



Community Health Workers Advancing Child Health Equity

Racism and Child Health



Racism is a root cause of health inequities.

As illuminated by Dr. Camara Jones, pediatrician, public health scholar, and anti-racism activist, racism is a discriminatory “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call ‘race’), that unfairly disadvantages some individuals and communities [and] unfairly advantages other individuals and communities.”¹ Racism has been part of our country’s history since its inception, creating contradictions of American democracy that reserved opportunity, freedom, health and prosperity to white people. Beginning with European colonization, racism was behind the subjugation, displacement and genocide of Indigenous people as well as the importation, exploitation and victimization of African slaves. It was codified into law through policies supporting segregation, redlining and exclusion of Black, Indigenous and People of Color (BIPOC) in order to sustain a system of power that excluded them. The COVID-19 pandemic has heartbreakingly demonstrated that health inequities confronting BIPOC communities are rooted in our country’s racism and its inextricable downstream effects on housing, transportation, economic opportunity, education, food, air quality, health care and beyond.

Racism impacts every state of a child’s development and continues to harm children by shaping the conditions in which they live, learn and play. It has been scientifically proven as a core determinant of child health that has a profound impact on the well-being of children, their families and their communities.² Racism experienced during pregnancy has been consistently linked to birth disparities and mental health problems in children and youth.³ The ongoing stress of experiencing racism can lead to inflammatory reactions that predispose children to chronic disease.⁴ Perceiving that they are living in a threatening world, children may exhibit behavioral characteristics such as hypervigilance and remain in a crisis mode, unable to resolve or predict the next threat.⁵ While overt and intentional discrimination based on race has been outlawed, racial inequities have accumulated over time and continue to persist in systems and institutions that shape the conditions in which children are raised. These systems and institutions, in turn, continue to harm children through policies, rules and practices that produce, sustain and normalize inequities between racial groups, operating behind the illusion of colorblindness and neutrality.⁶ The key indicators of racism within a system or institution are racially disparate outcomes, whether intentional or not. Inequities in education, income and health experienced by BIPOC children are all symptoms of racism and are sustained by a model of society that recognizes only individuals, not the collective group, as the victims of racial injustice. Racism ultimately hurts the health of our entire nation by preventing some children and their families from attaining their highest level of health. Accordingly, achieving health equity requires that we examine and dismantle the racism that exists within our institutions and systems as well as acknowledge collective harm, group responsibility and a right to collective redress.

Through a series of briefs on policing, health care and technology, The Children’s Partnership explores how children continue to be harmed by racism that is embedded in and perpetuated by institutions, systems and policies that shape the conditions that surround child health and well-being. Furthermore, we consider opportunities to disrupt oppressive systems, defer to community leadership, and demand bold innovations that put the well-being of our children first.

See more information on the Racism and Child Health series:

<https://www.childrenspartnership.org/what-we-do/health/racism-and-child-health/>

Introduction



Child well-being is harmed by the limited opportunities for meaningful community and family engagement within the systems that serve our children, particularly the health care system. The American health care system has historically engaged in exploitation, segregation and discrimination based on race and ethnicity, often ignoring valuable, cultural approaches to healing. The effects of such actions continue to this day in the form of persistent negative health outcomes for children and adults, which are experienced disproportionately by BIPOC communities.

Communities of color continue to experience discrimination as well as to be disproportionately impacted by systemic barriers that make it more difficult for them to be healthy and build prosperous lives. For millions of American families, navigating the health care system has meant experiencing delayed care or no care at all, onerous administrative requirements, unanticipated financial burdens, a maze of hoops and hurdles, and a lack of racially, ethnically and culturally diverse health care providers. Without a deep understanding of the barriers families face, health care systems risk perpetuating such barriers, further harming families' health and well-being. This is particularly true for children from BIPOC communities

who, because of the disproportionate lack of access to health coverage and care, are also at greater risk of having poor health outcomes.

This second brief in our series explores the impact of racism within the U.S. health care system as demonstrated by a lack of meaningful community leadership and engagement in care delivery. Within this context, the brief focuses on the community health workforce as a community-led, anti-racist solution in health care delivery for children, from prenatal development to adulthood. Anti-racist strategies are conscious and deliberate efforts that address and eradicate historic and present marginalization and inequality impacting BIPOC communities.

► **A community health worker (CHW) workforce is an anti-racist strategy because it shifts power through partnerships in which people who directly experience the conditions that cause inequities have leadership roles and avenues to share their perspectives with health care organizations.**

CHW programs also shift power by both employing and then equitably paying a workforce that is made up mostly of people of color. Shifting power supports a health care workforce that better reflects the communities served while also providing employment opportunities in those communities that stabilize families. Further, doing so creates a bridge between families and their communities and the health systems serving them that can support institutional changes in those systems to be more culturally, linguistically and ethnically responsive and diverse.

This brief explores how CHWs improve the health of children, particularly children of color, by connecting families to information, care and services while simultaneously improving the systems and conditions that determine health and well-being.

First, the brief provides an overview of our health care system's history of racial injustice, highlighting a lack of attention to the meaningful inclusion of community voice and perspective. Second, it presents findings from listening sessions The Children's Partnership hosted with child- and family-serving community health workers and promotores across California and identifies critical roles CHWs play in improving the health and well-being of children and families. Third, it offers examples of child-focused CHW initiatives that have a demonstrated impact in addressing health inequities among children of color. Finally, the brief provides policy recommendations for long-term support of the CHW model as an invaluable element of achieving health equity for children.

As the COVID-19 pandemic exacerbates the racial inequities in our health care system, CHWs continue to serve the most marginalized communities and assist communities in navigating the systems that have historically excluded them. If we are to transform our health care system into one that truly responds to children and their unique needs, we must fully integrate CHWs into that system, leveraging their unique abilities for both adults and children.

Regan's Story: Perspective From a CHW



Regan and her son

Regan was working in a children's hospital providing emotional support to pediatric patients when her son was diagnosed with a chronic illness. Seemingly overnight, she became the mother of a patient like the ones she served, gaining a newfound and personal understanding of the struggles faced by the families with whom she interacted daily. Despite her connection to the hospital setting and pediatric clinical knowledge, the challenges of navigating the health care system were made clear by the hurdles she confronted in trying to coordinate her son's care. In order to prevent other parents from facing the same challenges, she became an advocate. As Regan says, "I used my experiences to share with my coworkers, in hopes of improving patient care." Her challenges were not limited to the health care setting. The education system also required its own navigation — communicating absences and necessary support, filling

out paperwork for new medications, and adhering to necessary follow-up visits all while trying to support her son's learning journey. Regan became her son's advocate, empowering her son to openly communicate his symptoms to assist his teachers and school nurses in understanding the severity of his asthma and working together to develop an actionable plan that was continuously shifting due to changing educational and health care protocols and requirements.

As a result of her lived experiences, Regan became a clinical community health worker in 2019. Being part of the community herself means she sees firsthand families struggling to pay rent, to find healthy foods in their neighborhood, or to manage with only one car or no car at all. Using her knowledge, experience and connection to community to help families navigate the same systems in which she and her son are engaged, Regan can "find joy in helping to steer families in my community down a windy road of empowerment and resilience." Describing this role in her own words, she says, "Community health workers are the missing link in helping families with children manage chronic illness between health care systems. Utilizing community health workers in pediatric settings will help to advance many of California's health initiatives. California needs community health workers to keep helping meet the needs of a vulnerable population seriously impacted by poverty and a global pandemic."

Background

► The U.S. health care system has a history of racial injustice.

Medicine and health care in the United States is marked by centuries of racial injustice and myriad forms of violence against BIPOC communities, including inferior or lack of health care, forced experimentation and sterilization, exploitation, segregated medical facilities, and exclusion from medical education and organized medicine, among other examples.⁷ Health inequities that continue to impact BIPOC communities have been shaped by European conquest of Indigenous peoples and by 246 years of chattel slavery, followed by 100 years of state-sponsored social segregation, physical oppression, political subjugation and economic exploitation.⁸ Many respected intellectuals were involved in creating and perpetuating racist views and stereotypes that rationalized health policy that excludes Black, Indigenous and immigrant communities.⁹

► BIPOC communities have challenged and actively subverted racist structures in medicine to meet their own health needs through community-defined practices and care.

For example, throughout the history of their enslavement, African Americans and their descendants vigorously resisted the destructive effects of oppression and pursued health by relying upon their own knowledge, practices and resources.¹⁰ While health care remained segregated, Black communities established, funded and operated hospitals in underserved areas and established medical schools to provide medical training and education when Black



Community Health Workers/Promotoras de Salud in Montclair Supporting with Outreach for the COVID-19 Vaccine. Credit: "Community Health Workers in Action," <https://www.elsolnec.org/blog/community-health-workers-in-action/>, March 15, 2021.

physicians and health care workers were barred from other institutions.¹¹ Similarly, many indigenous health traditions and practices have been able to survive and even to thrive.¹²

Moving into the present, racism continues to impact children, women and families. As one example, our country is facing a maternal health crisis among Black and Indigenous

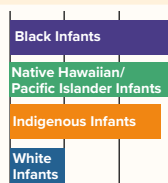
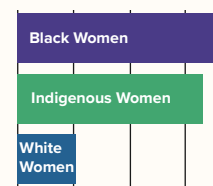
women. Nationally, Black women are 2.5 times more likely and Indigenous women are 2.3 times more likely to die from pregnancy complications than white women.¹³ Black infants are more than 2 times more likely, Native Hawaiian or Pacific Islander infants are 2 times more likely, and Indigenous infants are nearly 2 times more likely to die before their first birthday than white infants.¹⁴ At the same time,



MATERNAL AND INFANT HEALTH CRISIS

Black Women are **2.5X** more likely to die from pregnancy complications than white women.

Indigenous Women are **2.3X** more likely to die from pregnancy complications than white women.



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women of color continue to face disproportionate barriers to accessing health care. For example, they are more likely to lose health insurance coverage during a pregnancy and less likely to receive treatment for postpartum depression.¹⁵

Underlying these inequities is the lack of racially, ethnically, culturally and linguistically appropriate providers within our systems of care.¹⁶ While there are growing numbers of primary care child health practices that have become more family centered, preventive and developmental, and explicitly culturally and linguistically responsive and anti-racist, these are exceptions, and the transformations they make are not supported through current medical financing.¹⁷ **The health community must confront the painful histories of systemic violence to develop more effective anti-racist and benevolent public health responses to entrenched health inequalities, the COVID-19 pandemic and future pandemics. One way to do so, as this brief highlights, is to use, uplift and invest in a community health workforce.**



Carmen Madrigal (center) and Yoli Rodríguez distribute information in City Heights. (Alexandra Mendoza/U-T en Español) Credit: Alexandra Mendoza, "They are familiar with residents and neighborhoods", <https://www.sandiegouniontribune.com/news/health/story/2021-02-19/promotoras-play-important-role-in-vaccine-outreach-for-latino-communities>, February 19, 2021.

A COMMUNITY HEALTH WORKFORCE IS AN INDISPENSABLE COMPONENT OF ELIMINATING PERSISTENT HEALTH INEQUITIES.

Achieving health equity for children and their families requires our health care system to uncover, acknowledge and address systemic barriers through community-focused efforts that center and meaningfully engage people who come from communities that have been historically oppressed and excluded. Community health workers have been on the front lines of promoting the health of the communities they come from for decades. For example, promotores have promoted health among immigrant families and low-income communities who have been excluded from care.¹⁸ Community health representatives have been integral to improving health outcomes of Native American communities.¹⁹ Doulas have supported Black families in addressing the many factors – from income to the environment to nutrition to housing to language and others – that impact birth outcomes.²⁰ Peer counselors have served as life-saving mental health supports for LGBTQ+ and transgender youth.²¹ Investing in and using a community health workforce to support child and family health is an opportunity to begin to undo generations of injustice and repair the harm that continues to impact the health and well-being of historically marginalized communities. The current lack of racially and ethnically diverse providers and nurses makes this workforce even more critical.

Defining a Community Health Worker



Stephanie Dixon left, and Deundra Hundon demonstrate how the woman giving birth can be supported while in the bathroom during a birth training lesson by Bare With Me at the home of partners Heather Boxleft, and Julian Mocine-McQueen, right, in San Francisco, Calif., on Tuesday, March 12, 2019. Deundra Hundon and Stephanie Dixon are a mother-daughter doula duo, Bare With Me, who are part of a new partnership with the San Francisco Department of Public Health that aims to provide doulas to low-income Black and Pacific Islander women, who have some of the poorest maternal and infant health rates in the city. Credit: Ashley McBride, "With black babies, moms at high risk in SF, project pairs them with caregivers", <https://www.sfchronicle.com/bayarea/article/Black-babies-mothers-die-at-a-staggering-rate-in-13745368.php#photo-17182075>, April 8, 2019.

Community health workers are individuals working in the community who come from the community and have an intimate understanding of the communities they serve through shared ethnicity, culture, language or life experiences.²² According to the National Association of Community Health Workers and the American Public Health Association, "[c]ommunity health workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."²³

There are myriad terms used to describe individuals who are part of a community health workforce.

These include promotores de salud, community health workers, doulas, community health advocates, community health aides, community health representatives, barefoot doctors, peer counselors, peer specialists, peer support professionals, patient navigators, home visitors, outreach workers and relational care coordinators,²⁴ among others.²⁵

As community health workers is the umbrella term most often used to encompass a range of titles, positions and specialties, this brief uses "CHW" in reference to this wide category of a community-based workforce who protect and promote the health of their communities.

Community Health Worker Listening Sessions



OUR APPROACH: The Children's Partnership (TCP) seeks to promote equity and anti-racist values by creating avenues for people directly impacted by policy advocacy to contribute their experiences and knowledge. In the work to reform health care delivery to better advance child health equity, the use of listening sessions is an opportunity for active listening and incorporation of community needs, interests and recommendations into our advocacy.

METHODOLOGY: Recognizing the history of a community health workforce as a powerful model in improving health outcomes for children of color in California, TCP convened 10 community health workers in August 2020 for two listening sessions — one in English and one in Spanish. The vast majority of participants were women of color from Latinx and Black communities. Participants self-identified as community health workers, promotores, community health advocates, community navigators, and navegantes (navigators). Participants were asked open-ended questions about the children and families they serve, the health and well-being issues they confront and how they respond to them, the barriers they face serving their communities, and recommendations to address these barriers. What we heard in these listening sessions highlights the critical role of CHWs in supporting the health and overall well-being of children, particularly children of color.

The information and recommendations offered in this brief build upon the following overarching themes identified in the listening sessions regarding who community health workers are and the communities they come from and serve, as well as their work advancing health equity for children of color.

- ▶ **CHWs serve an incredible array of diverse and resilient populations of children and families across California.**

Participants in the listening sessions served both rural and urban areas of California, including Los Angeles County, the Inland Empire, Coachella Valley, Orange County and the Central Valley. They spoke about how they serve children and families with diverse backgrounds, including farmworkers, Black families, Latinx families, multi-generational households, youth who are the first generation of their families to be born in the United States, bilingual parents and children, Spanish speakers, Mixteco speakers, and mothers with young children — all communities that health care systems have historically failed or not served well.

- ▶ **CHWs support the physical, mental and social-emotional health of children.**

Participants highlighted helping children and youth with mental health issues and adverse childhood experiences, including low self-esteem, self-empowerment, bullying, trauma, suicide prevention and dealing with the pandemic. They also spoke about connecting children to dental and vision services. Additionally, participants help children with health issues that are exacerbated by the under-resourced, underfunded, and exploited environments they live in — including helping children with diabetes or obesity who live in food deserts access nutritious food and helping children and families who live near train tracks with asthma and related issues.



“for children to thrive, their village needs to thrive.”

- ▶ **CHWs support the adults that children rely on, building self-efficacy, confidence and health literacy.**

The participants spoke about how they help parents with issues that have a secondary impact on their children, noting how many of the children and youth they serve live in multi-generational households and that “for children to thrive, their village needs to thrive.” They spoke about how their efforts lead to self-empowerment for parents by helping them understand asthma plans and what to do when children are experiencing exacerbations, teaching parents about importance of mental health for themselves and their children, and supporting new mothers with lactation.

- ▶ **CHWs help families navigate multiple and complicated government systems including education, health care and social services.**

Social determinants of health — the conditions in which people are born, grow, live, and age and the wider set of forces and systems that shape their health and well-being — are more important than health care or individual choices in influencing health.²⁶ A key theme that emerged from the listening sessions was the ability of CHWs to empower



Malia Cohen, chair of California State Board of Education, addresses women participating in a post-partum training session with SisterWeb, a new doula partnership that trains Spanish-speaking, black and Pacific Islander women to be doulas and matches them with women in those communities, at Bayview Hunters Point Clinic in San Francisco, Calif., on Saturday, March 30, 2019. Credit: Ashley McBride, “With black babies, moms at high risk in SF, project pairs them with caregivers”, <https://www.sfchronicle.com/bayarea/article/Black-babies-mothers-die-at-a-staggering-rate-in-13745368.php#photo-17182075>, April 8, 2019.

parents and caregivers to address and improve SDOH by navigating and reforming systems that operate in silos, including public education, health care, and social services.

Participants spoke at length about how they help with the nuances of these systems, as well as the tools they need to advocate on behalf of their children. Participants spoke about the vital role they play in connecting children and families to essential services, including helping enroll children and youth into Medi-Cal and helping children, youth and families secure appointments to use their health, dental and vision benefits. Participants spoke about the range of resources they help connect children and families to that support their livelihood and well-being. This includes helping connect families to food, housing, transportation and other basic needs. It also includes connecting families to legal services, immigration and public charge resources, and access to high-speed internet and technology — particularly

since the onset of the COVID-19 pandemic. Navigating the public education system arose several times. One participant noted that schools are important because they tend to be a family’s first interaction with any type of government system. Another noted that CHWs build bridges between parents, teachers and schools by helping parents communicate about their child’s absence, complete paperwork, use school nurse services and address grievances.

- ▶ **CHWs are advocates for social justice who have a unique ability to improve the conditions in which children live, learn, grow and play.**

CHWs intimately understand the issues that community members face, both those directly related to health and those that result from social, economic, cultural or political exclusions and impact their life conditions. The participants emphasized how the families they serve face a range of challenges, including language barriers, lack of employment, lack of a living wage, food deserts, lack of transportation, lack of internet access or computers, environmental pollution, being underserved or mis-served by programs that are culturally incompetent, and being treated unfairly. With this knowledge, they engage in advocacy to address the

“We need to increase CHW presence at schools and serve as a bridge for families and children between education systems and health systems to support the long-term health, education and well-being of children.”

many non-clinical factors driven by structural inequities that shape the social determinants of health in their communities — including housing and food insecurity, underfunded public schools, economic insecurity, language barriers, and racial discrimination.²⁷ During times of crisis, CHWs act as vehicles for social justice and change as they advocate for the under-resourced communities they care for and come from.

“Much of the work of CHWs is instilling a sense of advocacy in every interaction they have with children or family members, an approach one participant has termed “trickle down advocacy.”

One participant, a promotora with *Visión y Compromiso*,²⁸ talked about the organization’s promotores model that is guided by a framework of community transformation, highlighting the role that CHWs play in improving community conditions that shape health.²⁹ Characterized by “servicio de corazón” (heartfelt service), this model extends beyond the disease-related functions of community health into social justice and health equity, whereby promotores actively challenge negative impacts resulting from inequitable distribution of power and resources in addition to institutionalized racism.³⁰ By putting into sharper focus this community transformation model by *Visión y Compromiso*, the discourse around the promotores and community health workforce at local, state and



national levels is changed, shifting from supporting a community health workforce solely dedicated to responding to community needs to one that also improves the conditions in which children live, learn and play; reduces inequities in health status; and promotes social justice.³¹

► Despite the incredible value that CHWs bring to advancing health equity and repairing the harm caused by historic oppression and racism, they face a severe lack of sustainable funding and a lack of recognition as legitimate and professional members of a health care workforce.

A primary barrier identified by participants in being able to continue their work was a lack of sustainable funding. Participants noted that red tape, rigidity around contracting, and stringent requirements and specifications at the state and county level prevent many CHWs (as well as community-based organizations (CBOs) who employ CHWs) from even applying for funding. They highlighted the need for technology and virtual platforms in the era of COVID-19, as many CHWs struggled to obtain the devices and programs necessary to shift immediately to virtual care. They also spoke about their own economic hardships and the need for increased pay. Lastly, participants

described the financial challenges of serving dispersed, rural communities, such as high transportation costs and travel time. CHWs identified the first step needed to overcome the barriers to expansion and sustainability was greater recognition of the workforce’s value. Without such recognition, many policy alternatives will fall short. Additionally, the lack of collaboration among different systems — particularly between health and education — as well as lack of collaboration within existing health provider networks was highlighted as a barrier to expansion. Participants spoke about their desire to increase CHW presence at schools and serve as a bridge for families in connecting them with school administrators and teachers to support the health, education and well-being of their children.

The findings from these listening sessions affirm that CHWs support children and families from historically marginalized communities with myriad health issues, address social determinants of health, and build advocacy capacity among both adults and children. We are grateful for the opportunity to learn from those who participated in the listening sessions and center their experiences in this brief.

Economic Justice for CHWs

As federal, state and local leaders continue to turn to CHWs to fill gaps in community-based pandemic response efforts, ensuring CHWs have the opportunity to achieve economic security now and in the future is paramount. CHWs often work in hourly positions that pay less than a living wage.³² Compared to licensed health care professionals, CHWs are paid drastically lower salaries, despite their many contributions to children, families, and communities and to the health care system itself. Additionally, there is also a high number of volunteer community health worker positions. While sustainability and employment are important, we must also recognize the important work of volunteers and strategies for moving them into full-time, paid employment. Boosting the wages of CHWs can help them overcome challenges with transportation, food security and other barriers that inhibit their ability to thrive and help others.

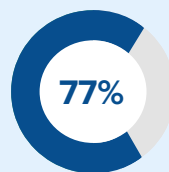
Reflecting the communities they serve, community health workers are a racially diverse workforce. One Bay Area survey found that across eight different counties, the majority of CHWs are women of color (77%), earn an annual salary of \$20,000 to \$25,000, and focus primarily on maternal and child health.³³ Ensuring that the role of a CHW is a good job where women (and men) can provide for themselves and their families while having access to a career pipeline will directly impact this growing workforce and strengthen our collective commitment to economic equity for everyone.

Additionally, beyond serving as resources to communities, community health workers are a resource to our health care delivery system. Despite not earning a living wage, several studies have demonstrated the financial value of CHWs and how such workers yield a high return on investment, reduce costs, improve quality of life and result in fewer missed school and work days. Perhaps the most illustrative examples of the impact that CHWs can have on children's health are those focused on children with asthma. In Seattle-King County's Medicaid program, CHWs performed home visits and environmental assessments for families of children with asthma. Over three years, for every \$1 invested in the CHW intervention, there was a projected \$1.86 return, including \$427,000 saved in direct medical costs, fewer school days missed and greater worker productivity (due to caregivers' decreased need to rearrange their schedules to respond to their child's asthma symptoms.)³⁴ Other similar CHW interventions have resulted in a reduction in the number of asthma-related emergency department visits and hospitalizations, increased caregiver confidence in managing their children's asthma, and improvement in the child and caregiver's quality of life.³⁵

Finally, CHWs play a unique role as community-centered researchers who, as a result of direct interaction and shared experiences with the populations they serve, can offer nuanced and granular information on the health and well-being of children and their families. Community health workers should be acknowledged for playing this dual role and be treated as health care professionals who make at least a living wage.



CHWs ARE A RACIALLY DIVERSE WORKFORCE



Majority of CHWs are women of color (77%), earn an annual salary of \$20,000 to \$25,000, and focus primarily on maternal and child health.

CHWS Propel Health Equity for Children

Building on the experiences shared during our listening sessions, this section provides specific examples of CHW initiatives in California and across the country that have a demonstrated impact or show promise in advancing health equity for Black, Latinx and Native American children. While formal engagement of CHWs around child health has been less robust than that for adults, findings from our listening sessions and research show that CHWs can play an enormously valuable role in improving the health of children, particularly children of color and/or those with low family incomes.

Disadvantage, discrimination and racism have accumulated over time in the form of systemic barriers to good health and well-being that disproportionately impact historically marginalized communities, including Black, Latinx, Native American, immigrant and LGBTQ+ communities. Children from these communities face greater threats to their health than white children, including poverty, environmental pollution, deportation, lack of affordable and stable housing,

lack of healthy food, under-resourced schools and more.³⁶ Place matters, and children of color are more likely to grow up in poor, marginalized and under-resourced communities.³⁷ It is no surprise, then, that these children also disproportionately suffer from a number of health conditions, including higher rates of elevated blood lead concentrations, asthma, obesity and dental disease.³⁸ Additionally, children from California's diverse racial and ethnic backgrounds have vastly different utilization rates of health care services.³⁹ Children in mixed status and immigrant families particularly underutilize preventive services, often due to cost, language and cultural barriers, and fear of apprehension by immigration authorities.⁴⁰

CHWs, given their background and connection to community, have a unique role to play in strengthening child well-being. Any effort that aims to effectively dismantle racism must reject all forms of marginalization and exclusion, ensuring that future generations grow up with the kinds of opportunity and support that are essential to success. When children

are learning who they are and how the world treats them and their families, they require attention in learning tolerance, inclusion, civic engagement and respect for the rights of others. CHWs play a critical role in modeling such a response and, when supported by the institutions in which they are placed, create more culturally and linguistically responsive environments overall.⁴¹

Further, the integration of CHWs into care for children can play a valuable role in supporting child health in a variety of areas, including improving maternal and newborn health,⁴² increasing the number of children who receive timely vaccinations,⁴³ increasing the number of children whose parents seek care for them when they are sick,⁴⁴ and reducing child morbidity and mortality,⁴⁵ among other benefits. If we are to transform our health care system into one that truly responds to children and their unique needs, particularly children from marginalized backgrounds, we must fully integrate CHWs into that system, leveraging their unique abilities for both adults *and* children.





COVID-19 Response and Recovery

The COVID-19 pandemic has disproportionately harmed low-income communities of color in California, increasing barriers to accessing care and widening health inequities for children of color. Among children, Latinx, Black, Native American and Pacific Islander children make up nearly 70% of cases, despite making up slightly over 50% of the state’s population of children.⁴⁶ Further, California’s immigrant communities have been devastated by the pandemic. Not only are they are excluded from federal relief, but they disproportionately experience high rates of job loss as well as risk exposure to COVID-19 by working on the frontlines: 1 in 3 undocumented workers in California is employed in an industry negatively affected by the COVID-19 economic shutdown while also making up about 33% of the state’s essential workforce.⁴⁷

CHWs are key to fighting the COVID-19 pandemic in California for BIPOC and immigrant children who are facing the most devastating consequences from the pandemic. There are numerous ways CHWs have engaged in pandemic recovery through partnerships with county public health departments. As noted above, given the value of CHWs as trusted messengers in the community, they have worked to ease fears, resolve questions and help increase acceptability of public health



Credit: Maria Ramos Pacheco, "El Paso promotoras provide COVID-19, vaccine information to underserved and vulnerable populations", <https://elpasomatters.org/2021/02/19/el-paso-promotoras-provide-covid-19-vaccine-information-to-underserved-and-vulnerable-populations/>, February 19, 2021.

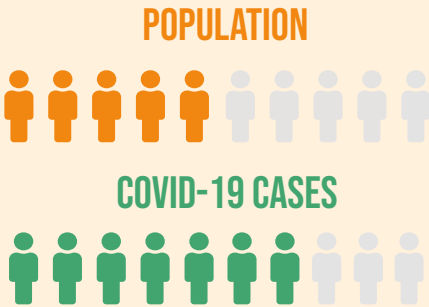
interventions. Promotores from El Sol Neighborhood Educational Center in San Bernardino, for example, engage in a variety of activities related to COVID-19 outreach and education. They provide information about COVID-19 testing and conduct direct testing to community members. They identify hot spots to target interventions, as well as provide education on vaccination distribution phases, help community members with scheduling vaccines, and organize strategic booths for vaccinating hard-to-reach areas and populations. They also help with social and mental supports, food and housing insecurity, distance learning, and other resources and services that support family needs.⁴⁸



A Whole Child Approach

A “whole child” approach considers both the child’s physical health and mental health and the social and economic conditions that shape a child’s development. These conditions include access to safe and stable housing, food, early education opportunities, and economic supports. They also include systemic racism and inequity, immigration concerns, and exposure to adverse childhood experiences (e.g., child abuse, separation or death of a caregiver). The focus of the whole child approach is on prevention and promotion, including universal screening to identify and connect children and their families to services — including preventive behavioral health services — to address concerns before major issues and challenges develop. Multiple surveys that The Children’s Partnership has distributed to families across the state in 2020 and 2021 with partners including Parent Institute for Quality Education and the Education Trust West highlight the myriad struggles that families continue to face, including food and housing insecurity, eviction, lack of broadband access, lack of

LATINX, BLACK, NATIVE AMERICAN, AND PACIFIC ISLANDER CHILDREN





child care, and lack of mental health and health supports.⁴⁹

In partnership with the East Bay Community Law Center in Berkeley, Project DULCE is an example of a whole child approach. The DULCE model adds a community health worker — a family specialist — to a child's pediatric care team. The specialist's role is to support families and connect them to legal consultation, helping many immigrant families navigate the complex and ever-changing immigration landscape. Specialists also provide resources that support healthy child development, especially during the first six months of a child's life. The DULCE Family Specialist meets with families at an infant's routine health care visits and provides home visits as well as telephone, email and text-messaging support.⁵⁰

In addition, CHWs support a family's ability to offer a positive environment for their children. Most working families need child care to keep their jobs and, for low-income parents, affordable care can mean the difference between emerging from, or remaining in, poverty. For many families, family, friend and neighbor (FFN) caregivers are their first teacher — caregivers whose role in the family and community has increased with the current pandemic. In 2017, Visión y Compromiso created the Family Caregivers Project to ensure that FFN caregivers have the skills and resources they need to support

children's health and cognitive and social-emotional development at every stage of life. Today, Visión y Compromiso is training promotores to deliver the 60-hour FFN training and parent engagement workshops in urban and rural communities across California.⁵¹ A stable FFN workforce is critical to essential workers and efforts to rebuild the economy, and it helps implement a whole child commitment for California families.



Environmental Exposure

The burden of chronic disease due to environmental exposures disproportionately falls on low-income

ENVIRONMENTAL EXPOSURE AND CHILDREN OF COLOR



1 IN 4 BLACK CHILDREN has been diagnosed with asthma.



LATINX CHILDREN MAKE UP 4 IN 5 CHILDREN living in California census tracts impacted by the highest environmental pollution burdens that cause and exacerbate asthma episodes.



BLACK CHILDREN ARE NEARLY 3X MORE LIKELY THAN WHITE CHILDREN to have elevated blood lead levels.

children and children of color. In California, nearly 1 in 4 (18%) Black children has been diagnosed with asthma.⁵² Nationally, Black children have a mortality rate from asthma that is eight times higher than white children.⁵³ Latinx children make up 4 in 5 children living in California census tracts impacted by the highest environmental pollution burdens that cause and exacerbate asthma episodes.⁵⁴ Children of color are also at a higher risk of lead poisoning. Across the United States, Black children are nearly three times more likely than white children to have elevated blood lead levels.⁵⁵ The following examples highlight CHW initiatives that address these inequities.

Asthma: St. John's Well Child and Family Center in South Los Angeles, in partnership with Strategic Actions for

a Just Economy, integrates CHWs into their patient- and family-centered care teams and deploys CHWs to conduct in-home education, prevention and case management. They identify and ameliorate housing-related asthma hazards such as mold, lead paint chips, dust mites, leaky pipes, rodents, cockroaches and other asthma triggers; increase caregiver knowledge to reduce excessive asthma-related emergency room visits and hospitalizations; and promote tenants' rights, advancing better housing conditions necessary to improve asthma control and sustain health.⁵⁶

Lead poisoning: In South Los Angeles, Esperanza Community Housing partnered with promotores to address the impacts of environmental pollution on the health of children and their families — the Healthy Homes model.⁵⁷ Promotores went door-to-door, building relationships with families, providing information and resources about the hazards of lead paint, and listening to families' concerns and priorities. During this outreach, promotores learned that most children had never been tested for lead, and, if they had been tested, they were often misled about the test results.⁵⁸ In response, promotores developed a policy campaign addressing lead testing and improving community conditions that resulted in changing lead testing policy at St. John's Well Child Clinic, decreased local lead poisoning, improved housing conditions, successful litigation against slumlords, and improved asthma management for children and adults in South LA.⁵⁹

In Flint, Michigan, CHWs were deployed to help families handle the toxic water crisis. The Crim Fitness Foundation Community Education Initiative School-Based Program, in partnership with the Genesee Health Plan and the Charles Stewart Mott Foundation, placed CHWs in each of the 11 Flint Community Schools. CHWs conducted health assessments; educated students, parents, caregivers, and neighborhood residents about health issues related to the

MATERNAL AND INFANT MORTALITY

Black Women

White Women

BLACK WOMEN ARE 4X MORE LIKELY than non-Latinx white women to die from complications of pregnancy and birth.

Black Infants

Multiracial Infants

Indigenous Infants

White Infants

BLACK INFANTS ARE 3X MORE LIKELY to die than white infants, regardless of the mother's education and income.

MULTIRACIAL INFANTS ARE NEARLY 3X MORE LIKELY, and **NATIVE AMERICAN INFANTS ARE NEARLY 2X AS LIKELY** to die compared to white infants.

contaminated water; provided resources and referral services; and helped children and families who were uninsured enroll in health care coverage and find a primary care physician.⁶⁰

and income.⁶² Multiracial infants are nearly three times more likely, and Native American infants are nearly twice as likely to die compared to white infants.⁶³ The following examples highlight CHW initiatives that can address these inequities.

Maternal/Infant Health and Early Childhood Development

The rates of maternal and infant mortality in California are at crisis levels for Black, multiracial, and Native American families. Black women are four times more likely than non-Latinx white women to die from complications of pregnancy and birth.⁶¹ Black infants experience the highest rates of mortality. California's Black infants are three times more likely to die than white infants, regardless of the mother's education

Doulas: There are numerous examples of the powerful work of community doulas to address alarming inequities in birth outcomes among women of color in California. In San Francisco, former San Francisco Supervisor Malia Cohen launched a landmark partnership between community-based doula organization SisterWeb and Expecting Justice, a San Francisco Department of Public Health birth equity initiative. SisterWeb provides pregnant Black, Latinx and Pacific Islander people who reside in the city of San Francisco with community doulas who offer culturally concordant peer-to-peer support that focuses on the perinatal year and the





early months of parenting, a sensitive period in which families have a unique openness to change, learning and growth. Another example is the Los Angeles County Black Infant and Families program, which provides access to Black doula care to decrease mortality rates impacting Black women at all socioeconomic levels.⁶⁴ The doulas provide emotional support, physical comfort, education and advocacy to women during pregnancy, childbirth and the newborn period.⁶⁵ The recently launched Frontline Doulas initiative led by Black Women Birthing Justice and Diversity Uplifts, Inc. similarly is providing Black families in LA County with support and services from Black community doulas at no cost to families, including physical, emotional, informational, psychosocial and advocacy support during the pregnancy, childbirth and postpartum period. These community doulas come from the communities they serve and support clients in navigating institutionalized racism and cultural incompetence within the medical setting.⁶⁶

Black Infant Health Program: As part of California's Black Infant Health Program, family health advocates in the Department of Public Health provide 10 prenatal and postpartum sessions to Black women in 13 counties, where over 90% of Black babies are born. Federally funded, this program aims to address the inequities in birth outcomes among Black mothers and babies through an evidence-based model rooted in Black cultural heritage and empowerment.⁶⁷ The program includes empowerment-

focused group support services and client-centered life planning to improve the health and social conditions for Black women and their families.⁶⁸

Childhood development: The Family Spirit Program is a culturally tailored home-visiting intervention delivered by tribal and Native CHWs (known as community health representatives, or CHRs) in Arizona to support young Native families who have infants and children ages 0 to 3 years old. CHRs help parents gain the knowledge and skills to promote healthy development of their preschool-aged children; address maternal psychosocial risks such as drug and alcohol use, depression, education, employment and domestic violence; and ensure children get recommended well-child visits and health care. Studies have shown that the program has increased maternal knowledge and parent self-efficacy; decreased maternal depression, substance use and behavioral issues; and resulted in fewer behavior problems in children through age 3 (which predicts lower risk of substance use and behavioral health problems over the life course).⁶⁹

likely to have tooth decay and suffer the consequences of untreated disease.⁷⁰ Additionally, the 2019 California Health Interview Survey revealed that statewide, nearly 1 in 5 Black children in California needed dental care in the past year but did not get it, compared to 1 in 14 across all children.⁷¹ The five million children enrolled in Medi-Cal, over 75% of whom are children of color, also face the additional hurdle of finding dental providers that accept Medi-Cal coverage.

One approach to addressing oral health inequities is providing care through a community-based workforce. Led by First 5 Riverside and First 5 San Bernardino, the Early Childhood Oral Health Assessment (ECOHA) electronic mobile application (app) was developed to increase Medi-Cal-enrolled children's use of preventive, risk-based and continuous dental care through an innovative community-based pilot project.⁷² ECOHA was designed to be used by the community-based workforce to address the oral health needs of young children, particularly low-income children of color. The pilot equipped CHWs with the tools and support they needed to develop relationships with families and work with them to address their children's oral health needs through the use of a specially developed app and supporting activities, including education and care coordination.⁷³ As a result, the ECOHA pilot reached nearly

Oral Health

Early childhood caries — or tooth decay — remains the most common chronic disease among children in the United States, despite being preventable.⁶⁶ Data continues to show profound racial inequities when it comes to tooth decay and the ability to access care: In California, children of color are much more

CHILDREN IN CA WHO NEEDED DENTAL CARE BUT DIDN'T GET IT

BLACK CHILDREN



ALL CHILDREN



10,000 families with the assessment, oral health education, and connections to dental care and other support services.⁷⁴

Another example from an agricultural city in northern California is the Contra Caries Oral Health Education Program, which used CHWs to improve the oral health knowledge of low-income, Spanish-speaking parents and the oral-health-related behaviors — such as toothbrushing — of their young children. Using interactive classes designed for and by Spanish speakers and led by promotores, parents learned about children's oral hygiene, caries causes, strong dental habits (e.g., toothbrushing with fluoride toothpaste, flossing), nutrition (e.g., reducing sugar intake, snacking and bottle use), and parent skill-building activities (e.g., how to initiate and what to expect during dental visits).⁷⁵



assistance work, fear and mistrust of government officials, and the time required to complete the enrollment process. California-based AltaMed, the largest community health center network in the nation, employs community health workers to enroll children and families in coverage. AltaMed enrolled more patients in Medi-Cal and Covered California than any other certified entity in California. As families try to understand the risks of applying for coverage and whether their information will be shared, having a trusted enrollment assister explain the current law protecting their privacy and its implications can make the difference in whether a child is enrolled. Another study showed the CHWs are significantly more effective in obtaining health insurance for uninsured Latino children than traditional Medicaid and CHIP outreach and enrollment. Children with CHW support obtained their health insurance faster, were significantly more likely to be continuously insured, and had parents who were much more satisfied with the process of obtaining coverage for their children.⁷⁹

mental health outcomes and access to high-quality, culturally competent mental health supports persist for children from marginalized communities. Data from the 2019 California Health Interview Survey found that over half (61% or ~38,000) of Black teen girls said they needed help for emotional/mental health problems like feeling sad, anxious, or nervous, compared to 45% of all teen girls and 32% of all teens.⁸⁰ Yet, 88% (~145,000) of Black teens did not receive counseling in the last year, including at least 42,000 Black teen girls and at least 103,000 Black teen boys.⁸¹ Latina youth are also facing a mental health crisis. Data from the 2019 California Youth Risk Behavior Survey found that over 1 in 3 Latina youth has considered suicide and nearly 1 in 7 Latina youth has attempted suicide.⁸² For lesbian, bisexual and queer Latina youth, the reality is even worse: Nearly half have considered suicide, and 1 in 3 lesbian, bisexual and queer Latina youth attempted suicide.⁸³ Other statewide California surveys have found that LGBTQ+ youth are 3 times more likely than non-LGBTQ+ youth to report contemplating suicide.⁸⁴

The COVID-19 pandemic has exacerbated these inequities and the mental health crises impacting BIPOC children. The ensuing school closures, social isolation and dramatically reduced access to services and care, combined with the overall threat of the virus and the collective and individual grief over loved ones who died from COVID19, have produced alarming mental health



Health Coverage

While California has made great strides in reducing the number of uninsured children, the work to improve the health and well-being of the state's children is far from over. The uninsured rate for California's children has stagnated at 3.1%, meaning about 300,000 children remain without health insurance, many of whom qualify for Medi-Cal or subsidized coverage through Covered California.⁷⁶ In fact, more than 150,000 California children dropped out of Medi-Cal in 2018, a trend some attribute to the Trump administration's anti-immigrant policies and efforts to overturn the Affordable Care Act.⁷⁷ In 2019, nearly 12,000 Black children and 214,000 Latinx children in California remained uninsured.⁷⁸

CHWs can help children and families overcome many common obstacles to health insurance enrollment — such as language barriers, lack of familiarity with how insurance and financial



Mental Health

Despite the enormous toll that mental health problems take on the well-being of youth and families, disparities in

MENTAL HEALTH AND BIPOC YOUTH



1 IN 3

Latina youth has considered suicide.



NEARLY HALF

of lesbian, bisexual and queer Latina youth have considered suicide

TEENS WHO NEEDED HELP FOR MENTAL HEALTH ISSUES



61% OF BLACK TEEN GIRLS



45% OF ALL TEEN GIRLS

3X

LGBTQ+ youth are more likely than non-LGBTQ+ youth to report contemplating suicide



88%

of Black teens did not receive counseling in the last year.

trends for young people. **California has experienced one of the greatest declines in children's mental health services during the pandemic, accelerating a decline in children's mental health care since 2016, putting California 48th in the nation in children with an unmet mental health need (30%) compared to a national best of only 5% in 2018.**⁸⁵

Many characteristics of CHWs make them ideal to improve the mental health of marginalized communities, including young people. In addition to their value to physical health care teams, CHWs offer the mental health system multiple attributes that align with the critical care offered by peer support specialists. Peer support — offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations — has been particularly useful in the context of providing services to young adults with significant mental health challenges because existing services and systems do not adequately attract, engage or serve young people.⁸⁶ Similarly, CHWs offer a relationship with the community, familiarity with the language and culture of the people they serve, and expertise working with families and individuals in community settings.⁸⁷

Promotores are skilled at building trusting relationships and expert at meeting communities where they are. Visión y Compromiso's team of promotores in Riverside County includes trained mental health educators.

Working primarily in the desert and Coachella Valley regions, promotores deliver presentations on mental health topics, facilitate support groups, and use a peer-to-peer approach to provide an integrated understanding of the mental health system, increase access to resources, and reduce stigma associated with service utilization. Since the pandemic began, many people are grieving the loss of family members and experiencing high levels of depression, stress, anxiety, domestic violence and isolation. To address mental health issues related to COVID-19, Visión y Compromiso created The Pláticas Project, training 12 promotores to lead eight-week emotional support pláticas (conversation groups) on Zoom. Using weekly topics and key points, facilitators guide conversations related to the physical, emotional, social, economic and educational impacts of COVID-19 on families.

Promotores are also used directly in schools and have helped to address chronic absenteeism and its connection to mental health concerns for students. Through the Promotores Academy, founded in 2011 by a partnership between El Sol Neighborhood Educational Center and the Institute for Community Partnerships at Loma Linda University,⁸⁸ CHWs complete a community health and education worker specialty training. Cohorts have been hired to work with San Bernardino City Unified School District to address chronic absenteeism, working with over 1,000 families and students.

CHWs work to provide these families and students with resources through home visitations as well as support in decreasing school absences and increasing participation and attendance in the district's Family Engagement Centers. They also assist with tutoring, mentoring, psychoeducation, informal counseling, resource-giving and many other activities.

The examples above show the strong evidence base for employing CHWs to address a variety of specific child health needs — environmental exposure, maternal/infant health and early childhood development, oral health, enrollment assistance, and mental health. For each, CHWs are effective — often more so than other professional specialists — because they establish trust and support those they serve, taking a whole child approach. Because they start where children and families are, CHWs are more comprehensive in their approach to care, despite their funding source. For example, CHWs may be working with families to address a child's asthma, but given their proximity to the family's needs, may find themselves responding to a related issue, such as the presence of lead paint. CHWs also make linkages around other child development and support issues. While the programs described above are notable for their demonstrated impact, the CHW workforce as a whole must be supported in ways that enable their responsiveness to both child and family needs and hopes.

Policy Landscape: An Opportunity for California



Dr. Mark Ghaly, Secretary, California Health and Human Services Agency (Photo: José Luis Villegas) Credit: Xenia Shih Bion, "Newsom Names Pediatrician as California HHS Secretary", <https://www.chcf.org/blog/newsom-names-pediatrician-california-hhs-secretary/>, March 15, 2019

Governor Newsom has made investing in children and strengthening the health care workforce a priority.⁸⁹ While the COVID-19 pandemic and resulting economic recession originally delayed the implementation of some of the governor's proposed investments, there is renewed energy for how the state can build back from the pandemic as a result of federal actions and better economic projections.

► **Now, California has an opportunity to leverage lessons learned from CHW programs — both prior to the pandemic and during — and become a national leader in integrating them into the state's health care workforce that serves children and families.**

The integration of CHWs into services provided to children and families enrolled in Medi-Cal, over 75% of

whom are Black, Latinx, Asian or American Indian/Alaska Native,⁹⁰ offers an opportunity to respond to the specific needs of diverse communities and move Medi-Cal toward equity. Prior to the pandemic, access to and utilization of preventive services by children in Medi-Cal was alarmingly low. A 2019 state audit of the Medi-Cal program revealed that the utilization rate of preventive services by Medi-Cal children has been consistently below 50%.⁹¹ Another state audit in 2019 found that 73% of eligible young children did not receive required tests for elevated lead levels in blood, despite a state law requirement.⁹² Children in mixed status and immigrant families particularly underutilize preventive services (such as prenatal care, dental care and immunizations), often due to cost, language and cultural barriers, and fear of apprehension by immigration authorities.⁹³ Additionally, the National Survey of Children's Health shows that few

children truly have a medical home that offers comprehensive care, including preventive services. This is particularly true for children who need such care most, such as those with special health care needs. The American Academy of Pediatrics (AAP) has established principles for medical homes that stress partnering with families and responding to social as well as medical health conditions.⁹⁴ The AAP also has set standards for well-child care (such as recommended screenings) through its program Bright Futures.⁹⁵ Both efforts can and should be advanced by the incorporation of CHWs or other allied health practitioners into primary care practice to ensure partnering with families and responding to social determinants of health. As highlighted in the examples in the previous section, CHWs can address these issues and more, offering California a path forward in supporting access to critical services for many of our most marginalized children.

Reflecting this opportunity, in his May 2021 revision of the state's budget, Governor Newsom has proposed to add CHWs and doulas to the class of skilled individuals who are able to provide Medi-Cal-covered benefits and services. The revision includes an investment of \$403,000 (\$152,000 general fund) in 2021-22 and \$4.4 million (\$1.7 million general fund) annually at full implementation to add doula services as a covered benefit effective January 1, 2022. It also includes a \$16.3 million investment (\$6.2 million general fund) in FY 2021-22, increasing to \$201 million (\$76 million general fund) by 2026-27, to add CHWs as a covered benefit in the Medi-Cal program, effective January 1, 2022.⁹⁶ As of the publishing of this brief, there has

been no detail released on the scope of services that CHWs would provide under the proposal, or whether their services would be available to all Medi-Cal beneficiaries, including all children. The budget must be passed by the legislature by June 15, 2021.

Additionally, California policymakers can establish children as a priority population as they leverage federal funding coming to California under the American Rescue Plan Act and future infrastructure legislation that supports developing a community health workforce. There is new federal funding under the American Rescue Plan Act for community health workers and for expanded community health services and preventive and developmental health services in underserved communities.⁹⁷ While this funding is likely to be made available through various federal agencies (including the Centers for Disease Control and Prevention and the Health Resources and Services Administration) and mechanisms (increases in block grants or new grants and notices of funding opportunity), they all can contribute to developing a broader and deeper community health workforce. California can serve as a national leader by ensuring integration into other activities at the state and community level for such workforce development and elevating children as a priority population. The greatest long-term gains from a robust community health workforce will be in improving the health trajectories and reducing the health disparities of the child population, but this requires intentional efforts to focus significant attention on children and their families (not solely on adults with disabilities and seniors with significant health problems).

Now is the time to look to how California has implemented this model for adults and ensure it is equity-centered, sustainable and available for children as well as adults. California policymakers have multiple

levers they can use to work toward an equitable, advanced child health system. It is especially important to identify long-term and sustainable financing of CHWs that is not dependent on applying for program or project grants or contracts, both in California and nationwide.

► **Policy mechanisms that states can use to secure federal Medicaid financing for coverage of CHW services include:**

- 1 federal waivers,
- 2 state plan amendments,
- 3 managed care contracts, and
- 4 administrative expenditures in Medicaid managed care.

1 Federal Waivers



The 1115 waiver is commonly used by states to test new delivery and payment mechanisms during a temporary (but renewable) demonstration period of 3-5 years.⁹⁸ A number of states have pursued a Section 1115 waiver as a pathway to secure Medicaid funding for CHWs. States have a significant amount of flexibility in what they can do through this option.⁹⁹ In Massachusetts, CHWs are reimbursed under a 1115 waiver that focuses on addressing pediatric asthma.¹⁰⁰ As part of this waiver, CHWs conduct home visits, where they help address challenges to medication adherence, identify environmental asthma triggers, and assist in advocating with landlords to address those triggers.¹⁰¹ Oregon also implemented a Section 1115 waiver that established community care organizations (CCOs) and requires that beneficiaries in CCOs have access to CHWs, including health navigators, peer wellness specialists and peer support specialists.¹⁰²

CalAIM

The California Advancing and Innovating Medi-Cal (CalAIM) proposal is a set of reforms to expand, transform and streamline Medi-Cal service delivery and financing. CalAIM seeks to build upon the lessons learned from Medi-Cal 2020, California's previous Section 1115 Medicaid waiver, and "leverage Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population."¹⁰³ CalAIM implementation was originally scheduled to begin in January 2021 but was delayed due to the impact of COVID-19. As a result, the Department of Health Care Services is proposing a new CalAIM start date of January 1, 2022.¹⁰⁴

Whole Person Care

CalAIM believes that by partnering with community-based organizations and community health workers, managed care is uniquely positioned to effectively and efficiently manage not only the basic health care needs of Medi-Cal beneficiaries, but also many of their broader social support needs as well. Known as Whole Person Care (WPC), for the past five years these pilots have illustrated the utility and impact of CHWs for adults. Created as part of the state's previous 1115 waiver (Medi-Cal 2020), WPC programs are designed to address not just physical and behavioral health but social needs of Medi-Cal beneficiaries as well. The pilots target particularly vulnerable Medi-Cal beneficiaries, such as individuals who are homeless, experiencing mental health issues or substance abuse disorder, have multiple chronic conditions, or are high utilizers of emergency departments. The pilots encourage the coordination of counties, cities, Medi-Cal Managed



Care Plans, providers, community-based organizations, and hospitals to treat the whole person. Notably, many of the WPC pilots integrate CHWs into their workforce to improve outreach and provide care coordination services.¹⁰⁵ Within the WPC program, there is an elevated role of CHWs for adult beneficiaries with multi-faceted needs, which presents a unique opportunity to expand the Whole Person Care program to include children.

Whole Child Care

The CalAIM proposal also incorporates the Whole Child Model.¹⁰⁶ The Whole Child Model is an organized delivery system that provides comprehensive, coordinated services for children and youth with special health care needs through enhanced partnerships with Medi-Cal managed care health plans.¹⁰⁷ The Whole Child Model eliminates a bifurcated system whereby children with conditions eligible for California Children's Services (CCS) receive their health services in two (or more) separate systems that do not always coordinate or communicate effectively.¹⁰⁸ Instead, health plans coordinate the child's full scope of health care needs, inclusive of primary

preventive care, specialty health, mental health, education and training, rather than multiple entities handling these efforts separately.¹⁰⁹ Since this model does not include explicit care coordination in partnership with community-based organizations and community health workers, is only available for children with CCS-eligible conditions, and does not address needs around social determinants, the Whole Child Model also presents a unique opportunity to explicitly incorporate CHWs and CBOs into the coordination of care and addressing of a child's needs across social determinants of health.



2 State Plan Amendments

States submit state plan amendments (SPAs) to the Centers for Medicare & Medicaid Services (CMS) to request permissible program changes, make corrections, or update their Medicaid state plan with new information.¹¹⁰ Unlike a 1115 waiver, an SPA, if approved, results in a permanent change in the state program. States have often tested a reform under a waiver and subsequently made it permanent through an SPA.¹¹¹ State

plan amendments are one pathway to securing Medicaid financing for coverage of CHW services provided by community-based organizations, health plans, hospitals and clinics.

Prior to the passage of the Affordable Care Act (ACA), CHW programs were primarily funded by community health centers, community-based organizations, hospitals and/or health systems through their own budgets or through grants.¹¹² However, the ACA included provisions that created incentives to enhance CHWs' role in the health care system, including Section 2713, which requires private and Medicaid health plans to cover a range of preventive services without cost-sharing (such as co-payments, deductibles or co-insurance).¹¹³ In 2014, CMS opened up payment opportunities for preventive services by allowing non-licensed practitioners, such as CHWs, to provide the services as long as the services are recommended by a physician or other licensed practitioner.¹¹⁴ Services eligible for reimbursement under this policy must involve direct patient care and primarily address an individual's health. They could also include things like preventive health counseling or investigating the source of a child's elevated lead levels.¹¹⁵ However, this policy is narrow in scope and excludes community-centered efforts such as outreach to increase enrollment in health coverage, food access or housing assistance, or addressing the underlying causes of lead in a child's environment.¹¹⁶ To take up this option to finance preventive services provided by CHWs, a state would need to submit an SPA,¹¹⁷ and so far no state has done so.¹¹⁸ In California, advocates tried to get the state to issue an SPA through SB 207 (Hurtado) to pay for Asthma Preventive Services by CHWs. While the legislation was not successful, advocates were able to secure \$15 million from the state for a pilot project.

States could also submit an SPA to cover CHW-provided services to

children beyond those focused solely on preventative care; however, there is not clear guidance from CMS on what the limits of this model might be regarding reimbursement for those services.¹¹⁹ At least four states have been successful in submitting SPAs for federal Medicaid reimbursement for other kinds of CHW services including health education, maternal and infant care, and care coordination. Nearly 15 years ago, before the ACA, Minnesota passed a statute authorizing CHW patient education and care coordination payment under Medicaid.¹²⁰ The state then submitted and received approval from CMS for an SPA that provides federal reimbursement for health education and care coordination that CHWs provide related to a person's mental health condition.¹²¹ In July 2017, Oregon received federal approval for its SPA for doula services, including emotional and physical support, provided during pregnancy, labor, birth and the postpartum period.¹²² In November 2018, Indiana also received federal approval for an SPA for reimbursement

of CHW services.¹²³ Finally, in June 2019, South Dakota received approval for an SPA for a number of CHW services including health system navigation and coordination, health promotion and health education. Examples of the many services that CHWs can provide in South Dakota under these categories include helping a patient arrange transportation to a medical appointment, attending an appointment with the recipient for a covered medical service, and providing pregnancy and infant care education, among others.¹²⁴

Historically, states have submitted SPAs for coverage of CHWs who work in clinics, hospitals and health plans. However, most of the community health workforce in California is engaged with CBOs who partner with clinics, hospitals and health plans. As a result, in order to meaningfully advance an equity-centered approach in Medi-Cal, CBOs must be included in any efforts to secure Medicaid coverage for CHW services.



3 Managed Care Contacts

Another pathway states have taken to secure

financing for CHWs is through managed care contracts between states and managed care plans. Because 90% of children enrolled in Medi-Cal receive services through managed care, this may be a viable option for California.¹²⁵ For example, through the language of its managed care contract, Michigan required its managed care plans to “support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience.”¹²⁶ Michigan’s contract also requires managed care plans to provide a minimum ratio of CHWs to beneficiaries of at least one full-time CHW per 5,000 enrollees and provides an additional incentive for the plans to contract with a clinic or community-based organization for CHW services.¹²⁷

Identifying specific contract language and appropriate incentives and accountability for managed care plans will enable managed care plans to make additional investments in CHWs that may have high long-term returns on investment but will not yield medical savings within a plan’s contractual period. While most state Medicaid contracts are limited currently in their focus upon children, attention to the child population is changing, and there are opportunities to draw from other states in developing specific contractual language.¹²⁸ This could include requiring additional per-member, per-month payments for care coordination or targeted case management designed specifically for CHWs or providing incentives



Promotora Virginia Dorantes explains to Gloria Alonso where to call for assistance for transportation to medical appointments. (Maria Ramos Pacheco/El Paso Matters) Credit: Maria Ramos Pacheco, “El Paso promotoras provide COVID-19, vaccine information to underserved and vulnerable populations,” <https://elpasomatters.org/2021/02/19/el-paso-promotoras-provide-covid-19-vaccine-information-to-underserved-and-vulnerable-populations/>, February 19, 2021.



to expand preventive services that incorporate CHWs. Additionally, where CHWs are supported by public funding, including through First Five, and could qualify as a service under Medi-Cal, there may be opportunities to leverage those public funds to draw down federal Medicaid funds to expand the reach of those CHWs. Managed care plans may be able to provide the management and technical expertise to do so, if this is part of their contractual expectations and reimbursement is available.

Medi-Cal Managed Care Reprocurement

The Department of Health Care Services (DHCS) is in the midst of a major reprocurement for Medi-Cal managed care plans (MCPs), the first such effort in over a decade. On September 1, 2020, the DHCS released a request for information (RFI) to solicit feedback and information from interested parties regarding the Medi-Cal Managed Care Plan (MCP) contract language and the upcoming Medi-Cal Managed Care Plan Request for Proposal (RFP). The final RFP is expected to be released in Summer 2021, and the reprocurement will impact millions of Medi-Cal

beneficiaries — including the 41% of all Medi-Cal beneficiaries who are children — by modifying the terms under which Medi-Cal MCPs serve beneficiaries.¹²⁹ Health plans are slated to submit their bids by mid-2021, and DHCS will make its decisions on which plans will serve the California market in December 2021, for an effective contract date of 2024.

DHCS MCP procurement goals include, among others, improved children's services, coordinated/integrated care, and reducing health disparities.¹³⁰ As part of the RFI, DHCS specifically requested public feedback on MCP contract changes and recommendations that address health disparities and inequities, as well as identify and address social determinants of health and increase MCP's community engagement.¹³¹ The Children's Partnership, along with our partners, submitted numerous recommendations around these topics that can advance child health equity, including, for example, requiring MCPs to make community health workers available to children and their caregivers by establishing a minimum ratio of CHWs to enrolled children and establishing a list of services that CHWs can provide.¹³²



4 Administrative Expenditures in Medicaid Managed Care

A fourth strategy that can be used by state Medicaid offices and health plans in securing sustainable and long-term coverage of CHW services are Medicaid administrative expenditures. Through this payment model, health plans with Medicaid contracts either directly employ CHWs or pay other CBOs for CHW services and treat these as administrative expenditures for services that are not approved as “medically necessary” but are essential to support the overall health and well-being of Medicaid patients.¹³³

With opportunities on the horizon through federal financing, CalAIM, and Medi-Cal Reprocurement, as well as renewed energy through the May revision of the budget, the time is ripe for California to integrate CHWs into pediatric care. California has an opportunity to confront the systemic health inequities that children and families face and lift up the workforce that has the deep understanding of their communities' needs.

Policy Recommendations



If promotoras run out of flyers, they tell people to take photos of the information with their phone. (Maria Ramos Pacheco/El Paso Matters) Credit: Maria Ramos Pacheco, "El Paso promotoras provide COVID-19, vaccine information to underserved and vulnerable populations," <https://elpasomatters.org/2021/02/19/el-paso-promotoras-provide-covid-19-vaccine-information-to-underserved-and-vulnerable-populations/>, February 19, 2021.

RECOMMENDATION 1



Center the voices of community health workers in health equity initiatives and design of the profession.

Policymakers at the state and local level, including our state's legislature, the Department of Health Care Services, the Department of Public Health, county departments of public health, and health plans, must ensure that community health workers play a leading role in guiding health equity initiatives and determining the future of the CHW model in California. Any discussions of the profession's future in California must be led by CHWs. In order to elevate the CHW profession, we must build the CHW pipeline and focus on its development, similar to how we focus on other health professions. Formally building the

pipeline for CHWs is critical to lending credibility to their role in the health care system and to ensuring there is a workforce sufficient to fill the vast gaps in the system.

Additionally, policymakers must consider CHW payment models that do not create barriers to entry or exclude communities of color and immigrants through, for example, academic-based certification or licensure requirements, as these communities have led CHW work throughout history and should be able to continue participating in and leading the field. Credentialing and certification programs are often implemented by a department of health or department of public health, or a board of nursing or other third-party entity.¹³⁴ Although some states have adopted CHW credentialing and certification legislation, it is not required by CMS for reimbursement purposes.¹³⁵ Currently, there are no legal requirements or an approval process for CHW credentialing and

certification in California.¹³⁶ In 2020, California passed legislation (SB 803) creating a state certification process for peer support specialists, finding that peer support specialists reduce hospitalizations and hospital days, improve client functioning, increase client satisfaction, reduce family concerns, alleviate clinical symptoms, and increase client self-advocacy.¹³⁷ As the process moves forward, peers are at the table. Any certification and/or licensure requirements implemented as part of new payment models should identify how historically marginalized communities, including BIPOC and immigrants, will be meaningfully engaged in their development. CHWs should be viewed as skilled and valued workers, and California must build a system that ensures they can perform their important roles. However, this requires recognizing their lived experience and ties to the community as foundational in their development.

RECOMMENDATION 2



Create a sustainable payment model for community health workers that provides services to all children and families and prioritizes funding for partnerships with CBOs.

Sustainable funding is a major barrier to increasing access to CHWs for children and families. California must look to Medicaid reimbursement mechanisms to leverage opportunities to increase access to CHWs for children through policy mechanisms that include federal waivers, state plan amendments (SPAs), contractual expectations in managed care plans, and administrative expenditures in Medicaid managed care. Described in more detail in the policy landscape section of this brief, other states have found success in pursuing these pathways to secure Medicaid reimbursement for CHW services. Through these policy mechanisms, California could seek federal Medicaid coverage for community health workers who are directly integrated into the pediatric or maternal care team or for partnerships with community-based organizations who employ community health workers that serve children and families. Through these pathways, CHWs could provide a range of preventive and non-clinical services, including education, health system navigation, and care coordination services for children. These services could address, for example, the alarmingly low access to blood lead screenings for children in Medi-Cal, which was highlighted by the 2019 state auditor's report, or the underutilization of preventive services (such as prenatal care, dental care and immunizations) among children in mixed status and immigrant families. They could also include doula services provided during pregnancy, labor, birth and the

postpartum period, or mental health services provided by traditional healers. Additionally, the Department of Public Health should continue long-term funding for programs that employ CHWs. It should also ensure the contracting requirements and grant programs not only work for counties, but also make dollars available for the community-based organizations that employ so many CHWs already in the state.

RECOMMENDATION 3



Require managed care plans to integrate CHWs into care for all children and families.

California has the opportunity to advance health equity by integrating a child- and family-focused community health workforce directly into its managed care plan contracts. Medi-Cal managed care is the primary way millions of children of color in California receive important

preventive and other health services. Through its managed care contracts, DHCS could follow Michigan's lead and incentivize or require its managed care plans to implement CHW services delivered by community-based organizations but target children and families. These services could include interventions that address social determinants of health or preventive services, health education, and care coordination. Through its managed care contracts, DHCS could also make CHWs available to all beneficiaries in managed care, including children, by establishing a minimum ratio of CHWs to beneficiaries and a minimum list of services that CHWs can provide, like ensuring children can access the preventive services to which they are entitled. Regardless of the mechanism that California uses to create a more sustainable payment model, the state must simplify its contracting process to make it easier for community-based organizations that represent CHWs to partner with the state to provide health, navigation and social services supports as well as receive Medi-Cal reimbursement.



Lorena Avilés (left), Carmen Madrigal (center) and Miriam Rodríguez (right) outside El Super in City Heights. (Alexandra Mendoza - U-T) Credit: Alexandra Mendoza, "They are familiar with residents and neighborhoods" <https://www.sandiegouniontribune.com/news/health/story/2021-02-19/promotoras-play-important-role-in-vaccine-outreach-for-latino-communities>, February 19, 2021.



RECOMMENDATION 4



Integrate community health workers into community settings, including schools and early learning programs.

Health and well-being are intimately connected to education, housing and employment opportunities. CHWs have served as a key connector for children and families between these systems, including education, housing and health. As suggested by a listening session participant, CHWs could be integrated directly within the systems that children and families navigate, including schools. CHW place-based initiatives are an effective approach to reduce health disparities among communities living in marginalized neighborhoods.¹³⁸ CHWs embedded in schools could connect kids and parents to important resources, such as broadband, laptops, food and health care. CHWs at schools could also play a key role in addressing trauma and grief caused by the pandemic by ensuring children have access to mental health services. They could perform safe home visits

for student and family health and wellness checks.¹³⁹ As schools begin to reopen, CHWs could be trained to assist nurses with COVID-19 screenings and vaccinations, health screenings, temperature monitoring, data collection and contact tracing to prevent the spread of disease,¹⁴⁰ and such a model could ensure better preparation for responding to the next pandemic. There is currently no well-established pathway for placing a CHW in a school either in California or nationally. However, there is untapped potential for CHWs within school and early learning settings, particularly those who already have the infrastructure to integrate them into school campuses within school-based community health clinics.

RECOMMENDATION 5



Engage community health workers in providing services using technology.

The COVID-19 pandemic has shown that virtual connections can render some services efficiently. However, there are feasibility and acceptability challenges to the use of digital

tools by CHWs. In considering the increased reliance on technology, dedicated efforts must focus on supporting CHW adoption and use of digital solutions. This includes providing CHWs with laptops and other hardware, dedicated training on new digital tools, technical support, reliable internet connectivity, and other administrative supports.¹⁴¹ These supports would help improve routine workflow and allow CHWs to take advantage of technology-enabled engagement with communities.

In addition, technology is increasingly playing a role in the implementation of programs to address patients' social conditions, particularly to facilitate referrals to community social services organizations. Community resource and referral platforms provide similar core functionalities: screening for social risks, a resource directory, referral management, care coordination, privacy protection, systems integration, and reporting and analytics.¹⁴² For some, engaging CHWs offers an opportunity to better engage community partners and serve communities in need. As a result, CHWs should also be involved in the design of and trained in SDOH technology systems that have been created largely without their voices.

Conclusion

Today, our nation faces unprecedented possibilities to respond to a long-overdue public outcry over structural racism and its historic and present-day impacts on the well-being of Americans, particularly BIPOC families. We must maximize this unique opportunity to reform existing policies and advance new ones that are accessible, equitable and effective.

For over a century, community health workers have acted as agents of change, social justice and overall well-being for the communities they serve and represent. Investments in community-based education, care coordination and support models such as CHWs not only improve families' health literacy and health outcomes, but are cost-effective investments in preventive care,

leading to both healthier children and adults in the long run.¹⁴³ Despite such evidence, the profession of CHWs does not yet have a standardized scope of practice or steady funding, and it is not fully integrated into the health care system. Often, it is not focused upon the unique needs and opportunities of elevating children's health trajectories. If we are to truly transform California's health care system, meet the particular needs of children, and advance equity, policymakers and public health leaders at the local, state and national levels must elevate the role of CHWs and ensure their sustainability.

CHWs are not a new concept; thus, any effort to advance racial equity in our health care system must recognize the invaluable role CHWs have played in improving access, quality and cultural competence in health care for decades — for populations across the age spectrum. As detailed above, the federal government, multiple states and health care organizations throughout the country have continually acknowledged the critical role of CHWs.¹⁴⁴ California has a wealth of exemplary practices employing CHWs and partnering with children and families in marginalized communities to advance health and development — but these remain exceptions to general practice. These can be used as a basis for diffusion, growth and continuous improvement, provided financing systems and investments support that diffusion and growth. The California Workforce Commission also recommended scaling the engagement of CHWs through certification, training and reimbursement, recognizing that their expanded use has the potential to deliver both more affordable and more culturally competent care while providing new opportunities to Californians with diverse backgrounds.¹⁴⁵

Although Americans from all backgrounds have benefited from a CHW model, as described in this brief, families from low-income BIPOC communities particularly benefit from the availability of CHWs. Because these communities are more likely to face barriers to health care, it is critical that the advancement of the model center their connection to our most marginalized, including children of color. While some CHW models and research have exclusively focused on adult populations, there are numerous promising efforts that focus on children and the whole family. As California looks to build a more equitable, prevention-focused health care system that addresses racial inequities, the time is now for elevating and supporting the essential CHW workforce.



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