Locally embedded and trusted US health workers have gathered data, spread messages, and built strong, organized, community responses during the COVID-19 pandemic. Their outreach has been key in confronting disparities and mitigating even worse outcomes in our hardest-hit communities.

The effectiveness of such community health workers is not just a lesson in addressing public health emergencies. It’s also a lesson in preparing for emergencies in the first place—and taking on slower-moving health disasters, such as chronic disease prevention and management.

Policy makers have a once-in-a-generation opportunity to take these lessons and crystallize them in a national Public Health Corps. Although national funding and structure are needed, the evidence shows that the workforce itself must be derived from the neighborhoods being served. When organized well, community health workers improve health outcomes and reduce health inequity. Across these neighborhood-based efforts, there are several common threads: identifying community concerns, risks, and causes of suffering; disseminating science-based information and promoting health literacy; generating health advocacy networks, particularly around racial equity; linking local knowledge with clinical expertise and public health surveillance; and creating a culture of disease prevention that acknowledges the social determinants of health.

Such community-based initiatives are certainly not new, but the COVID-19 pandemic has imbued them with a renewed urgency. For example, Detroit’s Community Health Corps, first announced in August 2020 and largely focused on meeting housing, food, and security needs, certified an initial cohort of 20 residents as peer counselors and case managers; they have already provided valuable assistance to affected residents. At the national scale, Gregg Gonsalves, PhD, MPhil, of Yale School of Public Health and Yale Law School, and Amy Kapczynski, JD, MPhil, MA, of Yale Law School, have called for a mass, federally funded jobs program even larger than the Works Progress Administration.

President Biden’s COVID-19 plan, which called for 100,000 new public health workers to perform culturally competent contact tracing and other outreach, represents a chance to leap forward with a Public Health Corps. The American Rescue Plan, recently passed by the Senate, includes $7.7 billion in funding for such workforce initiatives. Such investments could accelerate vaccination efforts; allow a more robust response to parallel pandemics, such as opioid overdoses and food insecurity; and provide much-needed jobs. Less tangible but no less impactful would be charging a replenished public health workforce with improving health by building social cohesion and trust.

From Pandemic Response to Community Empowerment

The community networks and relationships that have been built during the COVID-19 pandemic offer a head start in the development of a Public Health Corps. For example, in New York City, we have pursued a hyperlocal approach to response, relying on granular, near real-time data to identify zip codes with low testing rates and high test positivity and case rates to target coordinated outreach and support. We partnered with trusted community messengers from these neighborhoods to expand and simplify testing and vaccinations, tailor communications, and build tight, synchronized networks of care. In the Tremont neighborhood of the Bronx, for instance, we coordinated with prominent houses of worship to set up pop-up testing sites and mobile testing vans and engaged...
with hundreds of businesses, schools, and community-based organizations—and dozens of local clinicians—to test thousands of residents per week.

We continued this approach—listening with humility to community members, then channeling what we heard into action—in our planning for vaccine distribution. In December and January, in collaboration with the New York Academy of Medicine, we conducted 5 pilot public deliberations (guided discussions with a diverse cross-section of residents) on how to prioritize populations for vaccine access, and that input has guided our distribution rollout.

In many ways, a Public Health Corps would simply be an extension of what we have seen not only during the COVID-19 pandemic but also previous epidemic responses. Raj Panjabi, MD, MPH, of Harvard Medical School, and Mitchell Weiss, MBA, of Harvard Business School, point out the many public health successes, including during outbreaks of Ebola and Zika, that have resulted from community health contributions of the newly unemployed, a number still hovering at more than 10 million people in the United States.

A Vision for a Public Health Corps

A neighborhood-based Public Health Corps is fundamentally a group of community health workers structured by a backbone organization, such as a local health department. The community health workers would be the go-to people in the neighborhood for residents to identify concerns and to disseminate science-based, contextualized health information. They would nurture the networks needed to advocate for the health of every resident in the community. The community knowledge encompassed in the Public Health Corps would be systematically converted into community intelligence that complements other health surveillance systems. In times of crisis, they would step in to provide essential alerts, activate networks, and fulfill public health roles, such as contact tracing.

Community health worker programs that have been shown to be effective pay particular attention to recruitment and training of staff and have clear expectations for these workers' roles and competencies. Core skills laid out in consensus standards include community knowledge and lived experience, relationship building, and interpersonal communication. At this moment, there is particular opportunity to provide career pathways and professional growth for the temporary emergency workforce that was mobilized during COVID-19, particularly among marginalized populations.

Currently, community health worker programs in the United States are funded through grants, county and state budgets, and (rarely) Medicaid waivers, which limit their ability to take a whole person, public health approach. Additional federal funding is sometimes temporarily available during emergencies. Establishing a sustainable revenue model will require initial, stable federal or state funding—and ultimately will require reimbursement of community health worker services by multiple payers, starting with Medicaid and Medicare.

We can scarcely afford to build our public health workforce and infrastructure from scratch each time an emergency strikes. A community-based Public Health Corps could have immediate and tangible effects on health during the COVID-19 response and recovery, but it could also be a bulwark against future emergencies and a leap forward for community health in the times in between.
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