NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS (NACHW)

WHAT WORKS TOOLKIT SERIES

WHAT WORKS IN CHW APPROACHES AND INNOVATION SERVING NATIVE AMERICANS AND ALASKA NATIVES

NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

JANUARY 2025

TABLE OF CONTENTS

NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

ACKNOWLEDGEMENTS

SUBJECT MATTER EXPERTS (SMES)

Subject Matter Experts (SMEs) provided guidance and advisement to steer the development of the What Works Toolkit Series (WWTS). SMEs met bi-weekly in steering workgroups (a SME workgroup advised each of the four toolkits) for six months to design and develop the WWTS.

SMEs are CHWs and CHW-allies, each with decades of expertise serving people in re-entry or working with CHWs with lived experience. We are immensely grateful for the expertise and dedication SMEs brought to this work by centering equity, inclusion and CHW self-determination.

Mae-Gilene Begay, CHR
Navajo Nation

Chief Michelle Mitchum, CHW
Pine Hill Health Network

Ramona Dillard, CHR, CHW
Pueblo of Laguna

Iris Reano, CHR
Santo Domingo Pueblo

Joyce M. Hamilton
Hopi Tribe

CHW CONTRIBUTORS

The What Works Toolkit Series (WWTS) was developed through national CHW engagement, outreach and consensus building. Many CHWs participated in the development of the WWTS by sharing their expertise, observations, and innovations through a national survey, listening sessions, interviews and more. We extend gratitude to all CHW contributors and acknowledge their expertise as essential to the learning and consensus building that informed this toolkit.

Glirsa Magaly Pineda
Tatyana Denny
Angela Hough
Anne Sanderson
Dawn LeMiuex
Debra Hopkins
Jeff Mitchum
Jolene Keplin
Josie Scheindlinger
Kowashay Bigpond
Lisa Walker
Lucia Lee
Mindy Morris
Molly Morris
Nancy Turner
Rebecca M. Benally
Sami Enos
Sarah Fatt
Sylvia Giron
Timmy Nozie
Tracy Lee Crutchfield
Vicki Lynn Steff

Written by Neena Schultz, MSW, MPH, National Association of Community Health Workers

ABOUT NACHW

NACHW is the national voice for Community Health Workers (CHWs). A non-profit, member-driven organization, NACHW's mission is to unify CHWs across geography, ethnicity, sector and experience to support communities in achieving health, equity and social justice. NACHW supports CHWs (including Community Health Representatives (CHRs), Promotoras(es), and other workforce members) in promoting self-determination, integrity and social justice; advancing CHW professional identity; and amplifying CHW leadership and capacity building. NACHW's over 2250 active individual and organizational members hail from all 50 states, over 30 Indigenous tribes, U.S. territories and Freely Associated States. There are over 8,000 people on our national email listserv and over 15,000 in our COVID listserv.

Initiatives. NACHW cultivates and amplifies CHW professional identity, policy leadership and CHW Network capacity; centers racial equity, social justice, diversity and inclusion in our values and work; and promotes policies that respect, protect and authentically partner with CHWs and their Networks. We disseminate research and best practice for sustainability of CHW roles, services and organizations through reports, playbooks, tools, webinars and conferences and collect national data on CHW workforce trends, experiences, skills and opportunities. We are building a national feedback loop (database, mobile app, campaigns and engagement events) to activate members; we are national advisors regarding CHWs' roles during COVID-19 and for future pandemic response and resiliency.

Recognizing that progress emerges from collective effort, NACHW works in collaboration with individual CHWs and their local/state CHW Networks, Coalitions and Associations and in partnership with organizations supporting community health work - including the White House COVID-19 Response and Hunger, Nutrition and Health Initiatives, the U.S. Centers for Disease Control, Department of Labor, various U.S. federal agencies (HRSA, SAMHSA, Indian Health Services, the Office of Minority Health, and the Office of the Assistant Secretary for Health), national technical assistance nonprofits, state and location health departments, and a diverse set of partners who are CHW employers, researchers, service providers, advocates, and those committed to building CHW sustainability.

Unique Experience and Perspective. NACHW is the only national professional organization, led by CHWs in the Executive and Board positions, who deeply understand the CHW profession and its history, and who have developed major CHW led initiatives, including authoring seminal national research and workforce studies, the creation of a DOL classification for CHWs, created the APHA CHW Section, articulated core competencies, and launched dozens of state associations. Our north star is CHW self-determination, actualization and sustainability. Our skills and capacity to ignite national discussion and advocacy, inform federal, state and employer policies, and establish strategic partnerships to address CHW workforce challenges, emanate from our authentic participatory approach, expertise in organizing, and amplification of CHW leadership. NACHW's board represents the diversity of the CHW field and elevates CHWs in leadership.

NACHW amplifies and disseminates CHW-led, culturally diverse and proven strategies and approaches and deepens partnerships between community-based organizations, public health, healthcare and social services, to create a more accessible infrastructure for marginalized populations to improve their health.

The What Works Toolkit Series (WWTS) was launched to address the underrecognized, under-resourced, and undervalued leadership voice of CHWs to 1) understand complex health equity issues facing communities they serve and 2) lead, advocate, and develop innovative approaches that drive solutions.

WWTS focuses on four populations experiencing disproportionate health burdens: Native Americans/Alaska Natives (NA/AN), people experiencing homelessness, people who were formerly incarcerated, and Native Hawaiians and Pacific Islanders (NHPI)

THIS TOOLKIT SERIES AIMS TO:

- Explore the importance of CHWs' leadership voice to innovate in four key communities which experience wide-ranging health inequities: Native Americans/ Alaska Natives (NA/AN), people experiencing homelessness, people who were formerly incarcerated, and Native Hawaiians and Pacific Islanders (NHPI).
- Describe key elements of CHW-led public health innovation,
- Highlight "what works" in CHW-led innovation and highlight case examples, and
- Identify next steps for public health systems, funders, policymakers, CHW employers, and other partners.

APPROACH

To learn about "What Works" as well as CHW-led innovations in serving these communities, we invited CHWs to share their expertise through a national survey, listening sessions, and individual interviews. An environmental scan was also completed to learn more about specific health and social needs, CHW roles, and the landscape of community-based and CHW-led innovations. Methods are described more fully in the Methods section.

A framework for understanding CHW-led efforts and innovation was developed based on the findings of the survey and listening sessions. The model is used as a framework to discuss "what works" and describe CHW-led innovation in serving each of the four populations. Case examples of CHW-led innovations are highlighted and "what works" for partners (policymakers, funders, other partners) aiming to advance best practices and CHW-led innovation.

BACKGROUND

HEALTH EQUITY AND PUBLIC HEALTH WITHIN NATIVE AMERICAN AND ALAKSA NATIVE COMMUNITIES

Native Americans and Alaska Natives (NA/AN) maintain deep and vital connections to community and culture in the face of centuries of historic and ongoing colonial violence and dispossession. Native Americans and Alaska Natives continue to revitalize, reclaim and restore traditional practices, ways of being, and languages, in turn improving the health and wellbeing of NA/AN community members.

Native Americans and Alaska Natives constitute a vast and diverse population of close to one thousand indigenous Nations and tribes. There are 574 federally recognized tribes and several hundred more that do not seek or receive federal recognition (~400). Diverse cultural practices, governance structures, values, languages, social norms, relationships and kinship structures, health practices, food systems, spirituality and more represent the diversity of Nations and tribes in the contemporary United States. At the same time, similarities in values, traditions, and histories reflect shared experiences and community.

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

Indigenous populations across the globe face health inequities related to the historic and ongoing impacts of colonization and imperialism. Indigenous determinants of health (IDH or ISDoH) represent an approach to understanding and addressing social drivers of health through an indigenous perspective, oriented around indigenous knowledge systems and values, and accounting for factors that disproportionately impact indigenous communities. ISDoH include the same SDoH that impact all peoples such as housing and cost of living, but expand to also include indigenous values and practices, connection to community and culture, and more.[1] Domains of ISDoH include indigenous knowledge, identity, land, kinship, language sovereignty, governance.[2] Some examples of ISDoH include sustainable and sovereign indigenous food systems, land and water protections, cultural connectedness, connection to shared geography and community, Tribal sovereignty, and protection of traditional medicines.[2]

> ***"Our Indigenous understandings, practices, and beliefs have been retained through hard fought efforts to maintain languages, preserve cultural and community connections, sustain relationships and supports, and protect and sustain our connections to our lands and other living beings that are part of our shared environments"*** [2]

CHRs AND CHWs

Community Health Representatives (CHRs) are part of the CHW workforce, but CHR describes a specific role serving Native American and Alaska Native communities through the Indian Health Service (IHS). One of the oldest community health workforces in the country, the CHR program was established in 1968 by Congress. More than 1600 CHRs worked in the U.S. as of 2019. [3]

CHRs serve NA/AN communities in twelve designated IHS areas, on the lands of federally recognized tribes and native nations. CHRs have delineated scopes of work, training and oversight, funding mechanisms, and communities served. CHRs engage in community health education, screenings, home safety assessments, connect

EXAMPLES OF INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

people with healthcare, housing, and other resources. [4]

Indian Health Service (IHS) serves as the mandated federal system for providing healthcare to NA/AN communities. IHS services are only available to federally recognized tribes and continues to be vastly underfunded compared to other government payment systems (e.g., VA, Medicaid, Medicare).[5]

Tribes operate under Self-Determination contracts under the PL 93-638, Title 1 or Title 5 contracts to implement and fund most CHR programs. CHR programs near cities with large NA/AN populations are often consulted to coordinate and navigate care for non-reservation living tribal members.

Community Health Workers (CHWs) may also work in federally recognized tribal lands, but their scope of work may be different than a CHR, based on the needs of the community.

CHWs also serve NA/AN communities that are either not federally recognized (and denied IHS services) or who live outside of tribal lands including but not limited to urban areas. During COVID, tribes that did not have federal recognition (over 200) did not receive any of the federal resources and services through IHS despite experiencing the same challenges and burdens, resulting in added barriers to healthcare, vaccines, and testing or going without needed care. [6]

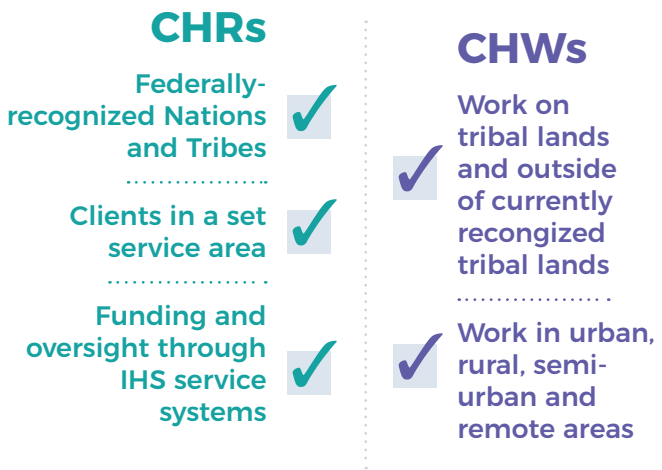
As trusted partners, CHWs and CHRs (CHW/CHRs) work to break down barriers to health and belonging, bridge gaps between western medical systems and NA/AN communities, by serving as connective tissue within the fractured public health ecosystem. Research evidence demonstrates CHW/CHR effectiveness in improving health outcomes in NA/AN communities. [4]

CHR/CHW ROLES

Common CHR/CHW roles include elder and rural outreach, resource and patient navigation, health education, cultural mediation, and addressing HRSN such as housing, shelter, basic needs, and more. CHRs/CHWs work with all age groups. Common CHR activities include addressing health needs and access to healthcare (screening, helping schedule and maintain healthcare appointments, and promoting healthy lifestyle

FIGURE 1.

CHRs and CHWs Overview



behaviors), advocating for clients, and individual and community outreach. [27] Similarly, tribal CHWs engage in cultural mediation, healthcare navigation and addressing HRSN.

CHWs also serve NA/AN who are not enrolled tribal members or do not live on tribal lands. Individuals may not be enrolled for many reasons, including but not limited to the ongoing impacts of historical trauma, displacement, and disenfranchisement. CHWs serving NA/AN community members not living on tribal lands or not enrolled tribal members flexibly meet many health and social needs, address barriers and restrictions to accessing services, and help NA/AN to build community and connect with culture.

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH (ISDOH) AND HEALTH-RELATED SOCIAL NEEDS (HRSN)

CURRENT STATE OF HEALTH EQUITY

Native Americans and Alaska Natives (NA/AN) include people living in sovereign Nations, pueblos and tribal lands as well as Native Americans who are displaced from or living away from their tribal lands.

Native Americans and Alaska Natives had established longstanding traditional healing and medical practices and indigenous approaches to health prior to colonization, many of which have been adopted by western medicine without common knowledge.[7] Today, NA/AN are impacted by longstanding health inequities and ISDoH stemming from centuries of colonization and imperialism and ongoing structural violence.[8] Health inequities are seen downstream through health-related social needs (HRSN) (e.g., access to food, housing, income), high rates of chronic health conditions, and a high burden of mental health, suicide and substance use.[9]

Disproportionate burdens of chronic health conditions stem from ISDoH and resulting HRSN. NA/AN communities have the highest rates of diabetes in the country, high rates of other chronic health conditions, dental problems, infant mortality[9], and victimization due to violent crime.[10]

Mental health and substance use: NA/AN communities experience disproportionate mental health burdens including psychological distress, depression and other mental health conditions; self-harm and suicide,[9] and alcohol and substance use disorder rates are higher than that of any other racial/ethnic group.[10] In addition, NA/AN have documented higher rates of trauma, post-traumatic stress disorder (PTSD), and exposure to violence (including the crisis of missing and murdered indigenous women (MMIW)), in addition to the well-documented ongoing impacts of generational historical trauma.[10]

> **Among many needs identified by CHR/CHW survey respondents, substance use was the most frequently identified health challenge facing CHW client populations, followed by mental health and physical health needs.**

Barriers to basic needs in NA/AN communities include utilities (running water, electricity, heat), infrastructure (e.g., lack of roads, bus routes), access to healthy food, mobile phone and broadband service, housing, transportation, clean water, and more. In addition to these material needs, ISDH includes connection to culture and community. NA/AN also experience barriers to accessing services and public benefits to which they are entitled.

> **CHR/CHW survey respondents identified food insecurity and hunger, poverty and cost of living, housing insecurity and homelessness, and employment and economic opportunity as the most pressing social and resource needs of their client populations.**

Barriers to accessing healthcare services include discrimination by providers, distance to/from remote locations requiring long-distance travel, access to transportation, lack of culturally and linguistically appropriate services, cost of services,

and mistrust due to past negative experiences and historical trauma.[11]

Structural violence, historical trauma and discrimination: NA/AN communities face ongoing threats to sovereignty, land and water rights, as well as language, culture, traditions, and more.[12,13] Historical trauma is widely understood as a driver of ongoing health inequities and burdens,[14] and is accompanied by imposition of western worldviews and dispossession of indigenous traditions.[15] Poverty and economic disenfranchisement is deeply connected to this history and continued marginalization. For example, while one in five Alaskans are Alaska Native, 16-35% of Alaska Natives lived in poverty between 2015-2019 (varying by Tribal health region) compared to 7% of non-Native Alaskans.[9]

CHR/CHW survey respondents identified subgroups that experience additional health barriers including elders and people with disabilities and/or chronic health conditions (including mental health), and people who are isolated or lack transportation.

POLICY AND PRACTICE LANDSCAPE

Inequitable federal response

With over a century of underfunding of IHS, federal funding inequities and continued structural violence and dispossession has resulted in an inequitable public health landscape. Despite federally designated funding mechanisms, tribal members of federally recognized tribes lack sufficient access to healthcare and social resources.[5] For eligible recipients of IHS services, IHS covers only "a fraction of" NA/AN health care needs.[10]

While more than 20 federal agencies serve NA/AN individuals, federal programs designed to support the social and economic wellbeing of Native Americans, including HIS, remain chronically underfunded. In 2016, IHS spent significantly less per capita than other federally funded healthcare systems such as Veterans Health Administration, Medicare, Medicaid and prison-based healthcare.[5,10]

In some high-income countries (e.g., Canada, Australia) robust and well-funded national efforts have sought to remediate the health inequities facing indigenous populations. However a similar large-scale effort has not been attempted in the United States.[15]

Recent Directions

Policy efforts seeking to advance NA/AN health recognize and center NA/AN expertise and promote community-driven and inclusive practices to positively impact ISDoH and build additional tribal public health infrastructure. Calls to integrate NA/AN expertise in addressing ISDoH have not identified CHRs/CHWs as a source of this community health expertise.[15] Two large government public health initiatives aimed at addressing ISDoH and improving NA/AN health include the following:

1. Good Health and Wellness in Indian Country (GHWIC) represents the Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion's largest investment to improve NA/AN health. This $100 million initiative focused on health promotion and chronic disease prevention including diabetes and smoking, through "policy, systems, and environmental, changes to create sustainable health improvements while addressing health disparities."[16] GHWIC includes a focus on traditional practices, community-clinical linkages and multidisciplinary care teams
2. Tribal Practices for Wellness in Indian Country (TPWIC)[17] supports Tribal programs to promote cultural connectedness for wellness and chronic disease prevention. GHWIC and TPWIC do not explicitly feature or name CHRs/CHWs or CHR/CHW leadership though grantees may employ CHRs/CHWs as program providers.[16,18]

CHW-led, Community-based Innovation

WHAT IS INNOVATION IN PUBLIC HEALTH?

Innovation includes strategies and practices that advance progress toward meeting public health goals. This includes developing new ways of doing things as well as improving current approaches. The Framework for Public Health Innovation (FPHI) identifies important components for public health innovation and types of innovations.[19]

WHY IS CHR/CHW-LED INNOVATION IMPORTANT?

Decades of public health evidence demonstrates CHR and CHW (CHR/CHW) effectiveness as essential frontline providers addressing social determinants of health (SDoH) and reducing health inequities in communities experiencing disproportionate health burdens. Despite this proven track record, CHRs/CHWs are often overlooked as community health experts in designing and developing innovative approaches to meet community public health needs – communities they serve and which CHRs/CHWs often are from or share common health barriers. Due to this unique position, CHRs/CHWs bring essential expertise anchored in professional and lived experience.

Programs that CHWs implement are often designed and developed by other providers, administrators, or researchers without full CHR/CHW partnership and equitable engagement. In a national CHW survey conducted by NACHW in 2022, only half of CHW respondents reported being able to lead discussions to improve services where they worked.[20]

Furthermore, CHWs often work in roles that are under-paid, limited term (e.g., grant funded), and lack autonomy and authority to innovate.20,21 Despite these challenges, CHWs are actively developing new approaches to improve public health systems, build community health capacity, reduce health inequities, and advance the overall health of all communities they serve. Often this work comes at personal cost, extra hours, and unpaid labor, out of pocket costs, and lacks funding and support for evaluation and sustainability. As a result, it is largely not found in evidence-based literature and our public health systems lose out on this potential well of innovation to improve community health.

Public health institutional leaders, including Federal Government agencies (e.g., HUD) and public health NGOs (NASHP), among others, have highlighted the importance of engaging communities and people with lived experience

"CHWs are versatile and natural leaders. They can effectively work across community and healthcare providers to accelerate community engagement among underserved populations and structural competency of healthcare providers and, ultimately, lead to patient-centered care and population health improvement for diverse communities."

– Trinh-Shervin et al, 2019

(PwLE) in the design of policies and programs and cross sector investment in community health.[23,24]

However, CHRs/CHWs have not been adequately highlighted for their essential role in driving public health innovation and policy development as unique stakeholders with shared community and cultural backgrounds, identities, and oftentimes lived experience of incarceration, homelessness, health conditions, and more. CHRs/CHWs must be included in these efforts to ensure innovations are community-driven, culturally relevant, and locally responsive.

WHAT IS UNIQUE ABOUT CHRS'/CHWS' PERSPECTIVES?

CHRs/CHWs are deeply immersed in the communities they serve—either as members of the community or as trusted partners. They build trusted relationships with clients and community partners, centering culturally aligned and trauma-informed approaches, and drawing on their own lived experiences.

CHRs/CHWs strengthen the health of communities by responding to multifaceted individual and community needs and by developing community public health infrastructure, partnerships and collaborations. Their unique position provides CHRs/CHWs with expertise and understanding of the immediate and long-term needs of clients and communities.

CHW-LED INNOVATION

TYPES OF CHR/CHW-LED INNOVATION (ADAPTED FROM GARNEY ET AL.'S (2022) FRAMEWORK FOR PUBLIC HEALTH INNOVATION):

Adaptation or new component: The addition of a new component to a public health program which does not change the overall intervention, including modifying how a program is implemented, often to make it more relevant for different populations. This would include tailoring evidence-based interventions for NA/AN individuals and communities.

New approach to addressing a public health challenge: Developing a new way of carrying out a program, establishing a new initiative or founding an organization. This includes development and implementation of new NA/AN CHW/CHR-designed programs and initiatives.

Paradigm shift / Reframing the way a problem is understood or addressed: Upstream innovation, policy or system improvement, including building new community health infrastructure, centering NA/AN and CHW/CHR leadership, indigenizing approaches to community health, and system transformation to change the root causes of health inequities.

> *"Innovation is iterative, so people become more familiar with the process as they participate. Through these interactions, people develop the capacity for innovation."*[24]
>
> *– Garney et al (2022)*

IMPORTANCE OF INDIGENOUS CHW AND CHR-LEADERSHIP

> ***"Indigenous communities hold the solutions to the challenges they face and are leading efforts to create a healthier future for all peoples."*** [5]

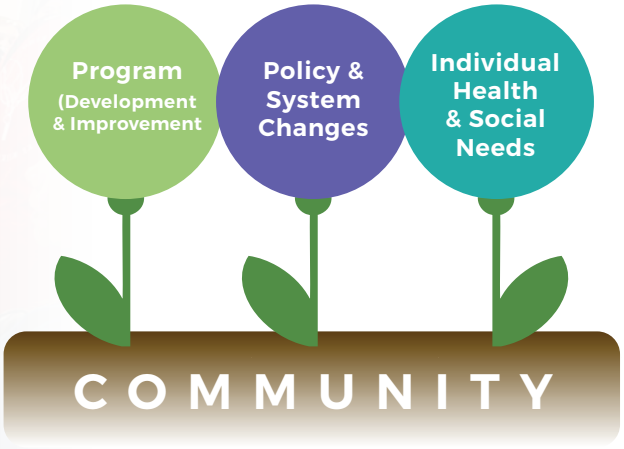
Although the importance of CHRs/CHWs as trusted messengers is well-established, the specific role of CHW/CHR leadership and innovation in developing and implementing approaches to addressing longstanding health inequities has been underexplored. Public health leaders continue to highlight the necessity of decolonizing health systems to address the health inequities faced by indigenous communities. NA/AN, along with other indigenous people, are being failed by public health systems.[12]

> ***"Ironically, many of the cultural grounded approaches...are actually a return to traditional worldviews and practices that were part of everyday life for indigenous communities and a source of their wellbeing prior to Western intrusion."*** [25]

Indigenous leadership in the development of solutions to health inequities is necessary for transforming health systems to better serve NA/AN populations.[5,15]

> ***"Given the paucity of empirically based health promotion interventions designed by and for American Indian, Alaska Native, and Native Hawaiian (i.e., Native) communities, researchers and partnering communities have had to rely on the adaptation of evidence-based interventions (EBIs) designed for non-Native populations, a decidedly sub-optimal approach. Native communities have called for development of Indigenous health promotion programs in which their cultural worldviews and protocols are prioritized in the design, development, testing, and implementation.***[26]

CHW Approaches and Innovations Areas of Focus



What Works:
CHW-led Innovations and Approaches

Key themes in CHW impact and innovation and selected case examples are described below according to each domain of focus:

Community is at the center of CHW work and innovation. CHW-led innovation across all domains is community-driven, informed by deep understanding of the community served, builds relationships and partnerships across sectors and expertise, prioritizes the desires of the community, and ensures community buy-in and accountability to the community served.

CHW-led efforts and innovations may operate along the continuum of prevention. While some innovations aim to address **individual health and social needs** (e.g., access to healthcare, diabetes management), others focus upstream through **program development and improvement**, targeting multiple social determinants of health, building community infrastructure or advocating for **policy or systems change**.

WHAT WORKS: CHR/CHW APPROACHES TO SERVING NA/AN COMMUNITY MEMBERS

CHRs/CHWs emphasized the importance of building trusted relationships with the clients and community members they serve. The importance of trust in CHR/CHW relationships with community members is emphasized in research literature as well by WWTS survey and listening session participants. Trust serves as a foundation for CHW effectiveness in health promotion, health education, and navigation.

Several values and principles reflected a core foundation of trustworthiness, as well as examples of What Works in building trusted relationships among CHR/CHW participants.

Best practices and emerging innovations across all areas of focus are essential for meeting the challenge of solving cross cutting and longstanding health inequities.

Time and patience

- The importance of relationships: build trusted relationships first, and maintain trust as an ongoing process
- Patience: Don't rush appointments, practice patience and listening
- Participating in community events

Cultural alignment

- Show respect for elders and for culture, follow traditional customs
- Speaking clients' native languages when possible
- Being on equal footing and being from the community
- Address the needs of the entire family, not just one family member
- Integrate traditional practices like smudging

Respect and compassion

- Developing relationships as partnerships rather than top-down education or service provision
- Giving space for community members to feel seen, heard, and valued; being friendly and kind; respect client dignity; show empathy and a non-judgmental attitude
- Respect and meet people "where they are at" and understand where they are coming from

Trust enables CHRs/CHWs to build positive connections through which health information, honest communication, health behaviors, and connection with resources can be supported.[4] The quality of this relationship is essential to the positive outcomes observed in CHR/CHW interventions.

INDIVIDUAL HEALTH AND SOCIAL NEEDS

CHRs/CHWs described routinely helping clients access HRSN. CHRs/CHWs connect clients with transportation, utility assistance, community and social support, access to mental health and physical healthcare and more.

Examples of key health and social needs addressed by CHRs/CHWs:

- Immediate basic needs and resources (housing, food, heat)
- Access to healthcare (cultural mediation, trusted referral networks, translation)
- Connection to community and culture
- Social and emotional support
- Health-focused cultural practices (e.g., smudging, sweats, cultural festivals)
- Culturally and linguistically appropriate health information

Immediate basic needs: CHRs/CHWs described the importance of addressing immediate basic needs such as food, housing and heat in the winter. However, the need to assist clients in accessing immediate needs often takes precedence over spending time building longer term supports and resources which is essential for supporting health and well-being.

Access to healthcare: CHRs/CHWs build trusting relationships with members of NA/AN who often mistrust mainstream health systems and providers due to historic and ongoing harm, discrimination and mistreatment.

CHRs/CHWs serving NA/AN community members described serving as cultural mediators, educating other providers about cultural norms and values that may impact their patients, and working with patients to explain health information, maintain trust, ensure respect for culture, and provide support and information. CHRs/CHWs also help clients navigate literacy and language barriers by translating materials and speaking in clients' native languages.

Mental health and substance use (MH/SUD): CHRs/CHWs support the mental health of NA/AN community members through a variety of roles including patient navigation and case management of existing services, and providing "adjunctive culturally appropriate psychoeducation to families, and help tap local cultural assets and resources to promote mental wellness."[28,29(p8)]

Native Nations, tribes and pueblos have been under-recognized innovators in addressing mental health and substance use. Many practices that have been adopted across the U.S. originated within Native communities including peer support related to substance use.

- Peer support practices for people with MH/SUD originated within and among Native Nations and tribes through traditional practices such as talking circles and sweat lodges. These traditional approaches are considered more effective for "supporting and sustaining recovery" among AI/AN clients compared to western models.[30]
- Stigma can present a significant barrier to accessing mental health services. CHRs, through trusted relationships with clients, help clients work through stigma and access needed services. CHRs and CHWs help combat the impact of stigma through positive regard and respect, person-centered and flexible care, warm hand offs and referrals including walking people into programs, helping clients feel comfortable, and partnering with mental health providers as part of interprofessional mental health care teams.
- CHR/CHW survey respondents and listening session participants described providing social support and community connections through culturally relevant community gatherings, often combined with health education. This includes culturally rooted health fairs and activities like elder socials, ice cream socials, coffee and donuts, craft events, and more.

Community

CHRs/CHWs build community and social connection and cohesion, key social determinants of health, at a time when the U.S. Surgeon General has reported an epidemic of social isolation,[31] build capacity within communities, and mobilize community members to address community needs and advocate for public health priorities.[32]

> *"Ironically, many of the cultural grounded approaches...are actually a return to traditional worldviews and practices that were part of everyday life for indigenous communities and a source of their wellbeing prior to Western intrusion."* [25]

CHR/CHW respondents shared many examples "what works" related to drawing on traditional cultural practices and values serving NA/AN clients. In addition to the cultural values required for building trusting relationships, CHRs/CHWs discussed utilizing traditional practices including smudging, sweats, sharing of foods, speaking in their Native language, sitting in nature, and spirituality.

> *"I have grown up aware of the cultural norms and traditions of the various cultures I work with and service. I instinctively use this knowledge to build trust and relationships. These are difficult values to teach and explain to people who have not had those life experiences." – Anne Sanderson, Certified SC Community Health Worker, Lumbee Nation*

Program

Program-level innovation includes improving the way a program serves clients, advocating for changes to the way something is done (e.g., advocating to make a program trauma-informed or culturally relevant) and starting new initiatives or organizations to address unmet community health needs.

Several program components were seen as representative of "what works" on a program level including building essential (but not directly funded) operations components into program budgets and MOUs/partnerships with trusted and culturally responsive healthcare systems.

To help address mistrust of medical systems, programs 1) provide access to language services, 2) offer CHW accompaniments and/or transportation to appointments, and 3) integrate traditional cultural values and practices. In addition to program delivery, ensuring CHWs are paid a living

wage (and especially that CHWs should not need to work multiple jobs) reflects an essential and foundational program/organizational priority.

Policy

CHRs and CHWs engage in policy advocacy as individual experts, organize other CHRs/CHWs and providers to advocate, and educate policymakers about the needs of community members and strategies to improve the health of their constituents. Policy success described included state waivers for reimbursement for (at least) some CHW services, funding for CHW innovations, and policy changes to address specific SDoH (e.g., transportation).

CHR/W-LED INNOVATION: CHR/CHWS' LEADERSHIP VOICE TO INNOVATE

We selected case examples of CHR/W-led innovations highlighting the strengths, assets, barriers and potential to transform and improve health among NA/AN clients. Case examples were selected from among WWTS respondents, word of mouth recommendations, and a landscape scan to identify, of CHR/W-led efforts.

Almost half (20 out of 47) respondents shared examples of innovative work they took on to address the health and social resource needs of their clients and communities. These innovations included COVID outreach and distribution, starting a tribal health clinic, teaching native cultural values and practices, providing native healing gifts for people in shelter, coordinating culturally rooted health and resource fairs, educating providers about client cultural norms and the impacts of intergenerational trauma on healthcare interactions, and helping people access housing and medical appointments.

> *"CHWs are natural community leaders, who share understanding of the life circumstances and social context that have an impact on health and disease vulnerability of community members; as such, they may be in a unique position to influence social factors such as social connectedness, social capital, and social support. Our review suggests that CHWs are being underutilized in these capacities." (Islam et al, 2015)*[33]

SPOTLIGHT: HOPI TRIBE COVID RESPONSE

by Joyce Hamilton, Director, Hopi Department of Health and Human Services

The Hopi Tribe is surrounded by the Navajo Nation with a population of 15,000+ with over half of enrolled tribal members living off the Hopi Reservation due to lack of job opportunities. The reservation is made up of villages situated in three distinct mesas; First Mesa, Second Mesa and Third Mesa. The Hopi continue to practice their traditional ceremonies which occurred at various seasons throughout the year. The Hopi language is spoken in many homes and many families continue to live without the modern amenities such as electricity.

Under the Hopi Tribe Department of Health and Human Services, the CHR program has been a long-standing workforce offering home visiting, health education, health promotion, and disease prevention education to members of the community. The Hopi CHR program employs members of the community which strengthens the workforce by using the Hopi language in the day-to-day work. The CHRs were instrumental during the 2020 COVID outbreak - Hopi was not immune to the virus; the CHRs were deployed as they are frontline health care workers who contacted every household to provide education and information about the deadly virus. The CHRs offered door-to-door campaigns to ensure Hopi Tribal members were educated about the virus and offered PPE supplies to the households.

BUILDING INDIGENOUS COMMUNITY HEALTH CAPACITY: NATIVES ALONG THE BIG RIVER AND GORGE NATIVE AMERICAN COLLABORATIVE

CHW leader: Dawn LeMieux, CHW, Columbia River Gorge, Oregon and Washington

About the region: The Columbia River Gorge is the ancestral home of four Native American, these tribes include the Confederated Tribes of the Warm Springs, and Yakama Nation, Nez Perce Tribe and the Confederated Tribes of Umatilla Indian Reservation, tribes who continue to advocate for protection of treaty rights and a balance for environment stability. As well as many Native American community members who are displaced from their tribal lands or not affiliated. The Columbia River Gorge is separated by the Columbia River between two states, the region is diverse in geography including urban, rural, off reservation, and semi-urban communities.

Photo Columbia River Inter-Tribal Fish Commission
https://critfc.org/member-tribes-overview/

Need for innovation: Native American community members face significant social and health disparities, including immediate basic needs (e.g., heating and weatherization in the winter, food access). Health and social services provided through the tribes are limited and oftentimes can be restricted to enrolled members living on tribal lands. Non-affiliated or displaced community members are unable to access these services and experience barriers to services through mainstream systems. Services they can access have often been culturally insensitive or harmful, resulting in deepened mistrust and avoidance of needed services. Previously many community agencies lacked cultural humility and community advocates to effectively serve Native community members and lack of culturally sensitive approaches deepened mistrust.

As a CHW and displaced tribal member who had experienced these barriers herself, Dawn LeMieux saw these challenges and stepped in to get to work. Dawn and partners have built indigenized and culturally responsive community health capacity which has transformed the public health landscape for Native community members through two key initiatives—Natives Along the Big Gorge coalition (acronym NABR & pronounced neighbor) and the Gorge Native American Collaborative.

> ***"Previously, the services that were meant to help and heal did more harm than they did good. During covid, we worked to revamp the outreach and services."***

Natives Along the Big River (NABR): Dawn co-founded NABR as a leadership coalition with very limited state funding. With three co-founders, Dawn expanded NABR through

community outreach. She visited community members where they lived, listened, built relationships, and brought culturally specific gifts. NABR membership grew from three co-founders to 30 members from diverse tribal backgrounds and geographical locations throughout the Columbia River Gorge.

NABR and GNAC youth and family event

NABR brings together community members to advocate for policy changes on a local, state and federal level where Native voices aren't typically heard. NABR has focused on immediate survival needs of community members by necessity. To prepare for the cold winter, NABR developed a community needs assessment and conducted outreach to Native American community members to assess weatherization needs, then brought together partners for a large-scale weatherization supply drive and distributed weatherization supplies to community members in need equitably. NABR also successfully advocated to remove bureaucratic barriers that Native community members faced in applying for heating assistance programs for both Oregon and Washington local programs. NABR continues to bring together Native American community members to advocate for and meet community health needs.

Gorge Native American Collaborative (GNAC): During COVID, Dawn saw the needs of community members skyrocket and collaborated with many social service programs to set a regular weekly meeting to discuss community needs and determine how best to work with Native American Community members to meet the need. GNAC - a social services collaboration partnership aims to increase staff and community volunteer education opportunities to improve our toolbox to become better allies for our communities and collaborate with health and social service organizations to better meet the needs of Native community members. Seeking annual culturally specific training for GNAC partners to attend and help them improve services and rebuild trust.

GNAC includes 35 programs, a variety of partner agencies including medical programs, state programs, nonprofit grassroots community-led organizations, and faith-based organizations. NABR participates as a steering committee for GNAC and often volunteers alongside GNAC events for Native American community members of all ages. GNAC hosts in-person engagement events which provide spaces to build trusted relationships between Native community members and health and social service organizations.

During COVID, GNAC engaged in direct response through pop-up clinics, vaccines and test kits, set up covid testing stations, pooled and distributed donated supplies, and brought partner organizations together to engage with community members. By collaborating on these COVID responses, services were able to improve events by reducing duplication or trying to recreate the wheel. During collaboration and planning meetings, programs would commit or offer services, supplies to support community success in health equity.

A GNAC initiative called INDFEAST provides a food box or individually pre-cooked meal to community members before the holidays. The first year, 20 households participated, and through word of mouth, 180 households signed up for this year's feast.

GNAC gathering and training

"The pandemic started the partnership between direct community members within NABR and social service programs in the GNAC."

Through NABR and GNAC, Dawn and partners led development of indigenous-centered community health capacity and connectivity between individual community members, community leaders and health and social service organizations to address the longstanding health burdens facing the community. Due in no small part to the impact of NABR and GNAC in building community infrastructure and visibility, there are now six Native-led organizations serving Native American community members, one of which is a Native medical outreach team.

Why it is innovative:

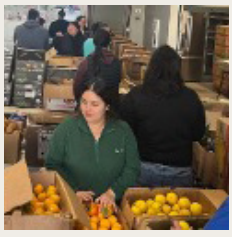
While CHWs are known for building individual trusted relationships, GNAC has built trusted relationships on a community-level. Before NABR, there was nothing in place to serve Native American community members who were falling through the cracks or harmed by existing service systems. Previously where there was hesitancy and mistrust of partner agencies, community members now are welcoming of agency staff, increasing the potential of community organizations to meet their health and social needs.

NABR and GNAC have built community public health capacity centered on the needs of Native community members. They have rebuilt trust between community members and agencies where past harms had ruptured health and social service effectiveness, ensured that Native serving approaches are Native-led and culturally responsive, established ongoing access to culturally aligned health services, and ensured that Native American community members have the same opportunities for health and wellbeing as all other community members. The scale of these efforts and sustained level of engagement reflects a paradigm shift in community leadership and engagement. Recognizing this transformative work, GNAC was awarded the 2022 Community Star award by the State Office of Rural Health.

NABR and GNAC youth and family event

GNAC group

Oregon Public Health Association Community Star Award Presented to GNAC, CHW Dawn LeMieux second from left



GNAC food distribution assembly

2024 Local Rhoots food distribution

BUILDING SOCIAL AND CULTURAL CONNECTION AMONG NATIVE AMERICANS AND ALASKA NATIVES IN AN URBAN SETTING: THE WIDOKTADWEN CENTER

CHW leader: Amanda Funk, CHW, Citizen Potawatomi Nation, Co-Founder, Widoktadwen Center Executive Director | www.widoktadwen.org

"I'm part of the Urban Indian diaspora, I have no access to IHS. I wanted to see what I could do to promote urban Indian health here where I am, knowing that so many of us won't have the option to return to our native communities, we may not even have the luxury of being connected to communities of native people."

Despite a high number and quickly growing population of Native Americans/Alaska Natives in Berks County, Pennsylvania, the state has one of the lowest number of NA/AN residents nationally. There was no visible NA/AN presence or community before CHW Amanda Funk, from Citizen Potawatomi Nation, started the Widoktadwen Center for Native Knowledge.

"How is it that such a significant population remains so invisible?"

Like many CHW-led innovations, the Widoktadwen Center started in conversation.

Over a decade before it was founded, the need for a cultural center to connect NA/AN community members was discussed. As they started to build programming, Amanda and co-founders realized how much culture is embedded in NA/AN health and wellbeing - "our culture teaches us how to be healthy."

Now an established nonprofit, the center provides cultural education, indigenous community health resources, and youth programming. As a small nonprofit, Amanda does much of the work herself and with her co-founder. They table at college health fairs,

public events, and festivals, and distribute resources from national NA/AN health organizations. In addition to Lenape, the original inhabitants of the area, the WC serves a diverse NA/AN diasporic community with members of dozens of Native Nations.

The WC has ongoing programming and one-time events. They share the importance of food sovereignty, lead foraging walks, connect people with Native and local foods, discuss food as medicine and local herbs, share homemade Native meals. Events highlight NA/AN community health and wellbeing including the two-sprit LGBTQIA community and Native American Healthcare Summit. Last year, the center launched the annual Good Medicine Indigenous Wellness Celebration, a gathering to connect with indigenous health knowledge and practices. The Firekeepers Youth Program connects youth with elders as a core component of an intergenerational focus.

Why it is innovative: The Widoktadwen Center addresses connection to culture and community as ISDoH for urban NA/AN community members, many of whom were disconnected and isolated from Native communities.

Culture and community connection are well recognized indigenous social determinants of health (ISDoH), however the unique assets and challenges of health and wellbeing for diverse urban NA/AN community members is less often discussed. The center focuses on connection to culture-as-health and indigenous health information.

> ***"Too many people left [the area] because they couldn't connect with their indigenous identity here. Not everyone has the option to leave. We need something here."***

IMPACT:

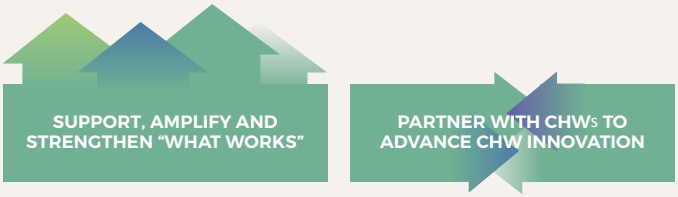
The Widoktadwen Center programs are not exclusive to NA/AN people but are situated within a native context. Amanda also focuses on building relationships with allies, bringing people in, and helping them to understand the challenges and how they can contribute. When tabling at community events, Amanda often hears a version of "Where have you been, I thought I was the only one." She says, "when you hear that over and over again, you realize how common of a problem it is that you have all these native people who don't even know about each other."

People are longing for connection…That's what I hope our center is a mechanism for, this connection, sharing of knowledge, and resources so that we don't have to feel that we are all alone, we don't have to do it all by ourselves. We weren't meant to live as individuals, that's not our cultural way…Medicine that comes from being in community and feeling comfort and safety in each other's company.

What Works for Partners:

How policymakers, funders and other partners help support, elevate, enhance and sustain CHW-led efforts to advance health for NA/AN community members

CHW participants shared their perspectives about "what works" in terms of actions, principles and strategies taken by partners that have positively impacted their work serving NA/AN community members. Many themes discussed by CHWs and SMEs aligned with the existing pillars of the NACHW SUSTAIN Framework for CHW Sustainable Financing[34] and the NACHW Policy Platform.[35]



SUPPORT AND SUSTAIN CHR/W LEADERSHIP IN ADVANCING "WHAT WORKS" AND CHR/W-LED INNOVATION

Partners including funders, employers, and policymakers can partner with CHR/Ws to sustain and advance "what works" and develop innovative solutions to addressing pressing community health needs. The following principles provide a preliminary set of guidelines – a starting point – for partners interested in partnering with CHR/Ws to understand, improve, scale, and sustain community health for NA/AN community members.

Key principles for partnering with CHWs to advance and sustain "What Works" and CHW-led innovation:

- Respect, center, and protect CHR/W leadership and expertise
- Provide expertise, training and support to support CHR/W professional development to build capacity around innovation, leadership and organizational development.
- Ensure equity, flexibility, and sustainability in funding CHR/W efforts and innovations
- Maintain CHR/CHW leadership in evaluation and dissemination

RESPECT, CENTER, AND PROTECT CHR/CHW LEADERSHIP AND EXPERTISE

Respect and protect CHW leadership: Partners seeking to support development or expansion of CHR/W-led innovation to serve communities must ensure equity and respect for CHR/Ws' unique expertise, time, and effort. This includes:

- CHR/Ws are fairly and equitably compensated: Better pay for CHR/Ws employed by CBOs and health systems, ensuring CHRs/CHWs are paid fairly and equitably for their work and receive full and equitable compensation including health insurance and other benefits.
- Engagement of CHR/Ws by partners is sustained, equitable and inclusive, CHR/Ws as full partners and leaders;
- Center CHR/CHW leadership: CHR/W leadership in innovation extends far beyond informing programs developed by others.
- Recognize CHR/Ws for their essential contributions to individual, community and social health and wellbeing.

CHR/Ws can be effective when paid a fair, thriving wage and receive full and equitable compensation including health insurance and other benefits.

This includes ensuring funding for CBOs to cover living wages, health insurance, administrative costs, programmatic costs to reduce barriers for clients (e.g., transportation, incentives, food), and more.

PROVIDE EXPERTISE, TRAINING AND SUPPORT TO SUPPORT CHW PROFESSIONAL DEVELOPMENT TO BUILD CAPACITY AROUND INNOVATION, LEADERSHIP AND ORGANIZATIONAL DEVELOPMENT.

- **Provide expertise, training and support:** in activities like data and evaluation, administrative tasks, fundraising, connecting CHR/W leaders with organizations or agencies with similar missions, providing in-kind resources and space, and more.
- **Help build relationships and connections:** with policy makers and funders—connecting CHR/W leaders with organizations or agencies with similar missions.
- **Support CHRs/CHWs from vulnerable subgroups:** Elders were frequently discussed as a vulnerable NA/AN subgroup due to social isolation and other barriers to health and social needs. Elders, like other members of vulnerable subgroups, can serve as CHRs/CHWs if provided with the necessary support such as scheduling flexibility including part-time options.36

ENSURE EQUITY, FLEXIBILITY, AND SUSTAINABILITY IN FUNDING CHW EFFORTS AND INNOVATIONS

Equity: Ensure equity in funding recipient and grantee selection: Funding must be directed to authentic CHR/W-led initiatives and CBOs that have roots in the community and community health work are prioritized. Funders should work to build internal capacity to understand the essential work that CHR/Ws do, the local landscape of CHR/Ws and CBOs, and avoid deepening inequities by restricting funding or inequitable funding.

- **Support small CBOs, integrate capacity building:** Support for small CBOs including capacity building support and guidance for CHR/W-led CBOs.

"The most engaged and impactful CBOs may be the smallest ones - they often don't have capacity to carry out funding requirements like reporting, financials and administrative tasks." - Oreta Tupola, SME

"Philanthropy further aggravates this schism when it requires Indigenous people to seek funding by category, like scientific research or cultural programming, environmental justice or food culture, or to justify the worth of their knowledge... instead of allowing practitioners to present their whole selves in applications, in projects, in programming, and ultimately, in the results of those efforts."[14]

Flexibility: Ensure funding and programmatic flexibility (e.g., timeline, determining funding priorities), remove funding silos: CHR/Ws respond to immediate, ongoing, and long-term needs in difficult and changing environments, in close collaboration and partnership with community members. This requires adaptation, flexibility and responsiveness to changes.

- **CHR/W Employers:** Ensure CHR/W employees have time and flexibility to innovate, adapt and improve programs and services.
- **Funding flexibility is essential for effective CHR/W-led innovation, including:**
  - **Ensure time for community buy-in and acceptance,** this can require time-intensive planning, relationship building, and ongoing engagement with community partners for innovations to be sustained and effective.
  - **When possible, remove restrictions** (e.g., overhead, administrative and indirect costs, diverse programs and activities) and barriers to eligibility (e.g., requirements of audited documents, operations budget to match funds) – these can prevent CHR/Ws from accessing needed startup funds.
  - **Funding for less recognized activities**

that improve programming and promote CHR/W leadership development like travel to present at conferences, building capacity in different locations, incentives for community members to attend an event, and translate culturally relevant materials to the community.

"Developing innovations requires a great deal of flexibility and the ability to trust a process, rather than entering a project with an outcome in mind, and then working towards that metric," and "innovation is iterative, so people become more familiar with the process as they participate. Through these interactions, people develop the capacity for innovation."[20]

"Federal funding requirements often hinder the ability of state and local governments, territories, tribes, Native-serving organizations operating off tribal land, nonprofits…To promote progress at all levels of government and encourage local adaptation and innovation, federal agencies must allow their funds to be used more flexibly." [37(p37)]

Support sustainability of funding: Partners must support a pathway toward sustainability for existing CHR/W programs and emerging CHW-led innovations.

- The SUSTAIN[34] framework provides guidance around sustainable financing for CHR/W programs and roles to enable CHWs to build on and sustain "what works." The ability of CHR/Ws to innovate requires sustainable, flexible funding—if innovations aren't sustained, community members lose the trust that is the hallmark of CHR/W work. Examples of support for sustainability may include:
  - unrestricted funding or long-term targeted funding
  - funding that builds toward sustainability through activities such as evaluation, capacity building, advocacy, business development, and ongoing fundraising.

MAINTAIN CHW LEADERSHIP IN EVALUATION AND DISSEMINATION

Support CHW leadership in evaluation and dissemination: Ensure that CHR/W-led innovations are included in the public health evidence base through integration of CHW leadership in program evaluation, funding for evaluation of CHR/W-led innovations, support for dissemination and championing CHR/W-led innovations.

"After all, metrics are an impersonal process to evaluate success and ensure money is well spent. But what if we decided to trust that Indigenous people have a knowledge-based, systemic, holistic approach to address health disparities, environmental justice, and cultural resiliency? What if we decided to "hear" their story of impact, instead of frantically trying to measure it?"[14]

In addition, addressing upstream social, economic and political and indigenous determinants of health is critical to advancing "what works." The social failures to address upstream determinants of health erodes CHR/Ws ability to focus on addressing long-term immediate needs such as affordable housing, cost of living, immigration barriers, language access, and barriers to accessing healthcare. These immediate needs often took precedence and took focus away from longer term needs to close the gaps in health equity.

WHAT WORKS
Innovation Worksheet for CHWs

Below are some suggested questions to guide you in developing an innovation plan. This is for your own reference to help identify areas where you may need more support or next steps. Not all questions will be relevant to each CHW or innovation or idea.

MY INNOVATION IDEA

PHASE 1: DESIGN AND DEVELOPMENT - BEFORE LAUNCHING THE INNOVATION

What is the need in the community that I want to address?

What are the changes I hope to see?

COMMUNITY ENGAGEMENT

How have I learned about the needs and desires of community members?

Do I have community buy-in for the innovation?

Which community voices am I most aware of? Are any missing?

PARTNERS AND ALLIES

Who are trusted allies, partners or champions that can help advocate, provide support, or help obtain funding? *Examples: other CHWs, other providers, organizational leaders, researchers, policy makers, funders.*

What are some ways I can build support and relationships with allies and partners?

What are the funding needs for each phase of the work?

What do I need to learn or do to obtain funding?

SKILLS AND TRAINING

What skills or training do you need? *(e.g., grant writing, financial management, policy advocacy)*

How can you get these skills? *(reminder: local and state CHW Networks and Associations often offer training opportunities)*

PHASE 2: IMPLEMENTATION - "THE WORK" OF THE INNOVATION

Who will be "doing the work" of the innovation?

What challenges do I anticipate?

How can I prepare to address these challenges?

How will I sustain operations and funding while carrying out the work? *Examples: volunteer assistance, support from partners.*

EVALUATION AND DISSEMINATION

How will I know what the impact of the innovation is? *Examples: satisfaction surveys, asking community members for feedback, collecting data, partnering with a researcher*

How will I let people know about this work? *Examples: sharing with CHW Networks and Associations; writing blogs, articles or other materials; talking to people in the community about it; building a website*

Methods

To learn about "What Works" and CHW-led innovations, serving the four WWTS populations, we conducted a national CHW engagement initiative including 1) a national CHW survey, 2) listening sessions, 3) individual interviews with key informants. We also conducted a landscape scan to identify CHW-led innovations and better explore the public health literature.

Our approach was guided by an advisory of 17 subject matter experts (SMEs) with decades of professional and lived experience as members of these populations: 24% were Native Hawaiian or Pacific Islanders, 24% were Native American; SMEs were from 8 states and affiliated with 5 Native Nations or Tribes. At least 3 had experienced homelessness or incarceration.

The survey was designed in close collaboration with SMEs and informed by the landscape scan and literature. We conducted two national recruitment efforts to engage CHWs and allies to share their experiences through a national survey. CHW respondents were able to select up to two populations that they predominately served from the four toolkit topics. There were 47 respondents who completed the survey who selected Native Americans and Alaska Natives as a primary community served.

Survey data was analyzed using descriptive statistics (quantitative data) and thematic analysis (qualitative data).

These survey respondents were invited to a listening session to discuss the themes from the survey in greater depth. Thematic analysis was used to identify key themes from the listening sessions. A consensus-based approach to identify and select case examples from among survey and listening

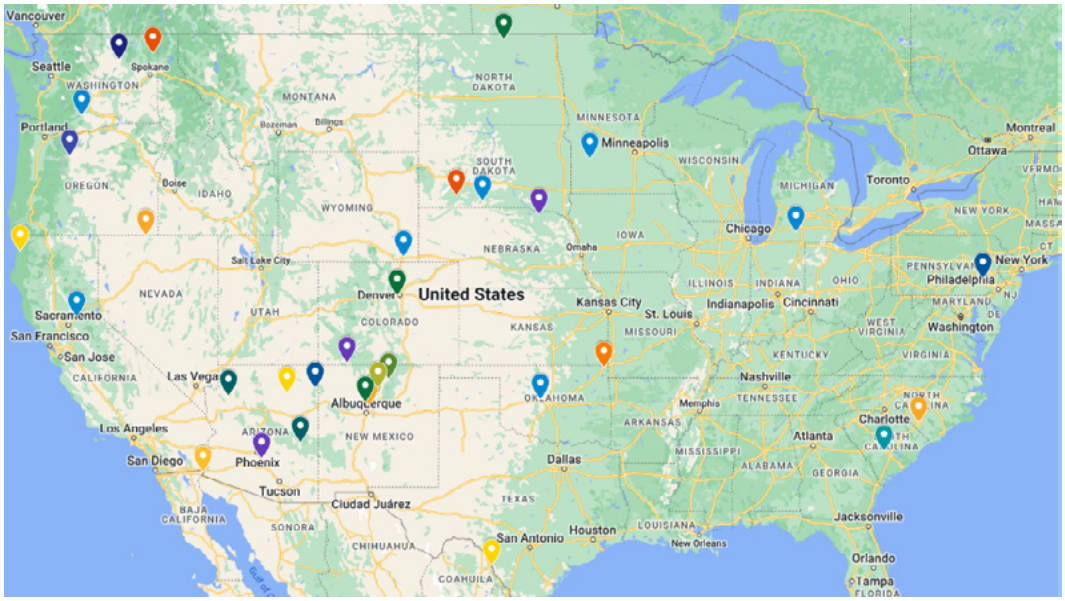


Figure 1. CHR/CHW Participant Location or Client Tribal Affiliations* – *Created using Google Maps

session participants, landscape search, and SME recommendations. Criteria for selection of case examples included CHW leadership, innovation, community involvement and empowerment, adaptability, impact on health outcomes, health and social needs addressed, sustainability, and diversity of examples.

Individual interviews were conducted with the CHWs highlighted in case examples to learn more about their work, startup, challenges and innovations. Case examples were developed based on key themes highlighted in these interviews.

TABLE 1. IHS SERVICE AREAS REPRESENTED AMONG RESPONDENTS

IHS Areas:

Albuquerque
- Pueblo of Santa Ana
- Ohkay Owingeh
- Santo Domingo Pueblo
- Taos Pueblo
- Pueblo of Zia
- Pueblo of Laguna

Phoenix
- Gila River Indian Community
- Hualapai Tribe
- Hopi Tribe
- White Mountain Apache Tribe
- Pima
- Cocopah Tribe

Oklahoma
- Peoria Tribe of Oklahoma
- Kickapoo Traditional Tribe of Texas
- Cherokee Nation

Great Plains
- Ponca Tribe of Nebraska
- Turtle Mountain Band of Chippewa
- Oglala Lakota
- Rosebud Lakota
- South Dakota Tribal Populations-Great Plains

California
- Yurok Tribe
- Chapa-De Indian Health Program, Inc.

Nashville
- Lumbee Tribe of North Carolina
- Pine Hill Indian Tribe

Portland
- Confederated Tribes of the Colville Reservation
- Fort McDermitt Paiute Shoshone Tribe of Nevada and Oregon
- Confederated Tribes of the Warm Springs
- Yakama Nation
- Nez Perce Tribe
- Confederated Tribes of Umatilla Indian Reservation
- Kalispel Tribe of Indians

Navajo
- Navajo Nation
- Ute (not specified)

Bemidji
- Anishinaabe Ojibwe
- Upper Sioux Community
- Nottawseppi Huron band of the Potawatomi

Alaska
- Anchorage area Native American community members

Resource List

[report] Seven Directions Cetner for Indigenous Public Health Indigenous Social Determinants of Health, https://www.indigenousphi.org/isdoh/about

[Training] Seven Directions Cetner for Indigenous Public Health Indigenous Social Determinants of Health training modules (https://www.indigenousphi.org/isdoh/training) and report (https://www.indigenousphi.org/isdoh/isdoh-training-modules-report)

[Toolkit] Rocky Mountain Tribal Leaders Council Good Health and Wellness Toolkit, https://www.rmtlc.org/good-health-wellness-in-indian-country-cdc/#1714659579822-86387564e1-2301

[Data dashboard] Health Data: Alaska Native Tribal Health Consortium Epidemiology Center, https://epi.anthc.org/health-data/

[Report] Alaska Native Health Status Report (2021), https://epi.anthc.org/wp-content/uploads/2024/11/Alaska-Native-Health-Status-Report-3rd-Edition.pdf

[Map] Native Lands Digital Map, https://native-land.ca/

References

1. National Indian Health Board. Indigenous Determinants of Health. Accessed November 13, 2024. https://www.nihb.org/idh/
2. Seven Directions. Indigenous Social Determinants of Health Training Module. Accessed May 5, 2024. https://www.indigenousphi.org/isdoh-training-modules/module-5
3. Rodriguez J. Tribal health workers aren't paid like their peers. See why Nevada changed that. Oklahoma Voice. https://oklahomavoice.com/2023/09/01/tribal-health-workers-arent-paid-like-their-peers-see-why-nevada-changed-that/. September 1, 2023. Accessed October 14, 2024.
4. Gampa V, Smith C, Muskett O, et al. Cultural elements underlying the community health representative – client relationship on Navajo Nation. *BMC Health Serv Res*. 2017;17:19. doi:10.1186/s12913-016-1956-7
5. Brown S. Supporting Indigenous-Led Solutions to Health Equity and Racial Justice - Blue Cross and Blue Shield MN. 2022. Accessed May 5, 2024. https://blog.bluecrossmn.com/our-communities/supporting-indigenous-led-solutions-to-health-equity-and-racial-justice/
6. O'Neill E. Unrecognized Tribes Struggle Without Federal Aid During Pandemic. NPR. https://www.npr.org/2021/04/17/988123599/unrecognized-tribes-struggle-without-federal-aide-during-pandemic. April 17, 2021. Accessed April 17, 2024.
7. Sabo S, O'Meara L, Yellowhair J, et al. Community Health Representative Workforce: Integration across systems and teams to address the social determinants of indigenous health and wellbeing. *Front Public Health*. 2023;11. doi:10.3389/fpubh.2023.1047152
8. Roberts N. 7 Native American Inventions That Revolutionized Medicine And Public Health. Accessed December 5, 2024. https://www.forbes.com/sites/nicolefisher/2020/11/29/7-native-american-inventions-that-revolutionized-medicine-and-public-health/
9. Bennett G, Cuevas K, Merchant A. Biden issues 'long overdue' apology for federal Indigenous boarding schools | PBS News. https://www.pbs.org/newshour/show/biden-issues-long-overdue-apology-for-federal-indigenous-boarding-schools. October 28, 2024. Accessed October 28, 2024.

10. Alaska Native Health Status Report. Alaska Native Tribal Health; 2021. Accessed November 17, 2024. https://epi.anthc.org/wp-content/uploads/2024/11/Alaska-Native-Health-Status-Report-3rd-Edition.pdf

11. U.S. Commission on Civil Rights. *Broken Promises: Continuing Federal Funding Shortfall for Native Americans.*; 2018.

12. Harvard T.H. Chan School of Public Health, NPR, Robert Wood Johnson Foundation. Discrimination in American: Experiences and Views of Native Americans.; 2017. Accessed May 5, 2024. https://legacy.npr.org/documents/2017/nov/NPR-discrimination-native-americans-final.pdf

13. Barcham M. Decolonizing Public Healthcare Systems: Designing with Indigenous Peoples. *She Ji J Des Econ Innov*. 2022;8(4):454-472. doi:10.1016/j.sheji.2022.10.004

14. Briones A dae R. Healthy Land, Healthy Food, Healthy People: A Cochiti Invitation to Join Us at the Table. Non Profit News | Nonprofit Quarterly. April 6, 2020. Accessed October 15, 2024. https://nonprofitquarterly.org/healthy-land-healthy-food-healthy-people-a-cochiti-invitation-to-join-us-at-the-table/

15. Sotero M. A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research. Published online 2006. Accessed April 10, 2024. https://papers.ssrn.com/abstract=1350062

16. Blue Bird Jernigan V, Peercy M, Branam D, et al. Beyond Health Equity: Achieving Wellness Within American Indian and Alaska Native Communities. *Am J Public Health*. 2015;105(Suppl 3):S376-S379. doi:10.2105/AJPH.2014.302447

17. GHWIC: Good Health & Wellness in Indian Country (2019-2024). Urban Indian Health Institute. August 29, 2019. Accessed November 17, 2024. https://www.uihi.org/projects/good-health-wellness-in-indian-country/

18. CDC. TPWIC Recipients and Funding. Tribal Practices for Wellness in Indian Country. September 13, 2024. Accessed November 17, 2024. https://www.cdc.gov/healthy-tribes-tpwic/php/funding/index.html

19. Indigenous Empowerment for Healthy Lifestyles. NACA. Accessed November 17, 2024. https://nacainc.org/health-promotions/indigenous-empowerment-for-health-lifestyles/

20. Garney WR, Wilson KL, Garcia KM, et al. Supporting and Enabling the Process of Innovation in Public Health: The Framework for Public Health Innovation. *Int J Environ Res Public Health*. 2022;19(16):10099. doi:10.3390/ijerph191610099

21. National Association of Community Health Workers. National CHW Survey. 2021. Accessed November 17, 2024. https://nachw.org/nationalchwsurvey/

22. Alavi S, Nishar S, Morales A, Vanjani R, Guy A, Soske J. 'We Need to Get Paid for Our Value': Work-Place Experiences and Role Definitions of Peer Recovery Specialists/Community Health Workers. *Alcohol Treat Q*. 2024;42(1):95-114. doi:10.1080/07347324.2023.2272797

23. Cherrington A, Ayala GX, Elder JP, Arredondo EM, Fouad M, Scarinci I. Recognizing the Diverse Roles of Community Health Workers in the Elimination of Health Disparities: From Paid Staff to Volunteers. *Ethn Dis*. 2010;20(2):189.

24. U.S. Department of Health and Human Services. Centering Lived Experience. Accessed November 17, 2024. https://www.hudexchange.info/programs/coc/centering-lived-experience

25. Greene K, Wilkniss S, Fiscus M, Roth E, Stevenson S, Tewarson H. Public Health Modernization Toolkit: Key Commitments, Priorities, and Strategies to Advance Collaboration between Public Health and Health Systems. NASHP; 2023. Accessed November 17, 2024. https://nashp.org/public-health-modernization-toolkit-key-commitments-priorities-and-strategies-to-advance-collaboration-between-public-health-and-health-systems/

26. Kaholokula JK, Ing CT, Look MA, Delafield R, Sinclair K. Culturally responsive approaches to health promotion for Native Hawaiians and Pacific Islanders. *Ann Hum Biol*. 2018;45(3):249-263. doi:10.1080/03014460.2018.1465593

27. Walters KL, Johnson-Jennings M, Stroud S, et al. Growing from Our Roots: Strategies for Developing Culturally Grounded Health Promotion Interventions in American Indian, Alaska Native, and Native Hawaiian Communities. *Prev Sci Off J Soc Prev Res*. 2020;21(Suppl 1):54-64. doi:10.1007/s11121-018-0952-z

28. O'Keefe VM, Cwik MF, Haroz EE, Barlow A. Increasing Culturally Responsive Care and Mental Health Equity With Indigenous Community Mental Health Workers. *Psychol Serv*. 2021;18(1):84-92. doi:10.1037/ser0000358

29. Cueva M, Cueva K, Dignan M, Lanier A, Kuhnley R. Evaluating Arts-Based Cancer Education Using an Internet Survey among Alaska Community Health Workers. *J Cancer Educ*. 2014;29(3):529-535. doi:10.1007/s13187-013-0577-7

30. U.S. Department of Justice. Culturally Responsive Pathways to Peer Programming in Tribal Communities. Bureau of Justice Assistance (BJA); 2023. Accessed July 3, 2024. https://www.cossup.org/Content/Documents/Publications/Altarum_Culturally_Responsive_Pathways_to_Peer_Programming_in_Tribal_Communities.pdf

31. U.S. Surgeon General. Our Epidemic of Loneliness and Isolation. Published online 2023.

32. Trinh-Shevrin C, Taher M, Islam N. Community Health Workers as Accelerators of Community Engagement and Structural Competency in Health. In: Hansen H, Metzl JM, eds. *Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health*. Springer International Publishing; 2019:167-177. doi:10.1007/978-3-030-10525-9_14

33. Islam NS, Zanowiak JM, Riley L, Nadkarni SK, Kwon SC, Trinh-Shevrin C. Characteristics of Asian American, Native Hawaiian, and Pacific Islander community health worker programs: A systematic review. *J Health Care Poor Underserved*. 2015;26(2, Suppl):238-268. doi:10.1353/hpu.2015.0062

34. Moeti R, Smith D, Rivera M. Approaches for Community Health Worker Sustainable Financing. Presented at: 2024; Envision Summit.

35. NACHW. The National Association of Community Health Workers Calls on Public and Private Institutions to Respect, Protect, and Partner with Community Health Workers to Ensure Equity During the Pandemic and Beyond. Published online 2023. www.nachw.org

36. Ameriks J, Briggs J, Caplin A, Lee M, Shapiro MD, Tonetti C. Older Americans Would Work Longer if Jobs Were Flexible. *Am Econ J Macroecon*. 2020;12(1):174-209. doi:10.1257/mac.20170403

37. U.S. Interagency Council on Homelessness (USICH. 1-Year Update on ALL INside: How USICH and the White House Are Helping Communities Address Unsheltered Homelessness.; 2024. Accessed September 11, 2024. https://www.usich.gov/news-events/news/1-year-update-all-inside-how-usich-and-white-house-are-helping-communities-address

Boston, MA, USA | info@nachw.org | www.nachw.org

NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

The National Association of Community Health Workers (NACHW) is a 501(c)(3) nonprofit membership-driven organization with a mission to unify CHWs across geography, ethnicity, sector and experience to support communities to achieve health, equity and social justice.