NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS (NACHW)

WHAT WORKS TOOLKIT SERIES

WHAT WORKS IN CHW APPROACHES AND INNOVATION SERVING NATIVE HAWAIIANS AND PACIFIC ISLANDERS

NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

JANUARY 2025

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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 Native Hawaiian and Pacific Islander CHWs, each with decades of expertise serving NHPI community members. We are immensely grateful for the expertise and dedication SMEs brought to this work by centering equity, inclusion and CHW self-determination.

Chauncey Hatico, CHW
Coordinator
Hawai'i CHW Association, Hawaii Public Health Institute

Chauncey Hatico is a Native Hawaiian Community Health Worker, rooted in his community. He joined Hawaii Public Health Institute in November 2023 as the Program Coordinator for the Hawai'i Community Health Worker (CHW) Association to support CHWs across Hawai'i. Before joining HIPHI, Chauncey worked as a CHW at HMSA Care Coordination, a CHW Supervisor at Hui Mālama Ola Nā' Ōiwi, and a Certified Medical Assistant at Queen's North Hawai'i Community Hospital. He has a CHW Certificate of Competence from Maui Community College and is a Certified Clinical Medical Assistant through the National Health Career Association. Chauncey is the Hawai' i Ambassador for the National Association of Community Health Workers. Chauncey is also a Musician, Kalo Farmer, Owner of Ku' u Ohana Farm, and Vice President of the Waipi' o Valley Taro Farmers Association. Chauncey believes that CHWs are vital in advancing health equity in Hawai'i.

Jessanie Marques, CHW
Founder and Executive Director
K'au Rural Health, Hawai'i

Jessanie Marques, affectionately referred to as "Auntie" Jessie, comes from Filipino, Native Hawaiian, Chinese and Japanese backgrounds which provide her intimate insight and lived experience of the inequity within families and communities that call Hawaii home. Auntie Jessie is a CHW and Founder and Executive Director of the Ka'u Rural Health Community Association Inc., a "grass roots" community based 501 C (3) non-profit organization serving a remote, rural underserved, geographically isolated vulnerable population in Ka'u. Auntie Jessie started Ka'u Rural Health as a response to a local healthcare system threatened with closure, and continues to provide CHW-led services and resources to her community members in Ka'u. In particular, Ka'u works to meet the many health and social needs of kupuna (elders), many of whom are living in rural and remote areas with very limited access to healthcare. In recognition of her tireless work serving her community, Auntie Jessie has been awarded the National Organization of Rural Health (NOSORH) "Community Stars" Award for the State of Hawaii

Nicole Moore, CHW
Operations Director
Hui Mālama Ola Nā 'Ōiwi
Native Hawaiian Healthcare System for Hawai'i island, Hawai'i

Nicole has been a CHW for most of her career, serving communities on the East Side of Hawai'i Island, as well as networking and providing service through partnerships through her role at Ke Anuenue AHEC. She has provided diabetes self-care support through Ke Anuenue, provided support for HPCA's CHW Certificate training program to the Big Island cohort, served on the

statewide CHW Conference planning committee from 2003-2006, supported community access to education through her role at UH Hilo. Nicole served as a NACHW Ambassador from 2019-2021 and is now the Operations Director at Hui Mālama Ola Nā ʻ Ōiwi, a part of the Native Hawaiian Healthcare System. Nicole is a tireless advocate for CHWs within Hawai'i and nation-wide.

Oreta Tupola, CHW, MSW
Executive Director
Utah CHW Association

Oreta M. Tupola is known for her advocacy and leadership in the state of Utah. Born and raised in Laie, Oahu, Tupola has deep roots in her community and has dedicated her career to serving its people. Tupola's journey into social health began with her involvement in education. She earned a Bachelor of Education from Brigham Young University–Hawaii and later a MSW from the University of Hawaii at Manoa. Her background in education shaped her commitment to improving the lives of the Community. In 2016, Tupola moved her family to Orem, Utah. During her time, Tupola focused on issues of health inequity, health disparities, and lack of access to resources for underserved communities. Throughout her career, Tupola has been a strong advocate for Native Hawaiian and Pacific Island rights and culture. She has championed initiatives to preserve and promote Pacific Island language, traditions, and practices. Additionally, she has been vocal about the importance of community inclusion and engagement in addressing sustainability for marginalized families in Utah. Tupola's leadership and dedication have earned her recognition and respect both on a state and national level. While her career continues to evolve, she remains committed to serving her community and fighting for the interests of all underserved populations.

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.

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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.

"NHPI groups in the U.S. have unique immigration and citizenship pathways which impact experiences from geography and immigration status to eligibility for safety net programs."

BACKGROUND

Native Hawaiians and Pacific Islanders (NHPI), the indigenous peoples of Oceania, are the first people from Hawai'i and the Pacific Islands that make up Micronesia, Melanesia and Polynesia. Pasifika peoples (NHPI) include many cultures and ethnicities with diverse and rich histories, traditions, languages, and practices.

NHPI living in the United States come from many ethnic and linguistic backgrounds including Kanaka Maoli (Hawai'i); Tagata Sāmoa (Samoa); Tongan (Tonga); Vosa Vakaviti (Fiji); Chuukese, Ifalikese, Kosraean, Pohnpeian; Yapese (Federated States of Micronesia); Chamorro (Guam), Marshallese (Marshall Islands); and Palauan (Palau). NHPI are one of the fastest growing ethnic groups in the United States—over 150 million people in the U.S. identify as NHPI.[1,2]

Native Hawaiians, Kanaka Maoli, are the first people of the land that makes up the current state of Hawaii, the land of the Kingdom of Hawai'i. Kanaka Maoli, like other Pacific Islanders, experienced good population health included including robust indigenous healing and medical practices, sovereignty, connection to the land ('āina), and in conflict resolution practices.[3,4] Native Hawaiians have a shorter life expectancy than other racial and ethnic groups in Hawai'i. The primary aim of this paper was to share data from the first year of a 5-year study with Native Hawaiian kūpuna (elders Colonization and imperialism brought mass

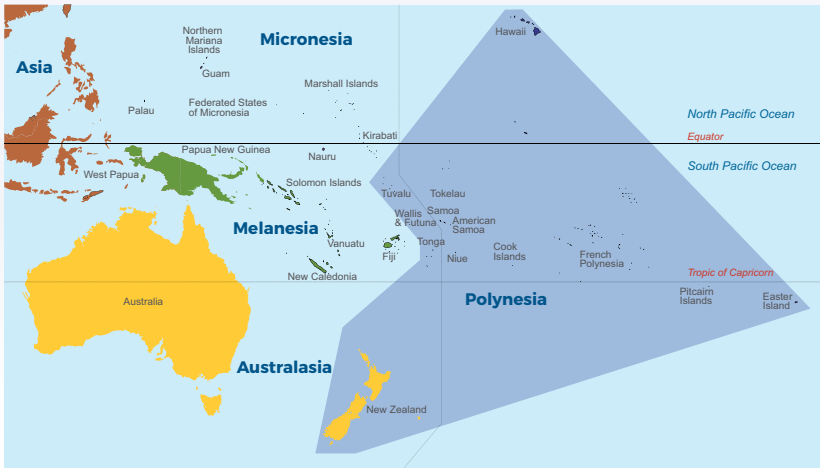


Image source: Wikimedia Commons

disease, conflict, changing food systems, and many socioeconomic forces that resulted in harm to physical and cultural health.

Like other Pacific Islanders, many Kanaka Maoli in recent decades have been displaced throughout the contiguous U.S. due to the continued impact of colonization and economic disenfranchisement. In the face of these challenges, NHPI communities in the U.S. continue to persevere to retain and revitalize their languages, cultures and communities.

NHPI groups in the U.S. have unique immigration and citizenship pathways which impact experiences from geography and immigration status to eligibility for safety net programs. For example, those born in Marshall Islands, Palau,

and Federated States of Micronesia have lawful non-immigrant status as part of The Compact of Free Association (COFA), a response to forced displacement caused by U.S. military testing. Almost 70 nuclear weapons were tested in the Marshall Islands, causing long-term health problems and environmental destruction.[5,6] People born in Guam and the Northern Mariana Islands are U.S. citizens by birth, while those born in American Samoa are U.S. Nationals, a more restricted status.

With histories and current realities deeply impacted by climate and environmental justice, Pasifika communities have continued to lead in fights for justice, health and equity, and climate justice.

The scope of this toolkit focuses on NHPI living in the states, however, NHPI in the U.S. also includes U.S. citizens and nationals living across territories in the Pacific.

CURRENT STATE OF HEALTH EQUITY AMONG NHPI COMMUNITIES

SOCIAL DETERMINANTS OF HEALTH (SDOH) AND HEALTH-RELATED SOCIAL NEEDS (HRSN)

> *"The "United States' colonial, post-colonial, and military actions in the region have resulted in adverse socioeconomic, health, and environmental pollution-related legacies among local and Indigenous [NHPI] populations"* [7]

NHPI communities in the U.S. retain unique cultures and histories, as well as some varying trajectories and barriers in the U.S, and at the same time share many common experiences, histories, values and practices.

Overall, NHPI experience disproportionate health burdens regardless of where in the U.S. they live, stemming from the legacies of U.S. colonization and imperialism in Hawaii and the Pacific islands.

Indigenous Social Determinants of Health (ISDoH)

Like Native Americans and Alaska Natives, NHPI public health includes indigenous determinants of health or indigenous social determinants of health (ISDoH). In addition to the SHoH that affect all communities and individuals, ISDoH include factors such as:

- the impacts of historical trauma and ongoing impacts of colonization and imperialism
- racism and discrimination
- displacement and environmental destruction
- sovereignty
- cultural wellbeing
- connection to the land and sea and traditional food systems[4]

Displacement: Many NHPI have been already displaced from their native lands and continue to experience additional displacements due to cost of living and other factors. Displacement represents an underemphasized social determinant of health which has wide-ranging impacts on physical and mental health.

Historical trauma: CHW respondents highlighted the impact of historical trauma as a key driver of the health inequities, burdens, and barriers experienced by NHPI communities. Many CHW-led innovations accounted for the impact of historical trauma and need to help people feel connected to culture and community in response to the overlapping historical traumas and displacement.

Social determinants of health (SDoH) impacting many NHPI communities include:

- **High cost of living and high rates of poverty:** As a group, NHPI experience high rates of poverty and uninsurance.[8]
  - Native Hawaiians (Kanaka Maoli): The most expensive state to live in, the cost of living in Hawaii is almost 80% above the national

average.9 Native Hawaiians experience the highest poverty rates of the major racial and ethnic groups in Hawaii.

- Marshallese: Despite the U.S. government's acknowledged destruction and resulting forced displacement, treaties have provided very limited restitution. Almost 30% of Marshallese (27%) live under the federal poverty level, along with 16% of NHPI overall in U.S. -- greater than the national average (12.6%). Much greater numbers live close to the poverty level.[8,10]
- CHW survey respondents highlighted the harmful impacts of extremely high cost of living in states like Hawaii and lack of affordable housing on the communities they serve.

- **Immediate basic needs:** Socioeconomic forces have caused crises of housing and food insecurity along with ongoing barriers to education and employment—necessary milestones that allow people to maintain basic needs.
  - CHW participants across all WWTS topics described how high levels of immediate basic needs results requires significant time and attention, delaying their ability to focus on securing and building sustainability toward longer term individual and community needs.
- **Access to healthcare:** CHW survey participants highlighted barriers to healthcare access among NHPI including lack of culturally informed care, language access, transportation, and availability of healthcare services. CHWs explained that historical trauma, cultural misalignment, and access barriers have resulted in mistrust of western healthcare systems and provider.

  Also documented are high rates of uninsurance or barriers to health insurance coverage, discrimination and prejudice,[11] and low utilization of services.[12]
  - Transportation: Due to limited availability of healthcare services especially in rural areas, transportation poses a significant barrier and can require traveling to other islands for care. This is especially challenging for kūpuna (elders).
- **Chronic health conditions:** NHPI communities experience disproportionately high rates of diabetes, identified as an epidemic within NHPI communities,[13] hypertension, and other chronic conditions.[12,14]
- **Mental health and substance use:** Mental health is linked to many health and social challenges among NHPI, including suicide, violence, substance use, incarceration, and homelessness.[15]
  - Mental health and substance use burdens were highlighted by CHW respondents including depression, suicide, and violence (including domestic and sexual violence), stemming from historical trauma and cumulative impacts of colonization, dispossession and displacement.
- **Special populations:** CHW survey respondents highlighted groups experiencing additional health burdens within the NHPI population including older adults (kūpuna (Hawai'i)), children (keiki (Hawai'i)), women, people with low technology comfort or access, people with disabilities and/or chronic health conditions (including mental health), rural residents, and people with a primary language other than English.[15]

POLICY AND PRACTICE HIGHLIGHTS

Most peer reviewed research on CHW interventions serving NHPI focuses on interventions targeting one condition or disease such as diabetes or breast cancer screening. Fewer focused on mental health and other risk factors and health related social needs.[16]

Data disaggregation: Data on NHPI health needs and outcomes have often failed to reflect

the diversity of the NHPI population, frequently grouping NHPI and Asian Americans together as one group. Policies and efforts to disaggregate public health data aim to allow for better understanding of the health needs and outcomes of NHPI ethnic groups.1,[17]

Policy and systems change successes: reflecting decades or more of effort were seen as improving the health of community members, improving and building systems for community health infrastructure, include:

- The Native Hawaiian Health Care Improvement Act most recently amended in 1992, established Papa Ola Lokahi, the organization tasked with planning and overseeing the Native Hawaiian Healthcare System, reduced barriers to healthcare access, services for remote patients, recognizes traditional healers.
- A large payer integrated payment structure for some Native Hawaiian cultural practices as "value added services" including Ho'oponopono (relationship balance and healing), lomilomi (Native Hawaiian physical therapy and massage), some la'au lapa'au (Native Hawaiian medicine and herbal remedies).
- Medicaid and benefit restoration for COFA citizens so that those present under COFA can access needed healthcare, SNAP, and earned social security which they had been denied.

CHW ROLES SERVING NHPI COMMUNITIES

CHWs work within and across community and clinical settings creating a web of support for NHPI community members.

Within the public health literature, CHW interventions serving NHPI include health education and counseling, recruitment, community outreach, and follow-up with participants. While these represent critical CHW roles, they do not represent the full scope of CHW efforts serving NHPI communities identified by the WWTS.

Additional roles and activities described by CHWs included healthcare and resource navigation; addressing intersecting SDoH and HRSN; advocacy; developing and carrying out innovative activities to address community health needs; cultural mediation and bridging; adapting and developing culturally relevant health education curricula; and social support, community cohesion and cultural connection.

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.[24]

WHY IS CHW-LED INNOVATION IMPORTANT?

Decades of public health evidence demonstrates CHWs' 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, 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 CHWs often are from or share common health barriers. Due to this unique position, 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 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.[25]

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 (PwLE) in the design of policies and programs and cross sector investment in community health.[27,28]

"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

However, 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. CHWs must be included in these efforts to ensure innovations are community-driven, culturally relevant, and locally responsive.

WHAT IS UNIQUE ABOUT CHWS' PERSPECTIVES?

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.

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 CHWs with expertise and understanding of the immediate and long-term needs of clients and communities.

CHW-LED INNOVATION

Types of CHW-led Innovation (Adapted from (Garney et al., 2022) to reflect CHW-led innovation approaches).

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.

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.

Paradigm shift / Reframing the way a problem is understood or addressed: Upstream innovation, policy or system improvement, including building new community health infrastructure, 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]

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**.

INDIVIDUAL HEALTH AND SOCIAL NEEDS

CHWs described routinely helping clients access HRSN, most notably, housing. CHWs translated materials, conducted outreach, and helped clients fleeing domestic violence access shelter and safety.

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

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

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

Culturally grounded approaches to addressing health inequities in NHPI communities include integration of traditional worldviews and practices such as use of traditional dance to reduce CVD risk and traditional food and diet for obesity.

A community-designed project called PILI 'Ohana Project (POP) deployed NHPI CHWs as community peer educators to enhance cultural relevance and sustainability, resulting in improvements in measures of diabetes and obesity risk.13

Ke Ku'una Na'au (KKN), another culturally grounded effort featuring CHWs, sought to reduce hospital readmissions among vulnerable Native Hawaiian adults. KKN, a program of the Native Hawaiian Health Program (NHHP) at Queen's Health System, integrated Native Hawaiian values and concepts focused on trust and care. KKN was found to be effective in reducing readmissions.25

WHAT WORKS: BUILDING TRUSTING RELATIONSHIPS AND CULTURALLY ALIGNED APPROACHES

Building trusting relationships is a foundation of CHW practice. CHWs emphasized the importance of trust, patience, listening, being from the community and being seen as being from the community or being on equal footing in serving NHPI community members.

- Patience and listening: CHWs emphasized the importance of taking time to build relationships with clients and community members, "really listening," not interrupting, and allowing people to tell their stories. CHWs take time to listen and understand where clients are coming from and what challenges and needs they are experiencing. Many CHWs described the ways in which profound client needs were only revealed to them once a trusted relationship was established.
- Care: CHWs discussed the importance of showing or demonstrations of care, keeping promises, and showing you are excited to see clients
- Shared lived experience: CHWs shared the importance of drawing on shared cultural, community and personal experiences.

"I always remember to listen to the client first, before I start. As a Native Hawaiian born and raised on the island, I know about the mistrust that my people have of the Westen outsiders" - Aunty Geri Kaleponi

- Cultural sensitivity and reducing barriers: Despite many shared and similar values and experiences, NHPI cultures are diverse and CHWs described the importance of not assuming and learning what is appropriate in a clients' culture. Culturally appropriate clothing, following customs, and translation of health material and information into client languages were also highlighted as essential.
- CHWs who were also CHW supervisors or employers discussed the importance of employing staff from similar backgrounds to their client population and ensuring equitable pay.
- CHW survey respondents identified key practices and factors for building trust including:

"The biggest thing is trust—CHWs live in the community, CHWs address the needs of the community because they understand the cultural, economic and social engagement that is needed, and barriers to access to healthcare."

– Auntie Jessanie Marques

- Spending time with clients (90%)
- Understanding the cultures clients come from and adapting to cultural norms and practices (86%)
- Building relationships with community leaders or gatekeepers (79%)
- Accountability (doing what I say I am going to do, returning data findings to the community after asking for data) (72%)
- Following clients' cultural norms or expectations (69).
- Most CHWs said that being from the community or having shared lived experience (76%) was essential for building trust, and almost as many highlighted the importance of community members seeing them as being from the community or having shared lived experience (72%).

Policy

CHWs engage in policy advocacy as individual experts, organize other CHWs and providers to advocate, and educate policy-makers about the needs of community members and strategies to improve the health of their constituents.

Community

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, 26, build capacity within communities and mobilize community members to address community needs and advocate for public health priorities.24

In addition to building trusted relationships with clients and community members that is foundational to all CHW practice, CHW respondents shared many examples of "what works" in serving NHPI clients, drawing on traditional cultural practices and values. This is essential to building and maintaining trust and efficacy of public health efforts.

> *"Ironically, many of the cultural grounded approaches…are actually a return to traditional worldviews and practices that were part of every-day life for indigenous communities and a source of their wellbeing prior to Western intrusion."* [13]

- Native Hawaiian values including Aloha (caring, love, compassion), lokahi (balance, harmony, unity), mālama (care, protection, stewardship), ha'aha'a (humility), kokua (helping one another, cooperation, reciprocity), kuleana (responsibility), 'olu'olu (graciousness), laulima (cooperation, many hands working together), ahonui (patience, perseverance), 'ohana (family), akahai (kindness), and pono (integrity, nurturing what is right and just.)[27]
- Tauhi vä (nurturing relationships (Tongan))
- Kilo (observation) and kino (body), an indigenous form of mindfulness.
- Respect for elders

Working for the community: CHWs described working for the community first and foremost. One respondent explained that sometimes accountability to the community has put them at odds with the mainstream/western systems and even their own employers. However, providing the highest level of care and support to the community in ways that work for community members is the priority.

"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 positiosn 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)[16]

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. For NHPI communities, integrating cultural practices and traditional knowledge and values represented an important innovation and component of effective practice.

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. For example, providing food was seen as an essential component of outreach and engagement of NHPI community members and when possible, can be written into program budgets.

To help address mistrust of medical systems, programs 1) provide access to language services, 2) offer CHW accompaniments to appointments, 3) conduct outreach to people where they are (e.g., churches, remote areas, villages, ceremonies), and 4) integrate traditional cultural understandings and practices into programming. In addition to program delivery, ensuring CHWs are paid a living wage (and especially that CHWs should not need to work multiple jobs) was seen as an essential and foundational program/organizational priority.

Designing programs to be culturally sensitive and relevant included of integrating traditional cultural practices and understanding that "our own cultural best practices work for us." Mainstream "best practices" may not be helpful or accessible for NHPI community members. Sharing knowledge of cultural practices empowers the culture and educates community members in health promoting knowledge and behaviors.

CHW-LED COMMUNITY-BASED INNOVATIONS: CHW'S LEADERSHIP VOICE TO INNOVATE

We selected case examples of CHW-led innovations highlighting the strengths, assets, barriers and potential of CHW-led innovation to transform and improve NHPI health. Case examples were selected from among WWTS respondents, word of mouth recommendations, and a landscape scan to identify, of CHW-led efforts.

In total, 17 out of 29 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, founding organizations to address community needs, coordinating culturally relevant health and resource fairs, helping people access housing, culturally rooted programming and health education.

INCREASING ACCESS TO CULTURALLY ALIGNED HEALTHCARE

CHW Leader: Geri Kaleponi, Ho'okuikahi Festival

Geri Kaleponi, known as Aunty Geri, is a community leader who has been a CHW far longer than she has held the title. Geri works as a CHW providing essential case management and navigation for kūpuna (elders), but much of her community health outreach work is done as a volunteer outside of her paid role out of a deep care for her community and Lahui (people).

Due to the historic harms and ongoing harmful practices of researchers and providers who come into the community, mistrust of the western medical system is common among kāne (men), and especially in remote villages. This results in people going without needed care and prevention.

Aunty Geri understands the high rates of diabetes, obesity, substance use, domestic violence, as stemming from the historical trauma and as she says, "what was taken from us before we were born." During the decades Aunty Geri has worked in the Kanaka Maoli (Native Hawaiian) community, she has observed the legacies of this historical trauma in everyone she encounters and remains dedicated to helping her community heal from it.

"You have to go to the people, they can't or won't come to you. They love it when you come, they are so appreciative, nobody really helps them, they don't have the help that they need. Why shouldn't they be able to get that, because of their demographics or financial status?"

Outside of her paid role as a CHW, Aunty Geri carries out community health initiatives with people most in need of health and medical care, but who also have mistrust of western medicine. One of her major efforts, she organizes an annual effort to reach kāne as part of a large gathering from men across all islands for Ho'oku'ikahi, a ceremony for kāne to honor King Kamehameha 1. Geri developed and currently leads programming to integrate community health resources as part of the gathering which brings men together to connect with and honor culture and history.

Aunty Geri has worked with a team of Native Hawaiian professionals to develop a comprehensive health and social needs assessment for attendees and currently coordinates a roster of Native Hawaiian doctors and nurses. She connects attendees with Native Hawaiian providers who understand their struggles and culture, so that they can get access to medical care. After 25 years of organizing this work, Geri says "they trust us because they see us every year". This event helps to put them in contact with Native Hawaiian providers.

Barriers to accessing healthcare, and mistrust of western healthcare systems due to historical trauma and past experiences of discrimination requires culturally centered approaches to serving the community. CHWs bring healthcare services and navigation to the community through outreach events, health fairs, and culturally rooted efforts.)

PACIFIC COMMUNITY OF ALASKA (PCA)

CHW Leaders: Tafilisaunoa (Tafi) Toleafoa, Executive Director and Mavis Boone, Director of Programs | Website: www.pcalaska.org

A group of NHPI community members posing for a photo at a PCA eventIt all began with a simple conversation. In the midst of the COVID-19 pandemic, a small group of Native Hawaiian and Pacific Islander (NHPI) community members recognized the negative impact the virus was having on NHPI communities in Alaska. Together, they gathered to share their observations, voice their concerns, and develop strategies to support their community through this challenging time. From these initial discussions, a new organization would emerge: the Pacific Community of Alaska (PCA), born from the collective determination to protect and serve Alaska's NHPI community during their time of greatest need.

Need for innovation: Although they knew NHPI were experiencing frequent hospitalizations due to COVID, the state data was not showing it, leading to inadequate public health response. As their first major effort, the group advocated for the state to disaggregate COVID data. Once disaggregated, the data confirmed high rates of hospitalization for NHPI - this became a call to action.

Alaska has one of the largest NHPI populations in the U.S. NHPI has been inadequately understood and served by public health systems that use aggregate data which groups together NHPI and Asian Americans.

PCA got to work immediately addressing the pressing needs of community members. Using the newly disaggregated data, PCA advocated for funding to support its efforts to serve NHPI communities deeply impacted by COVID. PCA got to work addressing pressing COVID-related needs. Misinformation was also prevalent, and high-quality information was only available in English. PCA translated important health information, provided vaccine education to community members, set up 12 pop-up clinics, administered vaccinations, distributed at-home tests, presented COVID health education sessions to churches, and engaged community members and churches to bring more people to get vaccines.

Once COVID slowed down, PCA expanded its services and shifted focus on addressing underlying health conditions and ongoing community needs. Building partnerships has been essential to PCA's growth and ability to serve the community. PCA became a 501(c)3 nonprofit in 2021. Tafi and Mavis are both "lifelong" CHWs.

Why it's innovative: NHPI experiences high rates of chronic health conditions including diabetes and hypertension, which led to the disproportionate impacts of COVID. During COVID, NHPI with underlying health conditions and who were immunocompromised were sent home without any guidance or follow-up regarding these chronic conditions. There is also a lot of historic mistrust of providers and misinformation has been prevalent.

PCA provides holistic community care, grounded in trusted, culturally relevant, trauma-informed CHW-client relationships.

Culturally rooted, CHW-led: PCA is a CHW-led CBO that mobilizes CHWs to address community health needs among NHPI in Alaska. PCA approaches health holistically and communally. PCA engages with families intergenerationally including extended families, as is common in NHPI cultures, and utilizes culturally sensitive approaches to avoid re/traumatization. PCA hires NHPI CHWs who "know the culture and how to speak with people, how to be respectful and make people feel safe and accepted."

Through culturally rooted programs and partnerships to address NHPI health, PCA has built community health infrastructure for NHPI in Alaska by partnering with trusted healthcare systems, and contributes to development of national NHPI- led, CHW-led public health organizational infrastructure as a member of the National Association Of Pasifika Organizations (NAOPO).

PCA has several core programs, mostly staffed by CHWs.

- **Health and wellness:** CHWs provide health education, outreach, and health and social resource navigation. Through relationships with clients, they help access needed resources (e.g., housing, health insurance, social security, etc.). PCA has also carried out community mental health promotion activities.

  "When people realize they have someone who speaks their language, they open up and share more about the barriers that are preventing them from accessing needed healthcare."

- **Domestic violence and sexual assault (DV/SA):** Alaska Pasifika Safe Homes program (APSH) provides culturally appropriate trauma-informed case management, navigation and resources for survivors of DV/SA and culturally sensitive DV/SA prevention programming like Talanoa and Film. Understanding these sensitive issues from a cultural lens allows PCA to filter the information for our people and provide culturally appropriate responses where necessary. The APSH Program was initiated and guided by the understanding that many NHPI families live in multi-generational homes where those affected by DVSA are not only the nuclear family unit but all members of

the home who are the extended family, for example, grandfather, grandmother, cousins, siblings, etc.

Many of the DV/SA resources available are not tailored for the NHPI community. The existing framework seeks to break up families where services are tailored to age-groups which in turn re-traumatizes families going through these situations. The APSH Program purports to maintain the family unit (whether nuclear or extended) as opposed to dismantling it whilst navigating their new circumstances.

- **Community response and civic engagement:** PCA serves as a community resource. It has been brought in to help with issues including voting rights and intimidation and police brutality. PCA carries out activities to help people understand their rights and help people access legal assistance when needed.
- **Community health promotion:** PCA provides opportunities for NHPI community members to come together, build community through culturally rooted health promoting activities including traditional dance (e.g., hula) and step-aerobics classes. PCA has provided interpretation and translation at health clinics to address language access as a key Social Determinant of Health (SDoH) within the NHPI community.
- **Partnerships:** PCA's CHW team has strong connections with primary care providers at the Anchorage Neighborhood Health Center (ANHC), a Federally Qualified Health Center (FQHC), to bridge the gap between NHPI community members and primary care. This partnership has been essential for serving some of the most disenfranchised community members, removing barriers to access related to cost, literacy, language or immigration status. PCA is also connected with the Alaska Department of Health, the Anchorage Municipality Health Department, the Providence Alaska Medical Center CHW program, ANHC, and other DV/SA providers and CHWs in Anchorage, Fairbanks, Juneau, Matanuska Valley and Utqiagvik.

PCA recently co-hosted the 2024 Pacific Health Gathering in Anchorage with NAOPO with over 300 attendees from across the US, Pacific Islands, and New Zealand. CHWs and other healthcare providers shared culturally appropriate best practices and innovations developed during COVID.

Challenges: The NHPI community in Alaska has experienced many nonprofits "going in and out" due to funding, which can

exacerbate mistrust of health providers. As a newer organization focused on comprehensive and holistic services and community-centered programming, accessing sustainable funding can be a challenge, as funding is often siloed for specific health behaviors or activities (e.g., smoking cessation). Often, funding doesn't allow CHWs to cross boundaries, systems and issues and address interconnected SDoH. Additionally, finding expertise within the community to build infrastructure reflects an ongoing challenge.

How PCA has addressed these challenges: PCA has worked to develop strong partnerships with various health care and DVSA providers,,. PCA maintains consistent communication with the local healthcare system, connects with their CHW team

and receives referrals from many partners. PCA has provided public testimony at the local assembly meeting to demonstrate the critical need for funding this type of CHW-led work. It also serves as a member of the Alaska Community Health Worker Network (AK CHW Network) currently being developed which will serve to elevate the Alaska CHW workforce.

IMPACT:

In the three years it has been active, PCA has served over 3,500 community members through individual services and hosted at least 30 community events during which they engaged over 1000 community members. PCAs impact is also seen in rich stories of community members they have helped, "stories that can't be captured in data and metrics."

Ka'u Rural health 25 year anniversary

ADDITIONAL CHW-LED CBOs SERVING NHPI

Many more NHPI CHW-led or co-led organizations provide critical community health capacity to address the health needs of NHPI communities throughout the United States, including We are Oceania (WAO), Arkansas Coalition of Marshallese (ACOM), Utah Pacific Islander Health Coalition (UPIHC), Kula no nā Poʻe Hawai'i (serving the Papakolea Hawaiian Homestead Region), and Pacific Island Knowledge 2 Action Resources (Pik2Ar) and Kalanihale (serving Milolii, Hawai'i).

NEED FOR AND BARRIERS TO CHW-LED INNOVATION FOR NHPI COMMUNITIES

Need for CHW-led innovation: Researchers have highlighted a "paucity of empirically based health promotion interventions designed by and for Native Hawaiians,[28] emphasizing the importance of community-led design of public health innovation. In addition, there is a lack of research on CHW interventions within the smaller Pacific Islander ethnic groups in the U.S. including Chamorran, Chuukese, Marshallese, Micronesian, Tongan, and other PI communities.[16]

> **NHPI public health scholars have called for culturally grounded and adapted approaches to addressing the overlapping chronic disease epidemics in NHPI communities.[13,29]**

The drive for innovation among NHPI-serving CHWs is evident – over two-thirds (72%) of CHW survey respondents said that if they had the funding and resources needed, they would help start a new program or initiative to help the community and the same number said they would "spend more time engaging in advocacy." Two-thirds said they "would improve the services or resources they deliver." CHWs shared ideas for building community health capacity, meeting the needs of vulnerable subgroups like elders and unhoused people, advocating for responses to upstream social determinants of health, and advancing workforce capacity among CHWs serving NHPI.

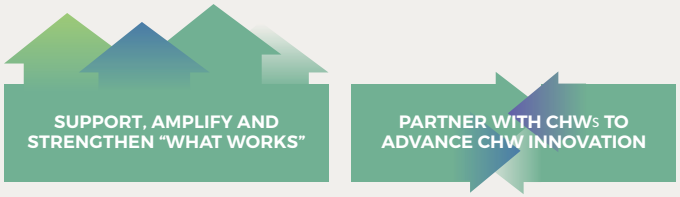
Barriers to CHW-led innovation: Despite the importance of CHW and community-led innovations, CHW respondents identified several barriers preventing them from engaging in this work including no or limited funding (including funding with restrictions that prevent innovation) and lack of services and resources (e.g., lack of affordable housing). Respondents consistently emphasized the importance of addressing SDoH on a policy level including but not limited to affordable housing, rural infrastructure, transportation, cost of living, affordable quality childcare, and sustainable funding for CHWs.

"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." [30(p37)]

What Works for Partners:

How policymakers, funders and other partners help support, elevate, enhance and sustain CHW-led efforts to advance health for NHPI 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 clients experiencing homelessness. Many themes discussed by CHWs and SMEs aligned with the existing pillars of the NACHW SUSTAIN Framework for CHW Sustainable Financing[31] and the NACHW Policy Platform.[32]



SUPPORT AND SUSTAIN CHW LEADERSHIP IN ADVANCING "WHAT WORKS" AND CHW-LED INNOVATION

Partners including funders, employers, and policymakers can partner with CHWs 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 CHWs to understand, improve, scale, and sustain community health for NHPI community members.

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

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

RESPECT, CENTER, AND PROTECT CHW LEADERSHIP AND EXPERTISE

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

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

CHWs 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 CHW 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 CHW leaders with organizations or agencies with similar missions.

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 CHW-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 CHWs do, the local landscape of CHWs 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 CHW-led CBOs.
- **Following in line with data disaggregation, funding must also be "disaggregated."** Often funding for AANHPI goes to Asian American agencies and NHPI don't receive equitable access.

"NHPI must be leading any efforts to address NHPI public health"

"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."[33]

Flexibility: Ensure funding and programmatic flexibility (e.g., timeline, determining funding priorities), remove funding silos: CHWs 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.

- **CHW Employers:** Ensure CHW employees have time, flexibility, and autonomy to innovate, adapt and improve programs and services.
- **Funding flexibility is essential for effective CHW-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 CHWs from accessing needed startup funds.

- **Funding for less recognized activities that improve programming and promote CHW 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.

"We are always talking about breaking down these silos, but the funding comes in silos and [we are] talking about intersectionality but the funding is siloed. We look at health holistically, but the funding is still siloed. When you're looking to help the community, you have to approach it holistically." - Mavis Boone, CHW, Pacific Community of Alaska

"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." [30(p37)]

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

- The SUSTAIN[31] framework provides guidance around sustainable financing for CHW programs and roles to enable CHWs to build on and sustain "what works." The ability of CHWs to innovate requires sustainable, flexible funding—if innovations aren't sustained, community members lose the trust that is the hallmark of CHW 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 CHW-led innovations are included in the public health evidence base through integration of CHW leadership in program evaluation, funding for evaluation of CHW-led innovations, support for dissemination and championing CHW-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?"[33]

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 CHWs 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.

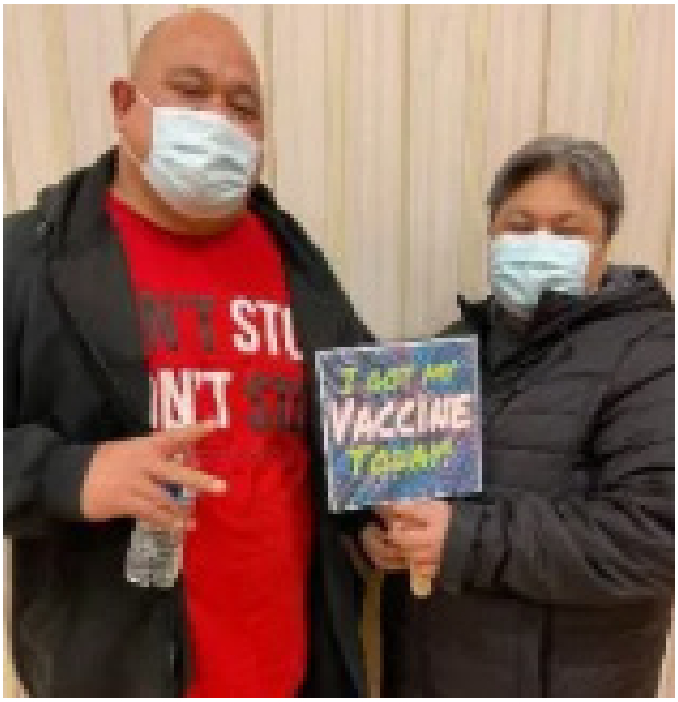
Methods

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 29 respondents who completed the survey who selected NHPI 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.



Pacific Community of Alaska Vaccination Event

Utilizing a consensus-based approach, SME workgroups identified and selected case examples from among survey and listening 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.

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*

Resource List

[data dashboard] AAPI Census Data: http://counts.aapidata.com/census2020/

[data] Hawaii Department of Human Services Annual Progress and Services Report: https://humanservices.hawaii.gov/wp-content/uploads/2021/01/Attachment-A-2021-APSR-Data-Booklet.pdf

[report] White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders (WHIAANHPI): https://www.hhs.gov/about/whiaanhpi/index.html

[article] (Re)constructing Conceptualizations of Health and Resilience among Native Hawaiians: https://www.mdpi.com/2313-5778/4/1/8

[report] A Health Equity Framework for Native Hawaiians: Mental Health: https://www.apiahf.org/resource/a-health-equity-framework-for-native-hawaiians-mental-health/

[resource library] Papa Ola Lokahi Resource page: https://www.papaolalokahi.org/reports-information

[resource library] Lili'uokalani Trust: https://onipaa.org/

[website] Kūkulu Kumuhana wellbeing framework: https://onipaa.org/kukulu-kumuhana

[report] Evaluation with Aloha: A Framework for Working in Native Hawaiian Contexts: https://onipaa.org/research-and-evaluation

[article] The Critical Role Hawai'i's Community Health Workers Are Playing in COVID-19 Response Efforts: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8538113/

[article] Challenges and Promise of Health Equity for Native Hawaiians - https://nam.edu/challenges-and-promise-of-health-equity-for-native-hawaiians/

[report] Native Hawaiian Health Task Force Report: Highlights and Recommendations: https://www.hawaii.edu/govrel/docs/briefings/2017/nhhtf_briefing-factsheet_01-17-17_hre-hwn-cph.pdf

[article] The Native Hawaiian and Pacific Islander National Health Interview Survey: Data Collection in Small Populations | Office of Minority Health https://minorityhealth.hhs.gov/news/native-hawaiian-and-pacific-islander-national-health-interview-survey-data-collection-small

[video] OHAHawaii A cultural approach to Native Hawaiian Mental Health: https://www.youtube.com/watch?v=B4_wf1RW8ww

[video] White House Initiative Asian American, Native Hawaiian, and Pacific Islander Mental Health Summit - https://www.youtube.com/watch?v=F0hjITBZidI

[podcast] NAOPO Pacific Pathways: Bridging Mental Health Gaps for Native Hawaiians & Pacific Islanders in Alaska (This episode features Native Hawaiian Pacific Islander community health workers from Pacific Community of Alaska, Mavis Boone, Kiyana Fonua, and Dash Popoalii, who were interviewed by a licensed professional counselor and mental health expert, Janet Ulukivailoa. They share some of their experiences that revolves around mental health, more importantly in their community in Alaska.) https://soundcloud.com/naopo/pacific-pathways-bridging-mental-health-gaps-for-native-hawaiians-pacific-islanders-in-alaska

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