COMMUNITY HEALTH ADVISOR LEGISLATION

RESEARCH & ANALYSIS
OF
U.S. CONGRESSIONAL LEGISLATION
CONCERNING COMMUNITY HEALTH ADVISORS

PHASE ONE OF A TWO-PHASE STUDY

PREPARED FOR THE VIRGINIA CENTER FOR HEALTH OUTREACH

INTRODUCTION

"COMMUNITY HEALTH ADVISOR LEGISLATION"

This research and analysis was done at the request of the Virginia Center for Health Outreach. This is the first phase (Phase One) a two-phase study on U.S. Congressional legislation concerning Community Health Advisors (CHA). Research indicates that eighteen bills, all proposed between 1994 and 1996, are the only CHA legislation within the last 20 years. Phase One analyzes nine of the eighteen bills. The other nine bills will be addressed in the second phase of the study (Phase Two). The set considered in Phase One deals with specific legislation that was designed comprehensively for CHAs and the populations they serve. By comparison, the other set of bills to be analyzed in Phase Two are part of a broader legislative initiative that focuses solely on chronically underserved populations in rural areas, but with CHAs playing a significant role in the initiative.

Phase One traces the history of nine of the eighteen bills proposed in the United States Congress. The historical record reveals that none of the legislation progressed further than subcommittee, however, the record does not explain why the legislation failed or what motivated its introduction into Congress. Nevertheless, the legislation did receive measurable support and many of the supporters of this prior legislation are current members of Congress.[1]

Phase One has been divided into a three-part analysis. Part One provides an historical summary of the nine bills containing CHA legislation. For reference, two charts have been included in the materials that summarize the history of the bills and provide information about the sponsors of the bills. Part Two is an analytical outline of House Bill 4841 from the 103rd Congress (1993-94), referred to as the "Moran Bill." The bill models the structure and basic

[1] The other nine bills also received measurable support.

functions of all the CHA legislation. Part Three offers a comparative analysis of the other eight bills containing CHA legislation.

Within the legislation analyzed in Phase One, there were various themes of importance to CHAs. One theme was the benefits offered to CHAs. First, the legislation offered funding to CHA programs. Second, it offered respect (legitimacy) for CHAs by officially defining them and incorporating them into the health-care system. Third, it offered coordination of organizations and resources. A second theme was the challenges for CHAs. The legislation deprived CHAs of control in the process. In particular, through drafting and amending in Congress and through potential regulations created by the U.S. Secretary of Health and Human Services, the legislation's components could be changed from what CHAs had originally proposed and its future interpretation would be left to those who are not CHAs.

Overall, although all this legislation failed and is no longer viable, it still provides a foundation to base decisions concerning future legislation for Community Health Advisors.

PART ONE

"HISTORY OF BILLS"

METHODOLOGY

The following summaries of the bills are categorized first by the Congress in which the bill was introduced (103rd and 104th), second, by the respective chamber of Congress in which the bill was introduced (House or Senate), and lastly by the order of introduction into each chamber of Congress. The summaries outline the progress on the bills from introduction to final outcome. In addition, total sponsorship for each bill is provided, including the number of previous sponsors that are current members of Congress. In particular, the summaries indicate those sponsors representing the state of Virginia.

SUMMARY

Of the nine bills, all were proposed during the 103rd (1993-94) and 104th (1995-96) Congress. Representative Bernard Sanders (I-VT), a current member of Congress, introduced three bills that included Community Health Advisor legislation. Two of those bills were solely "National Community Health Advisor Acts."[2] Rep. Sanders introduced into Congress both the first and the last Community Health Advisor bill.

Representatives from Virginia supported Community Health Advisor legislation. Rep. James P. Moran (D-VA), a current member of Congress, introduced Community Health Advisor legislation as part of a larger bill. Rep. Moran cosponsored Rep. Sanders' first Community Health Advisor bill, as did current Virginia Rep. Robert C. Scott (D-VA).

There are no available committee documents or amendments regarding the bills.

[2] These were the only two bills proposed independently of other legislation.

HISTORY OF U.S. CONGRESSIONAL BILLS CONTAINING COMMUNITY HEALTH ADVISOR LEGISLATION

103rd U.S. CONGRESS (1993-94)

U.S. House of Representatives

SANDERS I (H.R. 4024)

In March of 1994, Rep. Bernard Sanders (I-VI) introduced Bill H.R. 4024 "National Community Health Advisor Act" into the United States House of Representatives. It was referred to committee and then to subcommittee. No further action was taken.

H.R. 4024 obtained 47 cosponsors. Thirty-three sponsors are current members of the House. Representative Robert C. Scott (D-VA), a current member of the House, was an original cosponsor[3]. In addition, Representative James P. Moran (D-VA), also a current member of the House, was a sponsor of the bill.

MORAN (H.R. 4841)

In July of 1994, Rep. James P. Moran (D-VA) introduced Bill H.R. 4841 "Public Health Improvement Act of 1994" into the United States House of Representatives. Part Six of the bill is titled "Community Health Advisors." It was referred to committees and then to subcommittees. No further action was taken.

H.R. 4841 obtained 24 cosponsors, with one cosponsor withdrawing support. Sixteen sponsors, who supported the bill, are current members of the House. Rep. Earl F. Hilliard (D-AL), a current member of the House, withdrew his support in August of 1994. Rep. Moran, also a current member of the House, was the only sponsor from Virginia.

[3] An original cosponsor signs onto a bill on the date of introduction.

DEFAZIO (H.R. 5119)

In September of 1994, Rep. Peter A. DeFazio (D-OR) introduced Bill H.R. 5119 "Health Innovation Partnership Act of 1994" into the United States House of Representatives. Part Four of the bill is titled "Community Health Advisors." It was referred to committees and then to subcommittees. No further action was taken.

H.R. 5119 obtained one cosponsor. Rep. DeFazio is the only current member of the House. The proposed bill obtained no sponsors from Virginia.

SANDERS II (H.R. 5278)

In October of 1994, Rep. Bernard Sanders (I-VT) introduced Bill H.R. 5278 "The Jobs and Investment Act of 1994" into the United States House of Representatives. The bill included a "National Community Health Advisor Act." It was referred to committees and then subcommittees. No further action was taken.

H.R. 5278 obtained 6 cosponsors. Five sponsors are current members of the House. The proposed bill obtained no sponsors from Virginia.

U.S. Senate

GRAHAM I (S. 2346)

In August of 1994, Senator Bob Graham (D-FL) introduced Bill S. 2346 "Public Health Improvement Act of 1994" into the United States Senate. Part Six of the bill is titled "Community Health Advisors." It was never referred to committee. No further action was taken.

S. 2346 obtained no cosponsors. Senator Graham is a current member of the Senate. The proposed bill obtained no sponsors from Virginia.

GRAHAM II (S. 2452)

In September of 1994, Senator Bob Graham introduced Bill S. 2452 "Health Innovation Partnership Act of 1994" into the United States Senate. Part Four of the bill is titled "Community Health Advisors." It was never referred to committee.

S. 2452 obtained 2 cosponsors. Two sponsors are current members of the Senate. The proposed bill obtained no sponsors from Virginia.

104th U.S. CONGRESS (1995-96)

U.S. House of Representatives

OWENS (H.R. 805)

In February of 1995, Rep. Major R. Owens (D-NY) introduced Bill H.R. 805 "Job Creation and Investment Act of 1995" into the United States House of Representatives. The bill included a "National Community Health Advisor Act." It was referred to committees and then subcommittees. No further action was taken.

H.R. 805 obtained 12 cosponsors. Eleven sponsors are current members of the House. The proposed bill obtained no sponsors from Virginia.

SANDERS III (H.R. 2245)

In August of 1995, Rep. Bernard Sanders (I-VT) introduced Bill H.R. 2245 "National Community Health Advisor Act" into the United States House of Representatives. It was referred to committee and then subcommittee. No further action was taken.

H.R. 2245 obtained 18 cosponsors. Fifteen sponsors are current members of the House. The proposed bill obtained no sponsors from Virginia.

U.S. Senate

GRAHAM III (S. 308)

In February of 1995, Senator Bob Graham (D-FL) introduced Bill S. 308 "Health Partnership Act of 1995" into the United States Senate. Part Four of the bill is titled "Community Health Advisors." It was referred to committee, but was never referred to a subcommittee.

S. 308 obtained 2 cosponsors with one sponsor withdrawing support. Senator Graham is the only current member of the Senate who sponsored the bill. Senator Thad Cochran (R-MS), also a current member of the Senate, withdrew his sponsorship in July of 1995. The proposed bill obtained no sponsors from Virginia.

PART TWO

"MORAN BILL"

METHODOLOGY

To avoid confusion, the bill is referred to as the "Moran Bill" because Rep. James P. Moran, a current member of Congress, introduced the bill into Congress. The Moran Bill was chosen as the model bill to be analyzed for two reasons. First, it was one of the first bills introduced into Congress and many of the subsequent bills are patterned after it. Second, Rep. Moran is a congressman from Virginia and therefore his efforts are of more relevance to the Virginia Center for Health Outreach.

The following outline divides the Community Health Advisor legislation into eleven subject areas based mainly on how the legislation was structured. The outline contains all the substantive components of the legislation with the exception of some of the procedural requirements. For discussion purposes, within the outline, the legislation is referred to in present tense; however, the legislation failed and has not been considered in either chamber of Congress since.

SUMMARY

A. Synopsis

In essence, the Moran Bill, like all the bills, served five functions. First, it defined applicable parties, such as Community Health Advisors and applicants. Second, it delegated the responsibilities of the various parties, specifically the responsibilities of the Secretary of the U.S. Department of Health and Human Services, the state, the applicant, and Community Health Advisors. Third, it established requirements for CHA programs. Fourth, it determined the

process by which an applicant could apply for and receive an award, and lastly it authorized and structured the funding for CHA programs.

B. Points of Concern

1. Purpose – Health People 2000 Objectives

The purpose of the legislation was to assist the states in attaining the Healthy People 2000 Objectives set by the U.S. Department of Health and Human Services (HHS). HHS has re-focused those objectives to extend through the year 2010 (Healthy People 2010).

2. Designated Entities

The legislation provided that an applicant (recipient) could be an entity other than a state if it was a public or nonprofit entity, including an academic organization. Area Health Education Centers (AHECs) would have qualified as acceptable recipients under the definition.

3. Undefined Terms

The legislation contained important terms that were left undefined, such as "cost-effectiveness." These terms have been noted within the outline through the use of footnotes. Some of these terms are defined in a few of the other bills containing CHA legislation, however, most are not. The ambiguity of these terms may have been addressed ultimately through regulations promulgated by the Secretary of the U.S. Department of Health and Human Services. Of particular concern is the definition of a Community Health Advisor. Although the origin of this definition cannot be determined, it is relevant to note that the National Community Health Advisor Study (Study) contains a similar definition.[4] The Study established a "working definition" that Community Health Advisors "possess innate leadership abilities; are members of the community in which they work; promote health among groups traditionally denied or lack

[4] Final Report of the National Community Health Advisor Study as conducted by the University of Arizona and funded by the Annie E. Casey Foundation (1998).

health care; work to bring a more equitable distribution of health care resources; remain primarily identified with their community rather than an agency or program; use empowering methodology in their work; possess expertise based on their life experience and training; and participate in initial and on-going training tailored to meet specific needs of the community and program."

4. Limits on Use of an Award

Of the amount Congress would have appropriated for the Moran Bill, no more than 10% could have been used by the U.S. Secretary of Health and Human Services in conducting evaluations of CHA programs and in providing technical assistance to applicants. The applicant could not spend more than 15% of the award on the outlined statewide responsibilities including providing technical assistance in training and supervising CHAs. Lastly, the legislation required that no more than 15% of the award be expended on training CHAs. It is unclear whether this 15% pertained to the award given out by the applicant to various CHA programs within the state or whether it pertained to the award given by the Secretary to the applicant.

MORAN BILL
(H.R. 4841; 103rd U.S. Congress: 1993-94)

A. Bill Overview[5]

1. U.S. Representative James P. Moran (D-VA), a current member of Congress, introduced the bill in July of 1994.
2. The bill is titled the " Public Health Improvement Act of 1994." Within the bill, under Title I, subtitle F, is Part Six - "Community Health Advisors." The bill contains no independent title for this Part of the Act (i.e., it is not referred to as an Act in and of itself).

B. Congressional Findings[6]

The proposed legislation does not include any findings to support the need for Community Health Advisors.

C. Definitions

1. **Community Health Advisor (CHA)**[7] - an individual
   a. who has demonstrated the capacity to carry out one or more of the *Authorized Program Services*[8];
   b. who, for not less than one year, has been a resident of the community in which the community health advisor program involved is to be operated; AND
   c. is a member of a socioeconomic group to be served by the program.
2. **Authorized Program Services**

   The CHA program will:
   - collaborate with health care providers and related entities[9] in order to facilitate provision of health services and health-related social services, including collaborating with local health departments, community health centers, public hospital systems, migrant health centers, rural health clinics, hospitals, physicians and nurses, providers of health education, pre-school facilities, elementary and secondary schools, and providers of social services.
   - provide public education on health promotion and prevention of disease, illnesses, injuries, and disabilities.
   - provide health-related counseling.
   - provide referrals for available health services and health-related social services.
   - provide outreach services to inform the community about the availability of the services of the program.

[5] The CHA legislation served to amend the Public Health Service Act.
[6] Congressional findings are research findings used to support proposed legislation. The Moran Bill may have used research findings as a basis for the proposed legislation but it did not include them within the bill.
[7] The definition was consistent throughout all the bills.
[8] Italics indicate that the word or phrase is defined within the bill.
[9] The bill provided no definition for the term.

- assist individuals in establishing eligibility under various federal, state, and local health service programs and in receiving other program benefits.
- provide such other services as the Secretary determines to be appropriate (e.g., transportation and translation services).

3. **Other Relevant Definitions**
    a. *Financial Assistance* – means a grant, cooperative agreement, or a contract.
    b. *Funding Agreements* – an agreement required as a condition of receiving an award.
    c. *Official Poverty Line* – as established by the Director of the Office of Management and Budget and revised by the Secretary of Health and Human Services in accordance with Omnibus Budget Reconciliation Act of 1981 (as applicable to the size of the family and the family's income).

D. <u>Funding – Authorization of Appropriations</u>

1. The proposed legislation authorizes the federal government to provide up to 100 million dollars for the fiscal year 1995. $125 million for 1996, $150 million for 1997, $175 million for 1998, $175 million for 1999, and $175 million for 2000.
2. If the amounts made available for each year are insufficient for providing an award at least equal to the amount determined by the *Allotment Formula*, THEN the Secretary shall make awards from the amounts made available on a discretionary basis.

E. <u>Potential Applicants for an Award of Financial Assistance</u>

1. **State as Recipient**
   The state agency responsible for carrying out public health programs will administer the award.
2. **Designated Entities other than State**
    a. An entity other than the state may receive an award ONLY IF:
        - It is a public or nonprofit private academic organization (or other public or nonprofit entity); AND
        - has been designated by the state to carry out the program.
    b. The award will be administered in consultation with the state agency responsible for carrying out public health programs.

F. <u>Matching Funds (Funding Agreement)</u>

1. The applicant (state or entity) will make available non-federal contributions of at least 25% of the cost of carrying out a CHA program.
    a. Contributions may be:
        - directly or through donations from public and private entities.
        - in cash or kind, fairly evaluated[10], including plant, equipment, or services.
    b. Amounts provided by the state will be treated as non-federal contributions.

[10] The bill provided no definition for the term.

2. The state, whether or not it is the applicant, must maintain the same non-federal expenditures[11] as the state expended for the fiscal year preceding the 1st year for which an award is made. These expenditures count as part of the 25% non-federal contributions.

G. Allotment Formula - Determination of Amount of Award

The allotment formula is a complicated formula intended to provide a state with an award based on both total population and on the population of the state that has an income at or below 200% of the Official Poverty Line[12].

H. Responsibilities of the Secretary of the U.S. Dept. of Health and Human Services

1. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in coordination with specified agencies (Health Resources and Services Administration, National Institutes of Health, and the Substance Abuse and Mental Health Service Administration) shall be responsible for making an award of financial assistance to an applicant.
2. **Quality Assurance; Cost-Effectiveness**
   The Secretary shall establish guidelines for assuring:
   a. quality of CHA programs, including quality of training.
   b. cost-effectiveness[13] of the programs.
3. **Evaluations; Technical Assistance**
   a. The Secretary shall conduct evaluations of CHA programs, including:
      - determining if the programs are in compliance with guidelines; AND
      - disseminating information developed as a result of evaluations.
   b. The Secretary may:
      - provide technical assistance (TA) to recipients regarding planning, development, and operation of CHA programs.
      - carry out evaluations and TA directly OR through grants, contracts, or co-op agreements.
   c. No more than 10% of the amount appropriated by Congress for a fiscal year can be used for evaluations and TA.
4. **Number of CHA Programs Per Award**
   a. The Secretary will determine, within a state, the number of CHA programs funded under this award.
   b. There will be a CHA program carried out in at least one urban area of the state, and in at least one rural area.
5. **Indian Affairs**
   The Secretary shall ensure that CHA programs are carried out in cooperation with Community Health Representative Programs and do not supplant them, including not supplanting their funding.

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[11] Non-federal expenditures are those expenditures by the state that are for the development and operation of CHA programs that are designed to assist the state in obtaining the Healthy People 2000 Objectives.
[12] Upon analysis of the formula it appears to be mathematically invalid due to lack of necessary data.
[13] The bill provided no definition for the term.

I. Application for Assistance Procedures; State Plan

The application must contain:

a. each funding agreement described in the bill.
b. a "State Plan" describing the purposes for which the award is to be expended, including the manner in which the applicant will comply with each funding agreement.

J. Applicant Funding Agreements - Statewide Responsibilities

1. The applicant will:
   a. operate a clearinghouse to maintain and disseminate information on CHA programs (and similar programs[14]), including information on developing, operating, and training CHAs, as well as evaluating programs.
   b. collaborate with schools of public health to provide to CHA programs, in the state, TA in training and supervising CHAs.
   c. coordinate activities carried out in the state under the award, including between CHA programs and between CHA programs and related activities of the state and/or public or private entities.
   d. NOT expend more than 15% of the award on carrying out the above responsibilities and in administering the award, including receiving and allocating payments and monitoring compliance with funding agreements.
   e. The applicant will ensure that the CHA programs follow the *CHA Program Requirements*.

K. CHA Programs – Requirements (Additional Applicant Funding Agreements)

1. **Purpose of Award**
   a. The applicant will adhere to the purpose of the award, which is, through the use of CHA programs, to assist the state in attaining the Healthy People 2000 Objectives.
   b. The applicant can select one or more of the Healthy People 2000 Objectives to be given priority in the operation of a CHA program, subject to consultation with the entity that is to carry out the CHA program and the local health department.
2. **Identification of Community Needs**

   The Applicant will:
   a. identify the needs of the community for the *Authorized Program Services*, including identifying the resources of the community that are available for carrying out the program.
   b. consult (in identifying needs) with members of the community, with individuals and programs that provide health services in the community, and with individuals and programs that provide health-related social services in the community.
   c. consider such needs in carrying out a CHA program.

[14] The bill provided no definition for the term.

3. **General Program Requirements**
    a. A program will be:
        - carried out, under the identified purpose, in a community that has been identified as having a significant need.
        - operated by a public or nonprofit private entity with experience in providing health or health-related social services to individuals who are underserved with respect to such services.
    b. The *Authorized Program Services* will be carried out and provided principally by CHAs.
4. The applicant involved will give priority to developing CHA programs for Medically Underserved Communities[15].
5. The CHA program:
    a. will provide for ongoing supervision of CHAs, and the individuals serving as supervisors will include one or more public health nurses with field experience and managerial experience.
    b. will be provided in the appropriate language and cultural context. To meet this goal, CHA programs will have the appropriate number of advisors who are fluent in both English and at least one other relevant language.
    c. shall carry out a program to train CHAs to provide the *Authorized Program Services*, including practical experience in providing services for health promotion and prevention.
        - The program will provide for continuing education of CHAs.
        - No more than 15% of the award will be expended for the program of training.
    d. will prepare a report describing the activities of the program. The report will include:
        - the number of individuals served by the program;
        - the entities with which the program has collaborated;
        - an assessment of the extent of the effectiveness[16] of the program in carrying out its purpose; AND
        - such additional information as the Secretary may require.
6. The award can be used to provide compensation for CHA services.

[15] The bill provided no definition for the term.
[16] The bill provided no definition for the term.

PART THREE

"COMPARISON OF BILLS"

METHODOLOGY

The analysis is structured by the topical headings of the Moran Bill outline. The only language that is included under the bill heading is that which is different from the Moran Bill. The use of italics & bold within the text indicates that the following language is different from the Moran Bill. In two instances, Sanders II and Owens, the bills are so similar to Sanders I that they have been compared to Sanders I instead of the Moran Bill. Even so, unless stated otherwise, Sanders II and Owens retain the same dissimilarities as Sanders I has to the Moran Bill.

The comparative analysis has been divided into three sections. The first section includes four bills that are either identical to the Moran Bill or the only difference is the amount of authorized funding. The second section consists of three similar bills that have the same dissimilarities with the Moran Bill. The final section includes only Sanders III, which has been compared solely to the Moran Bill.

For discussion purposes, the legislation is referred to in present tense; however, all of the legislation mentioned in Part III failed and have not been considered in either house of Congress since. Like the Moran Bill, each bill is identified by the name of the sponsor who introduced the bill into Congress to avoid any confusion in identifying and comparing the bills.

SUMMARY

There were two types of legislation introduced, general and specific. Eight of the bills, including the Moran Bill, are considered "specific" because they outlined in detail the various components of the legislation. The specific bills contained various differences, but overall they

maintained the same detailed structure. By comparison, the last bill in the analysis, Sanders III, offered a more general approach to outlining various responsibilities and requirements. It was broader in its structuring, allowing for what appears to be a significant amount of post-enactment interpretation and definition.

SECTION ONE

GRAHAM I
(S. 2346; 103rd Congress: 1993-94)

Bill Overview

1. U.S. Senator Bob Graham (D-FL), a current member of Congress, introduced the bill in August of 1994. This was the first bill introduced in the U.S. Senate containing legislation regarding Community Health Advisors.
2. The bill is titled the "Public Health Improvement Act of 1994." Within the bill, under Title I, subtitle F, is Part Six – "Community Health Advisors." The bill contains no independent title for this Part of the Act (i.e., it is not referred to as an Act in and of itself).

THE BILL IS VERBATIM TO THE MORAN BILL ("MORAN").

GRAHAM II
(S. 2452; 103rd Congress: 1993-94)

Bill Overview

1. U.S. Senator Bob Graham (D-FL), a current member of Congress, introduced the bill in September of 1994.
2. The bill is titled the "Health Innovation Partnership Act of 1994." Within the bill, under Title III, subtitle E, is Part Four – "Community Health Advisors." The bill contains no independent title for this Part of the Act (i.e., it is not referred to as an Act in and of itself).

THE BILL IS VERBATIM TO MORAN, EXCEPT FOR THE FOLLOWING:

Funding – Authorization of Appropriations

The proposed legislation authorizes the federal government to ***provide up to*** 100 million dollars for each of the fiscal years 1996 through 2000.

GRAHAM III
(S. 308; 104th Congress: 1995-96)

Bill Overview

1. U.S. Senator Bob Graham (D-FL), a current member of Congress, introduced the bill in February of 1995.
2. The bill is titled the "Health Partnership Act of 1995." Within the bill, under Title III, subtitle E, is Part Four – " Community Health Advisors." The bill contains no

independent title for this Part of the Act (i.e., it is not referred to as an Act in and of itself).

THE BILL IS VERBATIM TO MORAN, EXCEPT FOR THE FOLLOWING:

Funding – Authorization of Appropriations

The proposed legislation authorizes the government to ***provide up to*** 100 million dollars for each of the fiscal years 1996 through 2000.

THE BILL IS ALSO IDENTICAL T0 GRAHAM II.

DEFAZIO
(H.R. 5119; 103rd Congress: 1993-94)

Bill Overview

1. U.S. Rep. Peter A. Defazio (D-OR), a current member of Congress, introduced the bill in September of 1994.
2. The bill is titled the "Health Innovation Partnership Act of 1994." Within the bill, under Title III, subtitle E, is Part Four – "Community Health Advisors." The bill contains no independent title for this Part of the Act (i.e., it is not referred to as an Act in and of itself).

THE BILL IS VERBATIM TO MORAN, EXCEPT FOR THE FOLLOWING:

Funding – Authorization of Appropriations

The proposed legislation authorizes the government to ***provide up to*** 100 million dollars for each of the fiscal years 1996 through 2000.

THE BILL IS ALSO IDENTICAL T0 GRAHAM II.

SECTION TWO

SANDERS I
(H.R. 4024; 103rd Congress: 1993-94)

Bill Overview

1. U.S. Rep. Bernard Sanders (I-VT), a current member of Congress, introduced the bill in March of 1994. The bill was the first bill introduced in Congress containing legislation regarding Community Health Advisors.

2. The bill is independent of all other legislation and was proposed solely as a bill for Community Health Advisors. It can be referred to as the "National Community Health Advisor Act."

THE BILL IS SUBSTANTIALLY SIMILAR TO MORAN, EXCEPT FOR THE FOLLOWING:

Congressional Findings

1. The bill cites barriers (geographic, cultural, literacy, transportation, etc.) for millions of low-income and underserved Americans in the current health care delivery system.
2. Public Health Service – determines that many health problems are rooted in poverty.
    a. "Health United States 1992 and Healthy People 2000 Review" – illustrates the acute access problem faced by rural areas and the inner cities.
    b. Death rates higher than suburbs (12% higher in rural areas and 19% higher in inner cities).
3. It is imperative to correct the fundamental and deep-rooted obstacles that low-income urban and rural Americans confront when trying to access medical care and preventive health services. For example, in 1991, only 3% of those women who qualified under Medicare, participated in mammography screening.
4. Local and indigenous members and residents of undeserved communities are uniquely knowledgeable about their populations' needs.
    a. They communicate to health and social service providers the needs of community members, provide quality health promotion, and disease prevention information to the community.
    b. They also serve as a link between their communities and providers to increase utilization of available preventive health service, increase effectiveness of the health care delivery system, reduce preventable morbidity and mortality, and improve the quality of life.

Definitions

1. **Authorized Program Services**
    a. In collaborating with health care providers and related entities in order to facilitate provision of health services and health related social services, the bill ***does not require*** the program to collaborate with public hospital systems, pre-school facilities, and elementary and secondary schools.
    b. In providing public education on health promotion and prevention the bill ***does not require*** the program to relate such activities to illness, injuries or disabilities but only to disease.
2. **Other Relevant Definitions**
    a. *Healthy People Objectives* – those established by the Secretary of Health and Human Services toward the goals of increasing the span of healthy life, reducing health disparities among various populations, and providing access to preventive services, which objectives apply to the health status of the population of the United States for the year 2000.
    b. *Medically Underserved Community* –

- a community that has a substantial number of individuals who are members of a medically underserved population, as defined in section 330 of the Public Health Service Act; OR
- a community, a significant portion of which is a health professional shortage area as designated under section 332 of the Public Health Service Act.

Funding – Authorization of Appropriations

The proposed legislation authorizes the federal government to ***provide up to*** 100 million dollars for each of the fiscal years 1995 to 2000.

Allotment Formula - Determination of Amount of Award

Sets a minimum award amount of $500,000 for a state or an entity designated by the state.

Responsibilities of the Secretary of the U.S. Department of Health and Human Services

1. The bill ***does not require*** the Secretary to coordinate with specified agencies when making an award of financial assistance to an applicant.
2. **Evaluations; Technical Assistance**
   The Secretary will conduct evaluations of CHA programs.
   May disseminate information developed as a result of evaluations

Applicant Funding Agreements - Statewide Responsibilities

The Applicant ***does not have to*** collaborate with schools of public health when providing CHA programs in the state technical assistance (TA) in training. The bill ***also leaves out*** the requirement to provide TA regarding supervising CHAs.

CHA Programs – Requirements (Additional Applicant Funding Agreements)

1. In providing for ongoing supervision of CHAs, ***there is no requirement*** that the individuals serving as supervisors include one or more public health nurses with field experience and managerial experience.
2. In providing CHA programs in the appropriate language and cultural context, ***there is no requirement*** that CHA programs have the appropriate number of advisors who are fluent in both English and at least one other relevant languages.

SANDERS II
(H.R. 5278; 103rd Congress: 1993-94)

Bill Overview

1. U.S. Rep. Bernard Sanders (I-VT), a current member of Congress, introduced the bill in October of 1994.

2. The bill is titled "The Jobs and Investment Act of 1994." Within the bill, under Title II, subtitle D, is Chapter Two – "Community Health Advisor Program." The chapter can be independently referred to as the "National Community Health Advisor Act."

THE BILL IS VERBATIM TO SANDERS I, EXCEPT FOR THE FOLLOWING:

Responsibilities of the Secretary of the U.S. Department of Health and Human Services

The bill ***requires*** the Secretary, like the Moran Bill, to coordinate with specified agencies (Health Resources and Services Administration, National Institutes of Health, and the Substance Abuse and Mental Health Service Administration) when making an award of financial assistance to an applicant.

OWENS
(H.R. 805; 104th Congress: 1995-96)

Bill Overview

1. U.S. Rep. Major R. Owens (D-NY), a current member of Congress, introduced the bill in February of 1995.
2. The bill is titled the "Job Creation and Invest in America Act of 1995." Within the bill, under Title II, subtitle D, is Chapter Two – "Community Health Advisor Program." This chapter can be independently referred to as the "National Community Health Advisor Act."

THE BILL IS VERBATIM TO SANDERS I, EXCEPT FOR THE FOLLOWING:

Definitions

Authorized Program Services

The bill ***has added*** that CHA programs will undertake special outreach activities to recruit individuals with disabilities for service as CHAs and ensure services are available to those with disabilities within the community being served.

Responsibilities of the Secretary of the U.S. Department of Health and Human Services

The bill ***requires*** the Secretary, like the Moran Bill, to coordinate with specified agencies (Health Resources and Services Administration, National Institutes of Health, and the Substance Abuse and Mental Health Service Administration) when making an award of financial assistance to an applicant.

SECTION THREE

SANDERS III
(H.R. 2245; 104th Congress: 1995-96)

Bill Overview

1. U.S. Rep. Bernard Sanders (I-VT), a current member of Congress, introduced the bill in August of 1995.
2. The bill is independent of all other legislation and was proposed solely as a bill for Community Health Advisors. It can be referred to as the "National Community Health Advisor Act."

THE BILL IS SIMILAR TO MORAN, EXCEPT FOR THE FOLLOWING:

Congressional Findings

1. Communities across America have joined forces with state health departments, academic institutions, and community-based public and non-profit organizations to improve the health of their neighborhoods and help us as a Nation reach the Healthy People 2000 Objectives.
2. Cites barriers confronting the medically underserved communities: poverty, geographic isolation, cultural differences, lack of transportation, low literacy, and lack of access to services.
3. Community Health Advisors (referred to as community leaders) are uniquely knowledgeable about their communities' needs. They are becoming bridges/links between their communities and local health and social service providers to break down barriers.
4. CHAs can also provide quality health promotion and disease prevention information to the community.
5. CHAs can increase utilization of available preventive health services, increase the effectiveness of the health care delivery system, reduce preventable morbidity and mortality, and improve the quality of life of their neighbors.
6. CHAs can be a critical part of our national challenge to meet the Healthy People 2000 vision.

Definitions

1. **Community Health Advisors** - The definition is the same except the bill uses the phrase "…a member of the **target population** to be served by the program" versus "…a member of the same socioeconomic group to be served by the program."
2. **Authorized Program Services**
    a. In collaborating with health care providers and related entities[17] in order to facilitate provision of health services and health-related social services, the bill ***does not specify*** with whom the program should collaborate.

[17] The bill provided no definition for the term.

b. In providing public education on health promotion and prevention the bill ***does not require*** the program to relate such activities to illness, injuries or disabilities but only to disease.
c. The bill ***does not require*** that CHAs provide outreach services to inform the community about the availability of the services of the program.
d. The bill ***does not require*** CHA programs to assist in increasing individuals' capacity to utilize services.

3. **Other Relevant Definitions**
   a. *Healthy People Objectives* – those established by the Secretary of the U.S. Department of Health and Human Services toward the goals of increasing the span of healthy life, reducing health disparities among various populations, and providing access to preventive services, which objectives apply to the health status of the population of the United States for the year 2000.
   b. *Medically Underserved Community* –
      - A community that has a substantial number of individuals who are members of a medically underserved population, as defined in section 330 of the Public Health Service Act;[18] OR
      - A community, a significant portion of which is a health professional shortage area as designated under section 332 of the Public Health Service Act.[19]
   c. *Secretary* – of the U.S. Department of Health and Human Services

Funding

The proposed legislation authorizes the federal government to appropriate ***such sums as may be necessary*** for each of the fiscal years 1996 through 2001.

Matching Funds (Funding Agreement)

The bill ***has no requirement*** that the applicant (state or entity) make available non-federal contributions of at least 25% of the cost of carrying out a CHA program. The applicant is not required to provide any non-federal contributions.

Allotment Formula - Determination of Amount of Award

Sets a minimum award amount of $500,000 for a state or an entity designated by the state.

Responsibilities of the Secretary of the U.S. Department of Health and Human Services

1. **Evaluations; Technical Assistance**
   The Secretary ***may not use more than 5%*** of the amount appropriated by Congress for a fiscal year on carrying evaluations and technical assistance.
2. **Number of CHA Programs Per Award**

[18] The population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

[19] An area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower [professional] shortage and which is not reasonably accessible to an adequately served area, OR a population group which the Secretary determines has such a shortage, OR a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage.

a. The bill ***does not specify*** that the Secretary will determine, within a state, the number of CHA programs funded under this bill.
b. The bill ***does not require*** that there will be a CHA program carried out in at least one urban area of the state, and in at least one rural area of the state.

Application for Assistance Procedures; State Plan

In addition to a State Plan, the bill requires that a Local Plan similar to the State Plan be completed by every community-based public or nonprofit entity that wishes to receive funds from the applicant.

Applicant Funding Agreements - Statewide Responsibilities

1. In providing technical assistance to CHA programs in the state for the training of CHAs ***there is no requirement*** to collaborate with schools of public health. In addition, the bill ***does not require*** the applicant to provide technical assistance (TA) to CHA programs regarding supervision of CHAs.
2. The bill ***does not require*** the applicant to coordinate activities carried out in the state under the award, including between CHA programs and between CHA programs and related activities of the state and/or public or private entities.
3. The applicant ***will provide*** TA to CHA programs in evaluating their CHA programs.
4. NOT expend more than 15% of the award on carrying out the ***above responsibilities*** and in administering the award.
5. The remainder of the award will be provided directly to CHA programs in the state for carrying out the duties outlined in the bill.[20]

CHA Programs – Requirements (Additional Applicant Funding Agreements)

1. **Purpose of Award –** The bill ***does not specifically*** outline the purpose of the award. It does indirectly refer to the purpose.
2. **Identification of Community Needs –** The bill ***does not*** outline the specific process by which the applicant will identify the needs of the community.
3. **General Program Requirements -** The bill ***does not specifically require*** that the services be principally provided by CHAs.
4. The bill ***does not require*** the applicant to give priority to developing CHA programs for Medically Underserved Communities.
5. Although there is a requirement for a training program, ***there is no requirement*** for continuing education (same 15% limit on expenditure).
6. The bill ***does not require*** that CHA programs provide for ongoing supervision of CHAs nor that the individuals serving as supervisors include one or more public health nurses with field experience and managerial experience.
7. In meeting the goal of providing CHA programs in the appropriate language and cultural context, the bill ***does not require*** that CHA programs have the appropriate number of advisors who are fluent in both English and at least one other relevant language.
8. Although the bill requires each CHA program to conduct an evaluation of its program, the bill ***does not specify*** what has to be in the report, such as number of individuals served or specification of the entities with which the program has collaborated.

[20] Only bill that provided for direct disbursement of funds to CHA programs after subtraction of 15% for applicant's statewide responsibilities.