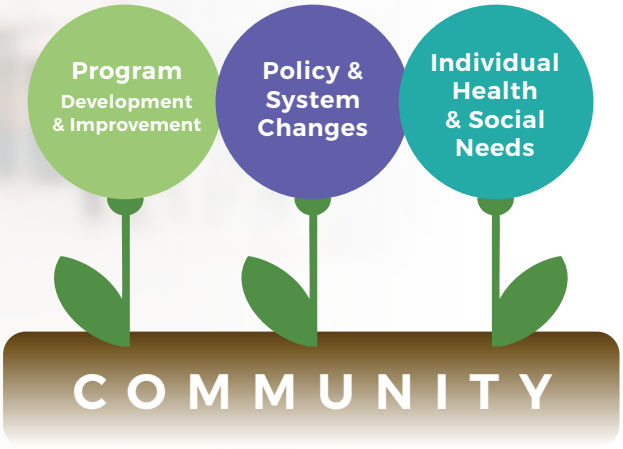
CHW Approaches and Innovations Areas of Focus



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.