(A) disseminating information to the public;

(B) improving access to services for persons living with paralysis and other physical disabilities and their caregivers;

(C) testing model intervention programs to improve health and quality of life; and

(D) coordinating existing services with State-based disability and health programs.

(d) Coordination of activities

The Secretary shall ensure that activities under this section are coordinated as appropriate by the agencies of the Department of Health and Human Services.

(e) Authorization of appropriations

For the purpose of carrying out this section, there is authorized to be appropriated $25,000,000 for each of fiscal years 2008 through 2011.

(Pub. L. 111–11, title XIV, §14301, Mar. 30, 2009, 123 Stat. 1454.)

CODIFICATION

Section was enacted as part of the Christopher and Dana Reeve Paralysis Act, and also as part of the Omnibus Public Land Management Act of 2009, and not as part of the Public Health Service Act which comprises this chapter.

§ 280g–10. Community Preventive Services Task Force

(a) Establishment and purpose

The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the ''Task Force'') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the ''Guide''), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

(b) Duties

The duties of the Task Force shall include—

(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

(2) at least once during every 5-year period, review[1] interventions and update[1] recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

(3) improved integration with Federal Government health objectives and related target setting for health improvement;

(4) the enhanced dissemination of recommendations;

(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

(c) Role of agency

The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

(d) Coordination with Preventive Services Task Force

The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

(e) Operation

In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5.

(f) Authorization of appropriations

There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

(July 1, 1944, ch. 373, title III, §399U, as added Pub. L. 111–148, title IV, §4003(b)(1), Mar. 23, 2010, 124 Stat. 543.)

REFERENCES IN TEXT

Appendix 2 of title 5, referred to in subsec. (e), probably means the Federal Advisory Committee Act, Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, which is set out in the Appendix to Title 5, Government Organization and Employees.

§ 280g–11. Grants to promote positive health behaviors and outcomes

(a) Grants authorized

The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

(b) Use of funds

Grants awarded under subsection (a) shall be used to support community health workers—

[1] So in original. Probably should be followed by ''of''.

(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

(3) to educate and provide outreach regarding enrollment in health insurance including the Children's Health Insurance Program under title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.], Medicare under title XVIII of such Act [42 U.S.C. 1395 et seq.] and Medicaid under title XIX of such Act [42 U.S.C. 1396 et seq.];

(4) to identify and refer underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

(5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

(c) Application

Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

(d) Priority

In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

(1) propose to target geographic areas—

(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

(B) with a high percentage of residents who suffer from chronic diseases; or

(C) with a high infant mortality rate;

(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

(3) have documented community activity and experience with community health workers.

(e) Collaboration with academic institutions and the one-stop delivery system

The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 3151(e) of title 29. Nothing in this section shall be construed to require such collaboration.

(f) Evidence-based interventions

The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

(g) Quality assurance and cost effectiveness

The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

(h) Monitoring

The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

(i) Technical assistance

The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

(j) Authorization of appropriations

There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

(k) Definitions

In this section:

(1) Community health worker

The term ''community health worker'' means an individual who promotes health or nutrition within the community in which the individual resides—

(A) by serving as a liaison between communities and healthcare agencies;

(B) by providing guidance and social assistance to community residents;

(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

(D) by providing culturally and linguistically appropriate health or nutrition education;

(E) by advocating for individual and community health;

(F) by providing referral and follow-up services or otherwise coordinating care; and

(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

(2) Community setting

The term ''community setting'' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

(3) Eligible entity

The term ''eligible entity'' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act [42 U.S.C. 1395x(aa)])), or a consortium of any such entities.

(4) Medically underserved community

The term ''medically underserved community'' means a community identified by a State—

(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 254b(b)(3) of this title; and

(B) a significant portion of which is a health professional shortage area as designated under section 254e of this title.

(July 1, 1944, ch. 373, title III, § 399V, as added and amended Pub. L. 111–148, title V, § 5313(a), title X, § 10501(c), Mar. 23, 2010, 124 Stat. 633, 994; Pub. L. 113–128, title V, § 512(z)(1), July 22, 2014, 128 Stat. 1716.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(3), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

AMENDMENTS

2014—Subsec. (e). Pub. L. 113–128 substituted ''one-stop delivery systems under section 3151(e) of title 29'' for ''one-stop delivery systems under section 2864(c) of title 29''.

2010—Subsec. (b)(4). Pub. L. 111–148, § 10501(c)(1), substituted ''identify and refer'' for ''identify, educate, refer, and enroll''.

Subsec. (k)(1). Pub. L. 111–148, § 10501(c)(2), struck out '', as defined by the Department of Labor as Standard Occupational Classification [21–1094]'' before ''means'' in introductory provisions.

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–128 effective on the first day of the first full program year after July 22, 2014 (July 1, 2015), see section 506 of Pub. L. 113–128, set out as an Effective Date note under section 3101 of Title 29, Labor.

§ 280g–12. Primary Care Extension Program

(a) Establishment, purpose and definition

(1) In general

The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

(2) Purpose

The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as ''Health Extension Agents'').

(3) Definitions

In this section:

(A) Health Extension Agent

The term ''Health Extension Agent'' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

(B) Primary care provider

The term ''primary care provider'' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

(b) Grants to establish State Hubs and local Primary Care Extension Agencies

(1) Grants

The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as ''Hubs'').

(2) Composition of Hubs

A Hub established by a State pursuant to paragraph (1)—

(A) shall consist of, at a minimum, the State health department, the entity responsible for administering the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments that train providers in primary care in 1 or more health professions schools in the State; and

(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1320c–2 of this title, consumer groups, and other appropriate entities.

(c) State and local activities

(1) Hub activities

Hubs established under a grant under subsection (b) shall—

(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and