NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS (NACHW)

**WHAT WORKS TOOLKIT SERIES**

# WHAT WORKS IN CHW APPROACHES AND INNOVATION SERVING PEOPLE EXPERIENCING HOMELESSNESS

NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

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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 CHWs and CHW-allies with decades of expertise serving people experiencing homelessness and developing and evaluating programming, and some have lived experience of homelessness. SMEs guided all aspects of our approach, including developing the survey instrument, leading listening sessions, identifying case examples and synthesizing key learnings.

**Catherine Haywood, CHW**
Co-Founder, Louisiana Community Health Outreach Network (LACHON)
Co-Founder, Women with a Vision
Co-Founder, National Association of Community Health Workers (NACHW)

**Claudia Hartz, CHW**
Behavioral Health Patient Navigator
Hawaii Island Community Health Center

**Angie Kuzma, MPH, CHW**
Policy and Advocacy Manager
National Association of Community Health Workers (NACHW)

## CHW CONTRIBUTORS

CHWs across the U.S. participated in the development of the WWTS by sharing their expertise and innovations through a national survey, listening sessions, and/or key informant interviews. We are grateful to all CHW contributors for sharing their stories, knowledge and the deep expertise that comes from CHWs' unique roles - expertise that forms the foundation for learning about and building consensus around "what works."

Alicia Hernandez
Alison Prior
Amanda Reid
Amanda Thompson
Ana Moncao-Conceicao
Angela Pruitt
Angelica Braden
Annie Morgan
Bob Branstetter
Bronte' Bailey
Brooke Jenkins
Cecilio Orta
Chloe Kidd
Christine Vang
Claire Fitiausi
Crystal Caday-Bargayo
Debora M Argueta
Deborah Locke-Rousseau
Denise Beck
Dewy Almanzar
Diosili Salazar
Doris A. Maldonado Méndez
Emma Petersen
Eric Harrison
Erica Cuesta
Etha Lasenby
Evelyna A Edwin
Florence Adegoke
Frances Gallardo
Georgia Hodge
Gerri Ashe
Gloria Queriapa-Valdes
Gri Saex
Hunter Ackerley
Ja'Len Husband
Jenni Rodriguez
Jessica Berning-Hill
Joana Goncalves
Joseph Mungathia Ekandi
Julie Sterling
Kathleen Banfield
Kavenia Clemons
Keisha Fuselier
Kelly Gibson
Lauren McQuade
Leticia Solis
Lina Roman
Loretta Richardson
Lynda K. Guess
Marianna Sova
Marlen Villatoro
Mary Montez
Mary Peavy
Maryam Oluwakemi Funmilayo
Matilda Webb
Mattie Clark
Melissa Mays
Michael Anderson
Nicole Sekelsky
Norman (Norm) Johnson
Patrice Simmons
Patricia Wilson
Philicia Turner
Precious Moore
Racquel Northrup
Ramona Román
Rebecca Backstedt
Regina Guevara
Renee D Wallace
Rosa Moody
Rosa Perez
Rose Marie Cazzani
Samuel Rontale
Sandra Putvin
Sashamarie Ayala-Nieves
Senge Ngalame
Serenity Kelly
Shanayla Stillman
Shannon Kelly
Sue Kucklick
Teresa Pinedo
Teresa Robert
Teresa Sosa
Terra Moreau
Tiffaney Partain
Tracy Ann Green
Vangie Tully
Vera Okungbowa
Magna Krieger
Wanda Price
Ya'nelle Powell
Yeny Arones
Yesica Saldana

Authors: Denise Octavia Smith, MBA, CHW, PN and 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:

1. 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).
2. Describe key elements of CHW-led public health innovation,
3. Highlight "what works" in CHW-led innovation and highlight case examples, and
4. 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 framework is used 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.

*"…the evidence shows that homelessness is largely the result of failed policies" 7(p15)*

# BACKGROUND

Homelessness represents one of the most intractable social, health and policy failures. Despite decades of policy efforts, progress has been piecemeal, limited and often temporary. People experiencing homelessness represent one of the most persistently underserved, at risk and undervalued populations in the country, face myriad health burdens, lack access to healthcare and health-related social needs (HRSN) such as housing, hygiene, food, social support, and basic safety. People experiencing homelessness face numerous health inequities and systemic barriers to health and safety.[1]

CHWs serving the unhoused population* include many with lived experience of homelessness or related challenges. As trusted partners, CHWs work to break down barriers to health and belonging by serving as connective tissue within the fractured public health ecosystem. Although the importance of CHWs as trusted messengers is well-established, the specific work of CHWs serving the unhoused population remains under explored.

## THE CURRENT STATE OF HOMELESSNESS IN THE U.S.

Over a million individuals and families experience homelessness annually, and many more are at risk of homelessness. Increasing numbers of the homeless population are unsheltered homeless (lack a "fixed, regular and adequate nighttime residence.")[3,4]

- Homelessness affects people and communities across age, race and ethnicity, gender, health status, geography, veteran status, citizenship and immigration status.
- Some groups experience disproportionate rates of homelessness: Native Americans and Alaska Natives, Native Hawaiians and Pacific Islanders, Black individuals, Latino/a individuals, LGBTQIA+ individuals, people with disabilities, people with HIV/AIDS, young adults leaving foster care, domestic violence survivors, and people in re-entry from incarceration [5,6]
- In addition to a lack of affordable permanent housing and long waitlists, there is a lack of safe, accessible shelter or interim housing options for people on waitlists. Often, shelters are full or deny entry to people most at risk, including those who are struggling with a mental health condition and/ or who have a substance use disorder (MH/SUD), have criminal records, live with a disability or chronic health condition, or identify as LGBTQAI+, despite anti-discrimination laws.[6]
- Building an efficient and effective homeless services system will require partners at all levels to understand and address these racial and health disparities.[6]

** Unhoused and homelessness are used interchangeably in this toolkit to reflect varied preferences of people with lived experience. The term unsheltered reflects an official government definition.*

## HEALTH EQUITY: SOCIAL DETERMINANTS OF HEALTH AND HEALTH-RELATED SOCIAL NEEDS

People experiencing homelessness face high rates of chronic health conditions (including physical, mental and substance use, vision and dental), and face multiple barriers to accessing healthcare.[5,7,8] The social determinants of health (SDoH) and health-related social needs (HRSN) experienced by people experiencing homelessness are multilayered and cumulative.

Common health barriers and HRSN reported by CHW respondents and documented in public health literature include:

- **Immediate basic needs:** Basic needs such as food and shelter often must be prioritized over accessing healthcare and needed social services.[9] CHWs described how this prioritization requires urgent responses and limits their ability to focus on longer-term needs.
- **Health-related social needs:** Transportation, access to hygiene (showers and laundry), phone and internet, social support, language and literacy, medication storage, security and safety, privacy, employment, and access to mail, identification and documents are common.[9]
- **Chronic health conditions:** Higher rates of and increased risk of chronic conditions including physical, mental health, and substance use conditions including HIV/AIDS, asthma, diabetes, and tuberculosis, which require ongoing care and management.[10]
- **Access to healthcare:** Despite high rates of unmet health needs, 60% of people experiencing homelessness lack health insurance and preventative care. This results in high rates of Emergency Department use,[6,11,12] a "costly revolving door between homelessness and the hospital healthcare system."[12]
- **Poor quality healthcare, bias, and discrimination:** Poor quality healthcare and adverse experiences include bias, discrimination, lack of care, paternalism, humiliation, dehumanization, and not being listened to.[9,11,13] Mistrust of healthcare providers or systems is not surprising given these experiences.
  - CHWs described experience witnessing firsthand or hearing about the dangerous and one CHW described lethal impacts of poor treatment on their homeless client population, including failing to provide necessary services and discriminatory care of people experiencing homelessness in healthcare systems and emergency rooms.
- **Mental health and substance use (MH/SUD):** Higher than average rates of MH/SUD include severe or serious mental illness (SMI) (21% of unhoused individuals), substance use disorder (SUD), (16%), suicide, and trauma prior to and/or as a result of the stresses of homelessness.[11] MH/SUD emerged as the most frequently reported health concerns among CHW respondents serving unhoused clients.

  *"untreated conditions, particularly mental health disorders and substance use problems, can propel people into homelessness by dismantling their financial stability, and these conditions can be made worse through periods of homelessness."*[10]
- **Violence and trauma:** Routine safety threats include exposure to unsafe sleeping conditions, environmental dangers, extreme weather, and interpersonal violence (domestic violence and sexual assault (DV/SA)). Homelessness is often traumatic, and personal histories of violence and trauma can increase risk for homelessness.[6,11]
- CHWs reported additional barriers and challenges facing their unhoused clients who are elders, people with disabilities or chronic health conditions, and people with low technology access.

## POLICY SPOTLIGHT

The ALL IN: Federal Strategic Plan to Prevent and End Homelessness was launched in 2022, leading to several local, state and federal policy initiatives nationwide aimed at tackling homelessness.[3] ALL IN highlighted homelessness as a public health issue, humanitarian crisis, and traumatic

experience with lasting impact. Notably, ALL IN emphasized the importance of centering people with lived experience (PwLE) in housing policy and initiatives and included PwLE in development of the plan.

The U.S. federal government first enacted policies targeting homelessness following the Great Depression as part of the New Deal. The 1980s is often considered the start of the modern era of homelessness in the U.S. due to social changes and crises including the HIV/AIDS epidemic, inadequate supply of affordable housing, economic recession, budget cuts, high unemployment and inadequately implemented deinstitutionalization. Since then, the country has seen increasing rents and stagnating wages.[2]

Recent federal policies included strategies for addressing homelessness, the American Rescue Plan (ARPA) and Coronavirus Aid, Relief and Economic Security (CARES), provided billions of dollars to move people into permanent housing and increase availability of housing and subsidies, along with other strategies. The Housing Supply Action Plan further sought to remedy policy failures,[14] and several Executive Orders addressed housing, structural racism, discrimination, climate crisis related housing needs, and many more related areas of focus.[6]

> *It is critical that people who have experienced or who are experiencing homelessness and housing instability lead and participate in the development and implementation of policies and programs. This includes…people of color …[and] other historically marginalized groups that are overrepresented in homeless populations, especially people identifying as LGBTQAI+ and people with disabilities."* [6(p29)]

Despite these accomplishments, anti-homelessness policies continue to criminalize homelessness, implement hostile architecture, and perpetuate barriers to accessing shelters and interim housing for people with disabilities, MH/SUD, communicable diseases, and criminal records, and/or who are LGBTQIA+.[6]

The federal homelessness strategy described in ALL IN centers on three priorities:

1. Availability of and access to safe housing;
2. Addressing immediate health and social needs of people experiencing homelessness; and
3. Prevention of new homelessness.

While ALL IN represents a time-limited political initiative, these core areas are representative of public health imperatives for prevention, intervention, and addressing SDoH. CHWs actively work within each of these housing priority areas.

## CHW ROLES SERVING PEOPLE EXPERIENCING HOMELESSNESS

CHWs serve both unsheltered and sheltered individuals experiencing homelessness, as well as chronic and episodic homelessness, elders, youth, families, people with immigration barriers, people with English as a second language or limited English fluency, and people with chronic health conditions including MH/SUD.

Common CHW roles serving people experiencing homelessness include street outreach/medicine, patient advocacy and navigation, community-clinical coordination, and case management.[1]

Street medicine and outreach partnerships reflect a core role of CHWs in serving people experiencing homelessness. Some programs, such as the HOPICS-Akido Labs partnership in California, integrate clinical care providers in community-based street outreach to connect unhoused people with needed physical, behavioral, and social needs care.[15] A case example of a CHW-led street medicine and outreach program is included below.

# 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.[16]

## 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.[2]

Furthermore, CHWs often work in roles that are under-paid, limited term (e.g., grant funded), and lack autonomy and authority to develop and innovate efforts to serve community members—despite deep understandings of community needs and cultural contexts.[3,4] Despite these challenges, CHWs are actively innovating to improve public health systems, build community health infrastructure, 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.[20,21]

**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.

Limited public health literature focuses on CHWs' roles serving people experiencing homelessness and the available literature focuses primarily on program development or outputs rather than impacts.[1,22] From the available literature, it appears that CHWs engaged in development of interventions have often been limited to informing (e.g., providing input) rather than leading design and development or having a decision-making role.

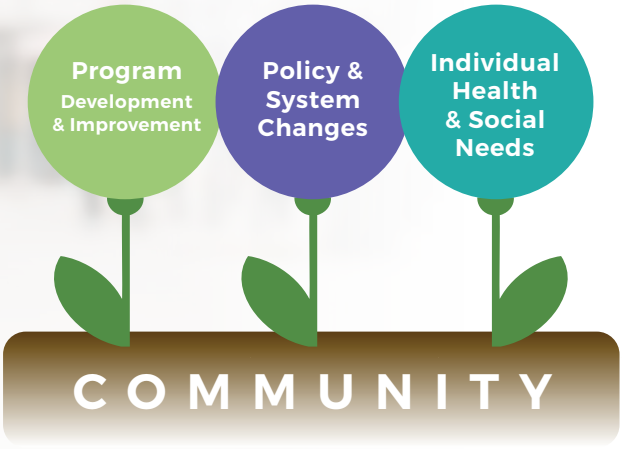
## CHW-LED INNOVATION

### 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."*
>
> *(Mccurry et al, 2024)*

CHW Approaches and Innovations Areas of Focus




# What Works:
## CHW-led Approaches to Improving the Health of People Experiencing Homelessness

### AREAS OF FOCUS FOR CHW APPROACHES AND INNOVATIONS

**Key themes in CHW approaches and innovations and selected case examples are described below according to each of the CHW Approaches and Innovations Areas of Focus.**

- Community is at the center of CHW approaches and innovation. CHW-led approaches and 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**.

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

### WHAT WORKS IN CHWS' APPROACHES AND EXPERTISE IN ADDRESSING HOMELESSNESS?

Two themes were consistently emphasized by CHW participants as essential components of what works in serving clients experiencing homelessness: 1) trusting relationships and 2) client advocacy, accompaniment, and social support.

**Building trusting relationships:** Building trusting relationships is a foundation of CHW practice. CHWs emphasized the importance of trust, patience, listening, being from the community, being seen as being from the community, and being on equal footing.

Trust enables CHWs to build positive connections through which health information, honest communication, promotion of health behaviors, and connection with resources can be supported.[23] CHWs build trust in many ways with unhoused clients, which they described as essential for

building supportive relationships with clients experiencing homelessness:

- Showing respect, compassion, consistency and follow-through
- Active listening, patience, honesty
- Sharing lived experience or being from the community
- Collaborative decision-making
- Community outreach
- Trauma-informed care
- Culturally relevant, concordant, and/or sensitive care

*"I don't look at them any differently from any other human being, people close if they can tell you are looking down on them. For some people it took six months until trust was built." – Kamailei Yniques, CHW, Hawai'i*

### CLIENT ADVOCACY, ACCOMPANIMENT AND SOCIAL SUPPORT

**Client advocacy** was also discussed as an especially important component of "what works" in serving people experiencing homelessness due to the many barriers faced by this population. Client advocacy was required to get housing or shelters and ensure clients receive emergency care. CHW self-care including using PTO was emphasized due to the risks of vicarious trauma.

CHWs described a key aspect of their role with unhoused individuals as **accompanying** people to services like emergency services, housing and shelter services to ensure they receive adequate care and to provide **social support** to people who may be scared or uncomfortable in service settings. CHWs also described the importance of proactively checking in on clients to make sure they know they are not alone.

## WHAT WORKS ACROSS IMPACT AREAS

### INDIVIDUAL HEALTH AND SOCIAL NEEDS

CHW survey and listening session participants described many elements of "What Works" in serving people experiencing homelessness, including:

- **Immediate basic needs:**
  - *Examples:* Obtaining and distributing urgent supplies including clothing, sleeping bags, tents, and food to unsheltered clients; securing emergency shelter. Street outreach and providing supplies were strategies used to address immediate needs and also ways to build trusted relationships with clients. Additional examples of what works included providing food if meeting during a mealtime or making sure they have eaten.
- **Health-related social needs:**
  - *Examples:* Finding and connecting clients with resources for affordable housing, transportation, medication storage, social support, language interpretation, helping access mail and ID, and more.
  - *Takeaway:* Due to the many barriers people experiencing homelessness face in accessing basic needs and other HRSN, CHWs provide comprehensive, individualized care to meet people where they are and address intersecting, urgent and ongoing HRSN.
- **Access to healthcare:**
  - *Examples:* Street outreach, providing transportation, respecting clients' autonomy and preferences, assisting enrollment in health insurance, storing medications in health centers, helping patients discharged from health systems, and advocating for client needs around translation and language access in medical settings.
  - **Takeaway:** In response to these barriers, including poor quality healthcare, bias, and

discrimination, CHWs serve as client advocates to ensure people experiencing homelessness receive adequate care, including accompanying patients to alleviate anxiety and ensure they receive adequate care.

- **Mental health and substance use (MH/SUD):** CHWs help connect clients with mental health treatment and also provide necessary social support and connection that can impact mental health outside of formal treatment.[24]

### 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, [25] build capacity within communities and mobilize community members to address community needs and advocate for public health priorities.[26]

### 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. 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.

Several program components were seen as representative of "what works" on a program level including building essential operations components into program budgets, including providing food and transportation for outreach to meet people where they are, and MOUs/partnerships with trusted and culturally responsive healthcare systems. Examples of essential operations components with costs include providing food and transportation for outreach to meet people where they are (encampments, soup kitchens).

To help address mistrust of and access barriers to medical systems, programs 1) offer CHW accompaniments to appointments, and 2) conduct outreach to people where they are (e.g., encampments, soup kitchens). 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 AND SYSTEMS CHANGE

CHWs engage in policy advocacy as individual experts, organize other CHWs and providers to advocate, and educate policymakers about the needs of community members and strategies to improve the health of their constituents. Several CHW respondents discussed serving in local housing policy roles such as affordable housing commissions or engaging in policy advocacy to address SDoH related to homelessness (e.g., housing, food)

## 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 health among people experiencing homelessness. Case examples were selected from among WWTS respondents, word of mouth recommendations, and a landscape scan to identify, of CHW-led efforts.

In total, 57 out of 175 survey respondents shared examples of innovative work they took on to address the health and social resource needs of their clients and communities. These innovative efforts included advocacy to add components to or change approaches of existing programs, cultural mediation and language access, and engaging in policy advocacy to address upstream SDoH. One respondent discussed advocating within a program for CHWs to be able to carry Narcan due to high overdose rates—a change which led to them being able to resuscitate a client who had overdosed.

# HAWAI'I STREET MEDICINE OUTREACH

## CHW leader: Kamailei Yniques, Hawai'i

Hawaii has one of the largest per capita homeless populations in the country due to the high and rising cost of living on the islands - the highest cost of living in the country as of early 2024 with housing costs three times and grocery costs over 50% more than the national averages. The Hawaii Island Community Health Center (HICHC) street medicine team provides outreach, healthcare navigation, and wound care to unsheltered homeless people on Hawai'i island.

Kamailei is a CHW kūpuna (elder) advocate and CHW leader at the HICHC and led the center's street medicine team for several years. The street medicine team conducts outreach to unsheltered people living in encampments. Despite significant medical needs, barriers to accessing basic medical care among this population are significant. Unsheltered people often cannot access transportation to go to a doctor, experience discrimination and resulting mistrust of providers, and lack health insurance to cover medical costs.

The street outreach team meets people where they are living, builds trusting relationships, and addresses urgent medical needs. In the face of the instability and dangers of living on the streets, the team represents a source of consistent support. The team returns to well known encampments but also identifies new encampments - driving around the island to find places people have set up tents. They also find people at other locations such as soup kitchens.

*"I don't look at them any differently from any other human being, people close up if they can tell you are looking down on them. For some people it took six months until trust was built."*

Through outreach to build trust and relationships, the team is respected and trusted within the unsheltered population. This trust allows the team to provide needed wound care, follow-up with individuals around healthcare needs, distribute hygiene kits and first aid, help with setting up insurance and appointments. For some people, they just moved to Hawai'i and don't know life outside of the encampments. Kamailei and her team assisted individuals get set up with health insurance, access to mail, and identification.

Building relationships—a hallmark of CHW practice—when people are unsheltered is challenging. However, through consistency in outreach, Kamailei has found that people started to trust her and she has become "the trusted person" for many people she has interacted with. If she couldn't find someone she expected to see, she would ask around until someone could help her locate them. Kamailei says that people she interacted with years ago still call her from time to time with questions because they know and trust her. As she says, "they know they aren't forgotten."

# CHW-LED ADVOCACY TO INCREASE FOOD ACCESS

## CHW LEADER: Lina Roman, CCHW

Lina Roman, a longtime CHW, works with individuals and families in Rhode Island experiencing a range of health and social challenges from homelessness to reentry and immigration barriers. Lina serves many unhoused clients. Many live in cars, under bridges, and some are "lucky" and can get into shelters. She helps her clients access food, clothing, phones, healthcare appointments, and other resources. When starting work with a client she first works to get them a free phone so she can remain connected with them. Unhoused clients cannot apply for SNAP, because they don't have a physical address, so she works to help them access needed documents.

**The need for innovation:** Dedicated to best serving her clients and community members, Lina began to notice patterns in the barriers preventing her clients from accessing emergency food assistance. Restrictive food pantry rules represented a consistent barrier - each food pantry had its own rules and hours, limited service to residents in a defined immediate area, had long lines, and did not allow for food selection. If a food pantry closed in one area at 4pm, a client from that area could not access food in a neighboring area with an open food pantry, regardless of emergency.

As a CHW serving clients with multiple barriers who could not travel to the food pantry, CHWs often went to food pantries to get food for their clients. Long food pantry lines interfered with CHW schedules and ability to manage the daily needs of their caseload. Food available at food pantries was often not accessible to unhoused clients because they did not have food storage or preparation equipment, or could only eat certain foods due to health restrictions. As a result of these cumulative barriers, Lina would sometimes pay out of her own pocket to ensure her clients got fed. The strain caused by these system barriers is ever present, as Lina said plainly, "we don't have support to do our jobs."

*Lina Roman*

**What was done:** Lina knew that something needed to change as she could not support her clients to meet their basic needs despite her best efforts. She got to work to change the policies that drove these barriers. Lina started by collecting signatures from CHWs, other providers and organizations, totalling more than 160 signatures. Lina delivered the petition to lawmakers at the Rhode Island State House, where she explained the importance of CHW to access all food pantries in the state and ability to bypass the long lines. Lina, in partnership with the CHW Association of Rhode Island, launched a social media campaign to raise awareness about the advocacy campaign and sent letters to food pantries across the state.

Through this effort, the head of a large food pantry reached out to Lina and they began a successful partnership to reduce barriers and improve access to the pantry for CHWs seeking food for their clients. On the ground, Lina worked to build partnerships with food pantries to ensure accessible and nutritious foods for her unhoused clients, including a pantry that has more accessible foods for unhoused clients like snack bars.

Her dream is to create a food pantry specifically for people who are homeless to provide nutritious foods that can be taken on the go.

**Why it is innovative:** This policy change improves the environment in which CHWs operate and meet the needs of their clients. It contributes to reframing of understanding health needs - the most transformative type of innovation within the FPHI. Lina's advocacy work, along with her tireless efforts to serve her clients and community, has helped to increase food access, build capacity and connectivity among CHWs and food pantries, and improved access to other basic needs and resources.

**Challenges:** Despite these important successes, Lina continues to serve clients in a resource strained environment. She and her fellow CHWs continue to need access to other resources for unhoused clients like bus passes. Community members, especially immigrants and undocumented community members often live in fear and as a result without access to basic essential needs.

**IMPACT:**

Lina successfully advocated to remove several barriers to food pantry access for CHWs to help clients in need of emergency food, including unhoused clients. A large food pantry in RI first allowed CHWs to bypass long lines and access food regardless of client geography following Lina's advocacy and outreach. This model spread to other areas of the state. CHWs now have much easier access to food pantries to ensure that their unhoused clients do not go without food and for clients with specific health and nutrition needs. Lina has demonstrated that CHW-led advocacy can indeed transform systems and service landscapes, build longstanding partnerships with multi sector organizations and meaningfully partner with policy makers to improve systems impacting social determinants of health.

# BROOKINGS CORE RESPONSE

## CHW LEADER: Diana Carter, CHW, PSS, CRM, Oregon

**NEED FOR INNOVATION:** Diana Carter started Brookings Core Response (BCR) in response to seeing the ways COVID-19 led to extreme hardships among people experiencing homelessness in Brookings, Oregon. Diana saw firsthand the lack of support for people without housing and the ways in which her peers living on the streets were denied services and access to basic needs (e.g., bathrooms) due to fears related to COVID-19—a frequent barrier exacerbated by the pandemic. These challenges weren't being reported or captured by public health systems. As a result, funds weren't coming into the community and even were being turned away from the community because of lack of capacity. Diana suspected that the funds coming in were less than other communities that had lower need because there was no data to demonstrate the need.

Drawing on her own lived experience with homelessness, Diana sought ways to help and sought out guidance from trusted CHW and CHW-ally mentors on how to start an organization as a CHW.

*"CHWs always find an answer even if the answer is no, we don't give up, we find an answer."*

BCR's first task was to collect data to assess the need in the community. Expecting about 30–40 in need, BCR found 400 people who lacked access to shelter. This data was essential for accurately understanding the need and enabled Diana to make the case to secure initial funding. BCR now leads the county's point-in-time count each year and has built a network of volunteers and community partners to assist in these efforts.

**Why it is innovative:** BCR was launched as an initiative, located in a church in 2020, and launched as a 501(c)3 organization in 2021 and now has 12 staff, all of whom are traditional health workers, an Oregon designation including CHWs. Almost all of their staff have experienced homelessness personally or have had similar experiences.

*"Hiring people with lived experience is the most important piece, especially when working directly with people. People's automatic reactions and the words that come out of their mouth are much different when they have lived experience. There are things you know if you have the experience, more trauma informed because they understand the language."*

**ABOUT BCR:** BCR core programming includes CHW resource navigation to assist with needs like access to healthcare, income support, obtaining identification and other documents, food and transportation. Housing services include housing case management, emergency shelter, and has recently received funding to build affordable housing units for veterans.

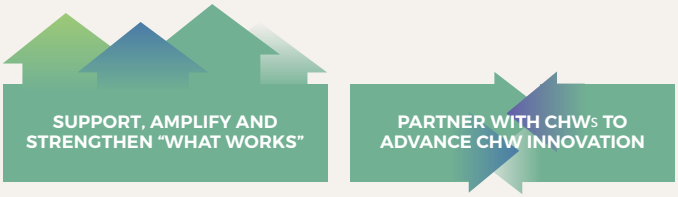
In response to a new state funding opportunity, BCR convened community partners to establish the Curry County Homeless Task Force, which has opened up additional funding and advocacy opportunities through the state government. After years of persistent advocacy and grant writing to diversify funding streams, this renewable funding stream allows for sustainable streamlined funding so BCR can focus on expanding and shoring up additional funds without worrying about sustainability of core programs.

**IMPACT:** Most recently, BCR opened a new day center with a community fridge and space for people to rest and gather during the day. In the first nine months of the year, BCR has provided about 600 walk-in services for unsheltered community members and has housed 42 households—close to 100 people—through its rapid rehousing program. BCR continues to innovate. Diana hopes to add a navigation center, shower trailer, community garden, bike repair station, and street medicine programming.

# What Works for Partners:

## How policymakers, funders and other partners help support, elevate, enhance and sustain CHW-led efforts to advance health for people experiencing homelessness

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[28] and the NACHW Policy Platform.[29]




### 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 people experiencing homelessness.

**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;
- Engagement of CHWs by partners is sustained, equitable and inclusive, CHWs as full partners and leaders;
- Center CHW leadership: CHW leadership in innovation extends far beyond informing programs developed by others.
- 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 CHR/W-led initiatives and CBOs that have roots in the community and community health work. 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.

**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 and flexibility 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.

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

- The SUSTAIN[28] 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.

**In addition, addressing upstream social, economic and political 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.

> *The best thing a policy maker, funder, or provider can do is to listen to the life experience of those that have become successful out of climbing out the bottom. But few do listen and few have walked in our shoes. They make policies that create barriers and harm.*
>
> *– Wanda Price, CHW*

# 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 175 respondents who completed the survey who selected people experiencing homelessness 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. 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

*[report]* ALL IN: Federal Strategic Plan to Prevent and End Homelessness https://www.usich.gov/sites/default/files/document/All_In.pdf

*[organization]* National Alliance to End Homelessness https://endhomelessness.org/

*[organization]* National Coalition for the Homeless https://nationalhomeless.org/who-we-are/

*[resource library]* SAMHSA Homeless and Housing Resource Center https://hhrctraining.org/

*[resource library]* National Health Care for the Homeless | Homelessness Resources on the Web https://nhchc.org/understanding-homelessness/homelessness-resources/

*[podcast]* "Our Community" Brookings Core Response "podcast library https://brookingscoreresponse.org/podcasts/

*[resource list]* National Association of Community Health Centers Homelessness Resources https://www.nachc.org/topic/patients-experiencing-homelessness/

*[webpage]* ProPublica Encampment Removal Reporting Form https://www.propublica.org/getinvolved/help-investigate-homeless-encampment-removals

*[toolkit]* National Center on Family Homelessness (NCFH) Trauma-Informed Organizational Toolkit for Homeless Services https://communityaction-partnership.com/external_resources/trauma-informed-organizational-toolkit-for-homeless-services/

*[resource list]* Community Action Partnership Homelessness Prevention Tools and Resources https://communityactionpartnership.com/housing-opportunities-and-homeless-prevention/

*[webpage]* NHCHC Hiring CHWs: A Resource Guide for HCH Programs https://nhchc.org/research/publications/chws/hiring-chws/

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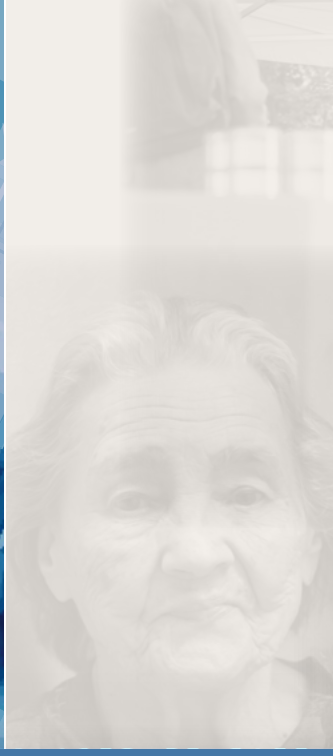

Boston, MA, USA | info@nachw.org | www.nachw.org



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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.