community served.” C3 is already widely disseminated and integrated into state CHW legislation, training programs, employers, academic researchers and national nonprofits and professional organizations. We recommend the legislation refer to this work that the CHW field has already produced on best practices and roles.

EDIT (to follow edit #6): Page 103, line 9, add 2 additional subsections:

“(8) adhere to existing workforce development, training and policy guidelines for community health workers that are currently endorsed by state and national community health worker professional organizations and integrated, to the extent practicable, into state and local training programs and policy; and

(9) Provide capacity building for both community health workers and the community.”

8. Ensure that the program leverages community health worker expertise.

While we are encouraged that the bill includes services to educate and outreach regarding enrollment in health insurance, we believe that CHWs are extremely well placed, trustworthy liaisons to conduct enrollment activities and make meaningful gains toward eliminating technology, literacy and administrative barriers to health care coverage access and enrollment.

EDIT: page 103, lines 10-12, “(D) in paragraph (4), as so redesignated, by striking “to educate” and inserting “educate, **enroll**,”;

Thank you for your consideration of our comments. Please do not hesitate to contact me at dsmith@nachw.org.

Sincerely,

Denise Smith

Executive Director, National Association of Community Health Workers