

GOAL 1

Action 1.15

WHITE HOUSE
BLUEPRINT
EVIDENCE TO
ACTION BRIEFS



Integrate behavioral health
supports in community settings



Maternal Health
Learning & Innovation Center™
MaternalHealthLearning.org

**THE WHITE HOUSE BLUEPRINT
FOR ADDRESSING THE
MATERNAL HEALTH CRISIS**

The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action Brief highlights Action 1.15 in the White House Blueprint in an effort to increase access to and coverage of comprehensive high-quality maternal health services, including behavioral health services (Goal 1).

Maternal Health Action 1.15

Integrate behavioral health supports in community settings by training [patient] navigators and CHWs to identify behavioral health needs and link families to local resources, such as medical homes, school-based and other community health centers, community-based organizations [CBOs], and local community social supports.

Contribution to Quality of Life

The [White House Blueprint](#) is a “whole-of-government approach to combating maternal mortality and morbidity” so that all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe.

The current structure of the reproductive health care system means that birthing people often navigate challenges in accessing information and resources; this gap can be mitigated through connections with culturally aligned patient navigators and community health workers.¹ These team members are integral to offering timely and relevant support.¹

Basic Facts

“Community Health Workers (CHWs) are a one-of-a-kind group of public health workers.”² They are a diverse, cross-sector, historic, community-based workforce,² also known as health advocates, lay health educators, community outreach workers, and health coaches.³ One role of a CHW is that of patient navigator. The first patient navigators were conceived in Harlem Hospital in New York City by Dr. Harold Freeman to help reduce disparities in access to cancer care.^{4,5} Even before Dr. Freeman’s formal development of a patient navigator program to address inequities in health care access, CHWs and their efforts date to the 1960s.⁴

CHWs connect people with critical services (informational, mental, physical, emotional, economic); can offer health screening and promotion activities; support people enrolling in health insurance and health benefits, including Medicare, Medicaid, and the Affordable Care Act’s insurance marketplace; direct clients to social services, including assistance from the Women, Infants, and Children program; and strengthen the health care system and community through bridging systems and resources for patients.¹

Evidence suggests that CHWs have the potential to reduce health care costs, address disparities, and improve health care outcomes.⁶ A systematic review published in 2022 found that CHW interventions were associated with improvements in knowledge related to pregnancy outcomes and infant health, the receipt of antenatal care, and when combined with clinical services, positively impacted birth outcomes.⁷ The strongest evidence supports CHW-led preventative care interventions focused on diabetes, cardiovascular disease, and health behaviors associated with cancer prevention.⁸ In addition, evidence suggests that because CHWs typically identify with the clients with whom they work (racially, ethnically, and/or socioeconomically), there is increased understanding, trust, and respect (see figures 1, 2A, 2B, and 2C), which leads to improved health behaviors and health outcomes, adherence to medical



recommendations, reduced amounts of stress and depression, newborn safe sleep practices, and increased engagement with the health care system.⁹

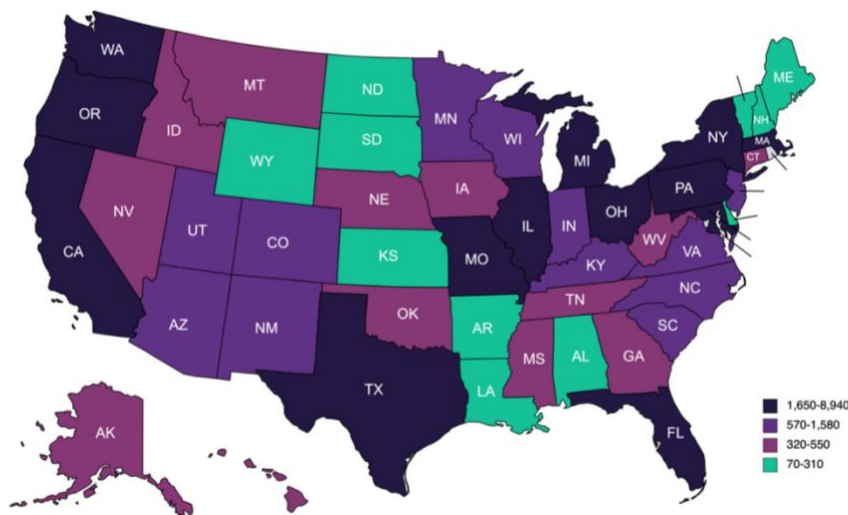
There are limited studies that focus on CHWs and supporting the behavioral and mental health needs of the perinatal populations; early findings are promising, however. One such study is the innovative community-based participatory research initiative Mental Health Outcomes for Mothers, which is developing and implementing a Community Mental Health Ambassadors model that trains CHWs to support pregnant women with behavioral health needs during pregnancy.¹⁰

To reduce coverage gaps, improve access to high-quality care, and address geographical barriers to health care access, the [White House Blueprint](#)¹¹ commits to increasing the public health workforce of patient navigators and CHWs who are trained to identify behavioral health needs and increase access to resources and clinical and non-clinical services by linking families who have been historically marginalized to local resources. These may include medical homes for children and youth, school-based health centers, federally qualified community health centers, other community or county health centers, and other local community support.

How are we doing?

Below we highlight data related to Action 1.15. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should be focused to improve health outcomes related to Action 1.15.

Figure 1: Employment of Community Health Workers (CHW) by State, May 2022



As of May 2022, there were approximately 61,300 CHWs in the US, with large variations by state. California and New York have the largest number of CHWs, compared with Alabama and Maine, which have the lowest number.

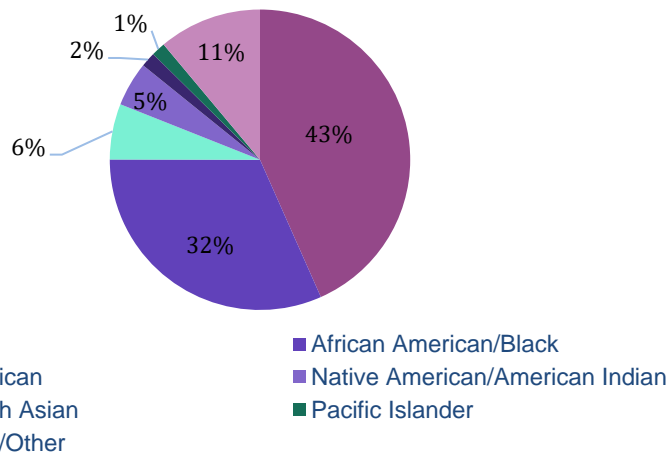
Source: U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics, [21-1094, Community Health Workers](#). May 2022. Accessed September 6, 2023.

Note: Data is limited for the CHW workforce due to reduced use of the Department of Labor classification 21-1094 established over a decade ago for CHWs. Contact HRSA/CDC for an estimate of the number of CHWs hired during the pandemic. Email communication with Denise Smith, CEO of the National Association of Community Health Workers.



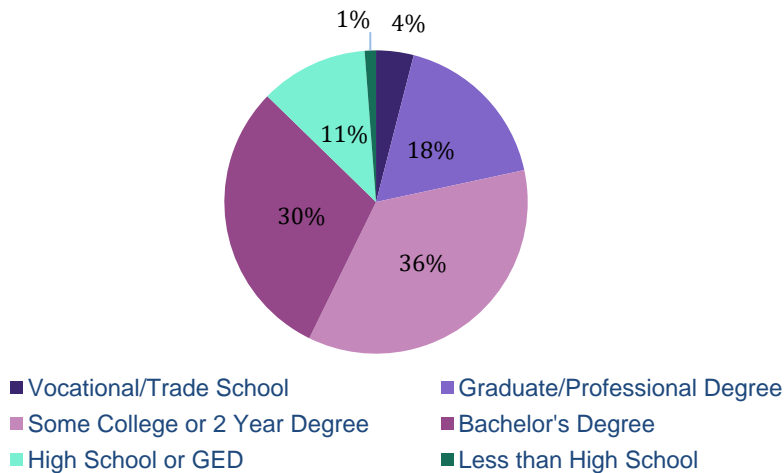
Figure 2: Demographic of US Community Health Workers (CHW), 2021

Figure 2a: Race and Ethnicity of CHW, 2021



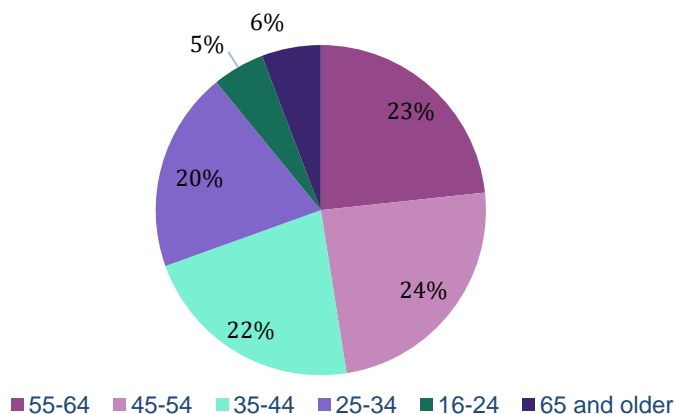
Source: National Association of Community Health Workers. [Community Health Worker Advancing Diversity in Community Health \(survey\)](#). 2021. Accessed September 2, 2023.

Figure 2b Highest Level of Education Completed



Source: National Association of Community Health Workers. [Community Health Worker Advancing Diversity in Community Health \(survey\)](#). 2021. Accessed September 2, 2023.

Figure 2c: Age of Respondents



Source: National Association of Community Health Workers. [Community Health Worker Advancing Diversity in Community Health \(survey\)](#). 2021. Accessed September 2, 2023.



Barriers such as low wages, high turnover, and low job security inhibit CHWs from becoming integral parts of our health care system. The Association of American Medical Colleges emphasizes that CHWs often do not receive living wages and lack opportunities for promotion.³ In 2022, CHWs earned a mean hourly rate of \$22.21 or an annual salary of \$46,190, compared with a national median annual income of \$53,664.¹

There is a lack of sustainable funding for CHWs and a lack of funding to invest in development and implementation of standardized CHW curricula for professional and continuing educational training. There also is limited reimbursement for many of the core functions that CHWs support in our health care system. Reasons for insufficient funding may include employers' perceptions that CHWs are a downstream participant in the health care system rather than an upstream necessity for improving inequities earlier in maternal health. Finally, many health insurance plans do not reimburse for CHW services, which leads to few organizations creating sustainable CHW positions. Further contributing to the challenge is the status of Medicaid coverage—not all states allow Medicaid payment for services provided by CHWs (see Figure 3).^{6,14}

What can be done to address the issue?

The [White House Blueprint](#) identifies actionable steps to address Action 1.15. In addition, experts from the maternal and child health field have identified the following innovative, evidence-informed strategies after a review of several databases and national repositories.

Maternal & Child Health (MCH) Innovations

MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program's Innovation Hub](#) (AMCHP), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what’s working” in the [Robert Wood Johnson Foundation's What Works for Health](#) (RWJ) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.

- [Community Health Workers](#). There is some scientific evidence that CHWs who provide culturally responsive support to clients and patients around referral and follow-up, education, case management, advocacy, home visiting, and more can improve maternal and infant health outcomes. (RWJ)
- [Center for Community Health Alignment \(CCHA\)](#). Housed at the University of South Carolina's Arnold School of Public Health, CCHA brings together PASOs, the Community Health Worker Institute, and Equity Through Meaningful Community Engagement to work collaboratively to address health inequities in the state.
- [Community Health Worker Initiatives](#). The following CHW programs follow American Public Health Association policies for CHW workforce development, which include having CHWs create and teach each training, as well as using adult education strategies that include in-person, practice-based learning.
 - [El Sol—Community Health Worker/Promotores Training Center](#). Based in California, the CHW and promotor model is a peer-to-peer empowerment approach in education, prevention, and early intervention.



- [Dia de la Mujer Latina](#). A CHW/promotor program based in Texas.
- [Community Health Workers Toolkit](#). This toolkit from the Rural Health Information Hub provides promising practices and resources to help communities implement a CHW innovation.
- [HealthConnect One](#). HealthConnect One offers perinatal training for CHWs, community doulas, and breastfeeding counselors. Its curriculum was co-created with community members and is structured to equip CHWs to offer ongoing support to birthing families. (AMCHP)
- [HRSA Health Workforce, Allied Health Workforce Projections, 2016–2030](#). This document provides projections of how CHWs can help inform public-sector and private-sector decision-makers on health workforce issues and needs.
- [National Association of Community Health Workers](#). The organization maintains a searchable database for resources, documents, and evidence on policies related to CHWs.
- [National Academy for State Health Policy](#). The organization provides information on CHW models that can be implemented at the local, county, or state level to address issues pertaining to perinatal health.

State Maternal Health Innovations from the Health Resources & Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) Grantees

The [State Maternal Health Innovations \(MHI\)](#) initiative, funded by [HRSA's MCHB](#), currently provides funding to 18 states to develop, implement, and evaluate state-level equity-centered innovations. Below we highlight innovations that address Action 1.15 from the MHI cohorts (2019–2024):

- [North Carolina](#). North Carolina's Maternal Health Innovation program supports CHWs and doulas in low-income and underserved areas to implement support and outreach services in the preconception, prenatal, labor and delivery, postpartum, and interconception periods.
- [Maryland](#). In 2019, Maryland established the requirements for its Department of Health to certify CHWs and to accredit CHW certification training programs.

Evidence-based Strategy Measures from the [MCH Evidence Center](#) Related to Action 1.15

Throughout the country, state level [Title V MCH](#) agencies develop measures to help track their efforts around improving the health and well-being of women, children, and families. Below are selected measures related to improving equitable maternal and child outcomes that can support [Action 1.15](#).

- Percentage of counties identified as having low utilization of preventive health visits among women that are served by a CHW. ([SC](#))
- Number of CHWs, doulas, or promotoras de salud certified in perinatal health modules through the NM Department of Health or colleges. ([NM](#))
- Number of OHA Office of Equity and Inclusion Certified CHWs. ([OR](#))
- Number of women receiving patient navigation for women's health services. ([TN](#))

Resources from the [MCH Evidence Center's Digital Library](#)

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, white papers with seminal and historic resources. The following may support Action 1.15.



- Association of State and Territorial Health Officials. [State Approaches to Community Health Worker Certification](#). 2022.
- Association of State and Territorial Health Officials and National Association of Community Health Workers. [Community health workers: Evidence of their effectiveness](#). 2020.
- Bakst C, et al. [Community-based maternal support services: The role of doulas and community health workers in Medicaid](#). 2020. Institute for Medicaid Innovation.
- Higgins E, et al. [Lessons for advancing and sustaining state community health worker partnerships](#). 2021. National Academy for State Health Policy.
- Kumar N, Muñiz MA. [What We Have Learned from Community Health Workers Throughout the Pandemic: Recommendations for Policymakers](#). 2022. Families USA.
- National Academy for State Health Policy. [State Community Health Worker Models](#). 2015. National Academy for State Health Policy.

Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit maternalhealthlearning.org/Blueprint for more details.

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13. National Association of Community Health Workers. [NACHW Toolkit for Public Health Departments](#). Accessed June 29, 2023.
14. Haldar S, Hinton E. [State Policies for Expanding Medicaid Coverage of Community Health Worker Services](#). Kaiser Family Foundation. 23 January 2023. Accessed August 24, 2023.





The MHLIC is available for consultation, coaching, and technical assistance to support your implementation of any innovations to improve maternal mortality and morbidity. For more information, visit <https://maternalhealthlearning.org/connect>.

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