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S. 3606

To provide for the establishment of a Health Force and a Resilience Force to respond to public health emergencies and meet public health needs.

IN THE SENATE OF THE UNITED STATES

MAY 5, 2020

Mrs. GILLIBRAND (for herself, Mr. BENNET, Mr. MARKEY, Mr. VAN HOLLEN, Mr. BOOKER, Ms. DUCKWORTH, Mrs. FEINSTEIN, Mr. REED, Ms. ROSEN, Ms. SMITH, Ms. HARRIS, and Mr. BLUMENTHAL) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To provide for the establishment of a Health Force and a Resilience Force to respond to public health emergencies and meet public health needs.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Force and Resilience Force Act of 2020''.

SEC. 2. HEALTH FORCE.

(a) PURPOSE.—It is the purpose of the Health Force established under this section to recruit, train, and employ

Americans to respond to the COVID–19 pandemic in their communities, provide capacity for ongoing and future public health care needs, and build skills for new workers to enter the public health and health care workforce.

(b) ESTABLISHMENT.—There shall be established within the Centers for Disease Control and Prevention a Health Force (referred to in this section as the ''Force'') composed of community members dedicated to responding to public health emergencies as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, including the COVID–19 emergency, and providing increased capacity to address ongoing and future public health needs.

(c) ORGANIZATION AND ADMINISTRATION.—

(1) IN GENERAL.—The Centers for Disease Control and Prevention shall—

(A) award grants, contracts, or enter into cooperative agreements for the recruitment, hiring, managing, administration, and organization of the Force to States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes through the Public Health Emergency Preparedness and Public Health Crisis Re-

sponse programs implemented through such Centers; and

(B) provide assistance for expenses incurred by States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes prior to the awarding of a grant, contract, or cooperative agreement under subparagraph (A) to facilitate the implementation of the Force, including assistance for planning and recruitment activities, as provided for in section 424 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5189b).

(2) DUTIES OF THE DIRECTOR.—The Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director'') shall—

(A) identify training resource packages to be utilized by the Force and develop new training resource packages, as needed, including by—

(i) collaborating with other Federal agencies, including the Health Resources and Services Administration; and

(ii) collaborating with Centers for Disease Control and Prevention implementing partners, including public health, health care, and community-based organizational partners, to identify and develop such training resource packages; and

(B) carry out any other activities determined appropriate by the Director to carry out this section.

(d) SERVICE.—

(1) MINIMUM REQUIREMENTS.—

(A) IN GENERAL.—The Force shall be composed of eligible members selected pursuant to guidelines developed by the Director in consultation with States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes funded entities. At a minimum such guidelines shall ensure that a member of the Force—

(i) is at least 18 years of age; and

(ii) has a high school diploma or equivalent or has successfully completed an employment literacy test.

(B) OTHER ELIGIBLE INDIVIDUALS.—

(i) CITIZENSHIP OR IMMIGRATION STATUS.—An individual who is authorized to work in the United States, including an individual with Deferred Action for Childhood Arrivals (DACA) or Temporary Protected Status (TPS) under section 244 of the Immigration and Nationality Act (8 U.S.C. 1254a), shall not be disqualified for appointment under this section as a member of the Force because of citizenship or immigration status.

(ii) BANKRUPTCY.—An individual shall not be disqualified for appointment under this section as a member of the Force because of the bankruptcy or poor credit rating of such individual determined to be the result of the coronavirus public health emergency.

(2) RECRUITMENT.—

(A) IN GENERAL.—The guidelines developed under paragraph (1) shall provide for Force recruitment information to be distributed at the national level through all available channels and partnerships as practicable. Such guidelines shall also, as practicable, require that

all graduating high school seniors be made aware of Force employment opportunities while in their senior year, and every 2 years thereafter, unless they opt out of receiving notifications or have joined the Force. As practicable, Federal and State Departments of Labor shall share information about Force opportunities with those individuals applying for or receiving unemployment benefits.

(B) RECRUITMENT BY STATE, LOCALITY, TERRITORY, INDIAN TRIBES, TRIBAL ORGANIZATIONS, URBAN INDIAN HEALTH ORGANIZATIONS, OR HEALTH SERVICE PROVIDERS TO TRIBES FUNDED ENTITIES.—With respect to the employment of Force members in States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes funded entities, such areas and entities shall support extensive recruitment efforts for Force personnel, including efforts to recruit Force members among focal communities as described in subsection (g), as well as low-income, minority, and historically marginalized populations.

(3) PREFERENCE.—Preference in the hiring of Force members shall be given to individuals who are veterans, unemployed or underemployed, recently furloughed community-based nonprofit, public health or health care professionals, or from focal communities as described in subsection (g).

(4) TRAINING.—

(A) INITIAL TRAINING.—

(i) IN GENERAL.—Not later than 14 days after the date of enactment of this Act, the Director shall identify an evidence-informed training program for Force members in accordance with this paragraph. Such initial training program shall focus on building public health surveillance knowledge and skills, particularly contact tracing knowledge and skills, to address training requirements for Force members to successfully conduct contact tracing activities under subsection (e)(1). States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes shall determine which Force recruits will be provided with initial training

to meet State, locality, territory, and Tribal public health needs.

(ii) REQUIREMENTS.—The initial training program under this subparagraph shall—

(I) be adaptable by State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities to meet local needs;

(II) be implemented as quickly as possible by either or both of the Centers for Disease Control and Prevention and State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities, based on local needs and abilities;

(III) be distance-based eLearning that can be accessed with a smartphone, with the goal of limiting opportunities for disease transmission while maximizing knowledge and skills

acquisition and retention among Force trainees;

(IV) include refresher training at regular and frequent intervals as determined appropriate by the Director;

(V) include training components on personal safety, including staying safe around animals in home- and community-based settings, use of personal protective equipment, and health privacy and ethics;

(VI) include standardized testing to measure knowledge and skills acquisition and retention; and

(VII) use individual results of such standardized testing to ensure that only successfully trained individuals are maintained as Force members.

(B) ADDITIONAL TRAINING.—Not later than 90 days after the date of enactment of this Act, the Director shall identify and, as necessary, develop additional evidence-informed training resource packages to provide Force members the knowledge and skills necessary to

conduct the full complement of activities describe in subsections (e) and (f). States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes shall determine which Force members will be provided with additional training to meet State, locality, territory, and Tribal public health needs.

(C) MISCELLANEOUS.—Where determined necessary, the Director may—

(i) recommend training under this subparagraph that includes face-to-face interaction;

(ii) collaborate with public universities, including nursing, medical, and veterinary schools, community colleges, or other career and technical education institutes, community health centers and other community-based organizations, federally recognized Minority Serving Institutions, as well as public health associations and State and local health departments, to develop and implement training under this subparagraph, particularly for skills that typically have licensure requirements; and

(iii) develop training and communications materials in multiple languages.

(D) TIMING.—The training provided under subparagraph (A)(i) shall be designed to be completed by Force members within 14 days of the start of such training. The training programs under subparagraph (B) shall be made available where necessary to ensure that Force members are fully trained as soon as possible after commencing such training.

(E) SPECIALIZED TRAINING.—In organizing the Force under this section, the Director may elect to establish divisions of Force members who receive specialized comprehensive training, including divisions of Force members who have met State licensure requirements, have prior relevant experience, or have supervisory skills or demonstrated aptitude.

(F) PAYMENT DURING TRAINING.—Individuals shall be paid for each hour spent in training (including refresher training) under this paragraph at a rate of not less than $15 per hour (to be increased each year based on increases in the Consumer Price Index for such year).

(5) SALARY AND BENEFITS.—

(A) IN GENERAL.—Members of the Force shall be paid directly by State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities and subpartners using funds provided by the Centers for Disease Control and Prevention under grants, contracts, or cooperative agreements under this section. All Force positions shall be salaried with health and retirement benefits, including paid family leave. Payment of salaries and benefits shall be in accordance with the policies of the State or unit of local government involved and have the approval of the State or the Centers for Disease Control and Prevention, as applicable.

(B) OVERTIME PAY.—The entire amount of overtime costs, including payments related to backfilling personnel, that are the direct result of time spent on the design, development and conduct of Force activities are allowable expenses under this section. Such costs shall be allowed only to the extent that payment for such services is in accordance with the policies

of the State or unit of local government involved and have the approval of the State or the Centers for Disease Control and Prevention, as applicable. Dual compensation under this paragraph shall be prohibited.

(6) PLACEMENT.—To the extent feasible, as determined by State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities, members of the Force shall be recruited from and serve in their home communities. Force members may be physically co-located with local public health, health care, and community-based organizations, including community health centers, as determined appropriate by funded entities.

(7) SUPERVISORY STRUCTURES.—Members of the Force shall receive ongoing supportive supervision from staff members of State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities or their sub-partners, as described in paragraph (9). Entities funded under this section may choose the most appropriate supervisory structure to use based on local needs, and may promote Force members into supervisory roles.

Such supervision may be also be provided by Disease Intervention Specialists. The Centers for Disease Control and Prevention shall provide or direct their implementing partners to provide, technical assistance and training opportunities to such funded entities to strengthen supportive supervision skills and practices.

(8) SUPPLIES AND EQUIPMENT.—Members of the Force and their supervisors shall receive all necessary supplies and equipment, including personal protective equipment, through State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities, which may use funds awarded under grants, contracts, or cooperative agreements under this section to pay for such supplies and equipment.

(9) SUBAWARDS.—As authorized by the Centers for Disease Control and Prevention, State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities may make subawards to local partners, including community health centers and other community-based and nonprofit organizations, in order to facilitate Force

member recruitment, management, supervision, management, and retention as well as to facilitate Force integration into existing public health, health care, and community-based services.

(10) SERVICE IN PUBLIC HEALTH EMERGENCY.—A State, locality, territory, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes receiving funding under a grant, contract, or cooperative agreement this section shall assign one or more Force members to respond to a public health emergency in the area served by such entity. Such Force members shall be under the supervision and management of the State, locality, territory, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes involved.

(11) SERVICE POST EMERGENCY.—A State, locality, territory, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes may retain one or more Force members to continue to work in the area served by the entity after a public health emergency has ended in order to—

(A) prevent and respond to future public health emergencies; and

(B) respond to ongoing and future public health and health care needs.

(12) LIMITATION.—A Force member may not be assigned for international deployment on behalf of the Health Force.

(13) FUNDING.—All costs associated with the service and functions of Force members under this section, including salary and employment benefits as well as associated direct and indirect costs, shall be paid by the Federal Government through grants, contracts, or cooperative agreements to States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to Tribes.

(e) ACTIVITIES TO RESPOND TO THE COVID–19 PANDEMIC.—The Force shall provide for the training and employment of Force personnel to address the COVID–19 pandemic, including by conducting or assisting with the following activities, where such activities are aligned with State licensure requirements:

(1) Conducting COVID–19 related contact tracing.

(2) When available, supporting the administration of diagnostic, serologic, or other COVID–19 tests.

(3) As appropriate based on State licensing requirements, supporting the provision of palliative care, including by providing support to palliative care teams for seriously ill patients.

(4) When available, supporting the provision of COVID–19 vaccinations, flu vaccinations, and recommended vaccinations for individuals who have missed vaccinations because of the pandemic.

(5) Sharing COVID–19 public health messages with community members, including debunking myths and misperceptions, and building health literacy.

(6) Providing data collection and entry or other administrative duties in support of epidemic surveillance and to meet broader health information system requirements.

(7) Providing community-based and direct-care services, including food and medical supply delivery.

(8) Providing coordination or case management of public health and human services needs related to COVID–19.

(9) Carrying out any other activities, including those described in subsection (f), as determined appropriate by the Director.

(10) Carrying out any other activities, including those described in subsection (f), as determined appropriate by State, locality, territory, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funding recipients, in accordance with grant, contract, and cooperative agreement scope and stipulations.

(f) ACTIVITIES POST-EMERGENCY.—After the COVID–19 emergency concludes, the Force shall provide for the training and employment of Force personnel to prevent and respond to future public health emergencies and respond to ongoing and future public health and health care needs. Under this subsection, Force members shall carry out or assist with activities described in subsection (e) as well as any of the following activities, where aligned with State licensure requirements:

(1) Sharing public health messages with community members.

(2) Providing home-based check-ins for new mothers and infants.

(3) Providing vaccination schedule reminders, especially for parents and legal guardians of children under the age of 6.

(4) Providing services to help community members navigate medical, behavioral health, well health, and social services.

(5) Connecting community members with health and social services, including services provided by the Federal or State Governments and community-based organizations.

(6) Providing or supportive provision of additional perinatal health services, such as serving as doulas, peer supporters, certified lactation consultants, and home visitors.

(7) Providing community-based information to local health departments to inform and improve health programming for hard-to-reach communities.

(8) Preventing the spread of sexually transmitted disease, including through contact tracing.

(9) Supporting the provision of mental and behavioral health services, including mental health first aid and peer-to-peer support.

(10) Other activities determined appropriate by the Director.

(11) Other activities, including response to localized public health emergencies, as determined appropriate by State, locality, territory, Indian Tribe, Tribal organization, urban Indian health organiza-

tion, or health service providers to Tribes funding recipients and in accordance with grant and cooperative agreement scope and stipulations.

(g) FOCAL COMMUNITIES.—State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities shall dedicate a substantial number of Force members to addressing the needs of focal communities. To be designated as a focal community, a community shall at a minimum—

(1) be in the bottom 50 percent of the United States in terms of life expectancy, infant mortality, poverty, or other measure, as recommended by the National Academies of Sciences, Engineering, and Medicine and approved by the Director; or

(2) be identified as a ''most vulnerable'' community according to the Centers for Disease Control and Prevention's Social Vulnerability Index.

(h) COORDINATION AND COLLABORATION.—

(1) FACILITATION.—

(A) IN GENERAL.—The Director shall facilitate coordination and collaboration between the Force and other national public health service programs within and external to the Department of Health and Human Services, including

the Public Health Service and Medical Reserve Corps.

(B) ADVISORY GROUP.—Not later than 6 months after the date of enactment of this Act, the Director shall convene a stakeholder advisory group comprised of the leadership of other national health service programs, other relevant Federal agencies, including the Department of Labor and the Centers for Medicare & Medicaid Services, and leaders representing State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities. Such advisory group shall meet on a yearly basis to provide guidance for the programmatic success and longevity of the Force.

(2) STATES, LOCALITIES, TERRITORIES, INDIAN TRIBES, TRIBAL ORGANIZATIONS, URBAN INDIAN HEALTH ORGANIZATIONS, OR HEALTH SERVICE PROVIDERS TO TRIBES COLLABORATION.—

(A) IN GENERAL.—States, localities, territories, Indian Tribes, Tribal organizations, urban Indian health organizations, or health service providers to tribes shall ensure coordination and, as appropriate, collaboration between

the Force and local public health, and health care, and community-based programs, to ensure complementarity and further strengthen the local public health response.

(B) ADVISORY GROUP.—Not later than 3 months after the date of enactment of this Act, an entity that receives a grant, contract, or cooperative agreement under this section shall convene a stakeholder advisory group comprised of community leaders and other key stakeholders to meet on a regular, recurring basis to provide guidance for the programmatic success and longevity of the Force.

(C) STATE COMPACTS.—In accordance with section 115 of the Housing and Community Development Act of 1974 (42 U.S.C. 5315), two or more States to enter into agreements or compacts, for cooperative effort and mutual assistance in support of community development planning and programs carried out under this section as such programs pertain to interstate areas and to localities within such States, and to establish such agencies, joint or otherwise, as such States determine appropriate

for making such agreements and compacts effective.

(i) MONITORING.—The Director shall develop a performance monitoring template for State, locality, territorial, Indian Tribe, Tribal organization, urban Indian health organization, or health service providers to Tribes funded entities adaptation and use under this section. Such template shall at a minimum require the reporting of the number of Force members hired, the role hired into, and the demographic characteristics of Force members. Such data shall be shared by entities receiving grants, contracts, or cooperative agreements under this section to the Centers for Disease Control and Prevention on a regular, recurring basis. Such data shall be made publicly available.

(j) LEARNING AND ADAPTATION.—The Director shall develop a learning and evaluation component of the Force to identify successful components of local activities conducted under this section that may be replicated, to identify opportunities for continuing education and career advancement for Force members, and to evaluate the degree to which the Force created a pathway to longer-term public health and health care careers among Force members, and to identify how the Force impacted the health knowledge, behaviors, and outcomes of the community members

served. Results of this learning shall be made publicly available.

(k) REPORTING.—Not later than 180 days after the end of each fiscal year, the Director shall submit to the Congress a report which shall contain—

(1) a description of the progress made in accomplishing the objectives of Force under this section;

(2) a summary of the use of funds under this section during the preceding fiscal year;

(3) a list of each recipient of a grant, contract, or cooperative agreement under this section and the amount of such grant, contract, or cooperative agreement, as well as a brief summary of the projects funded by each such recipient, the extent of financial participation by other public or private entities, and the impact on employment and economic activity of such projects during the previous fiscal year; and

(4) a description of the activities carried out under this section.

(l) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated, and there is appropriated, to carry out this section, $55,000,000,000 for each of fiscal years

2020 and 2021, such amounts to remain available until expended.

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

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

SEC. 3. RESILIENCE FORCE.

(a) IN GENERAL.—For the period of fiscal years 2020 through 2022, the Administrator of the Federal Emergency Management Agency shall appoint, administer, and expedite the training of a 62,000 Cadre of On-Call Response/Recovery Employees, under the Response and Recover Directorate (referred to in this section as a ''CORE employee'') under the Office of Response and Recovery, above the level of such employees in fiscal year 2019, to address the coronavirus public health emergency and other disasters and public emergencies.

(b) DETAIL OF CORE EMPLOYEES.—A CORE employee may be detailed, through mutual agreement, to any Federal agency that is a participating agency in the White

House Coronavirus Task Force, or to a State, Local, or Tribal Government to fulfill an assignment for the Task force, including—

(1) providing logistical support for the supply chain of medical equipment and other goods involved in COVID–19 response efforts;

(2) supporting COVID–19 testing and surveillance activities;

(3) providing nutritional assistance to vulnerable populations; and

(4) carrying out other disaster preparedness and response functions for other emergencies and natural disasters.

(c) REQUIREMENT.—As soon as practicable, the Administrator of the Federal Emergency Management Agency shall make public job announcements to fill the CORE employee positions authorized under subsection (a), which shall prioritize hiring from among the following groups of individuals:

(1) Unemployed veterans of the Armed Forces.

(2) Individuals who have become unemployed or underemployed as a result of the coronavirus public health emergency.

(3) AmeriCorps members, Peace Corps Volunteers, or United States Fulbright Scholars who have

had their service terms ended as a result of the coronavirus public health emergency.

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

(5) Members of communities who have experienced a disproportionately high number of COVID–19 cases.

(d) HIRING.—The Federal Emergency Management Agency shall hire employees under this section, pursuant to section 306 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5149), and make use of existing statutory authorities that permit regional offices and site managers to advertise for and hire such employees.

(e) TRAINING.—The Administrator of the Federal Emergency Management Agency may make appropriate adjustments to the standard training course curriculum for employees under this section to include on-site trainings at Federal Emergency Management Agency regional offices, virtual trainings, or trainings conducted by other Federal, State, local or Tribal agencies, including training described in section 2(d)(4).

(f) CLARIFICATION.—For the purposes of employing individuals under this section—

(1) no individual who is authorized to work in the United States, including individuals with Deferred Action for Childhood Arrivals (DACA) or Temporary Protected Status (TPS) under section 244 of the Immigration and Nationality Act (8 U.S.C. 1254a), shall be disqualified for appointment under this section because of citizenship or immigration status; and

(2) no individual shall be disqualified for appointment under this section because of bankruptcy or a poor credit rating determined to be the result of the Coronavirus public health emergency.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Administrator of the Federal Emergency Management Agency, $6,500,000,000, for each of fiscal years 2020 through 2022, not less than $1,500,000,000 of which shall be made available each such fiscal year for the administrative costs associated with carrying out this section.

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