By Alice T. Chen, Denise O. Smith, Bisola O. Ojikutu, and John Auerbach

COMMENTARY

The Community As A Full Partner: A New Model For Public Health

DOI: 10.1377/hlthaff.2024.00033
HEALTH AFFAIRS 43, NO. 6 (2024): 805–812

Alice T. Chen (ATYChen@gmail.com), Washington, D.C.

Denise O. Smith, National Association of Community Health Workers, Boston, Massachusetts.

Bisola O. Ojikutu, Boston Public Health Commission, Boston, Massachusetts.

John Auerbach, ICF, Reston, Virginia.

ABSTRACT **The COVID-19 pandemic demonstrated a need to strengthen the US public health system by shifting toward much greater community engagement and leadership. In November and December 2023, we conducted separate online surveys of community-based organizations and large metropolitan health departments to identify barriers and opportunities for building a public health system with strong community partnerships. Identified barriers included mistrust, siloed health departments with structural challenges in funding community-based organizations, and insufficient shared decision making. The surveys helped inform our six policy recommendations: establish state and local community councils to formalize the roles of community-based organizations in public health decision making; dedicate funding to these organizations; offer funding that is not limited to a specific disease or condition; simplify procurement and reporting processes directed to community-based organizations; create a training and technical assistance program for these organizations; and increase public health worker diversity, including sustainable funding for community health workers.**

Public health after the COVID-19 pandemic must transform into a more effective force for improving health, especially in those marginalized communities that are at highest risk. Lessons from the pandemic reveal the imperative need to move from siloed public health departments to a distributed ecosystem that fully engages the diversity, innovation, relationships, and resourcefulness found within community-based organizations (CBOs). The authors of this article come from a variety of public health and community backgrounds and together witnessed the extraordinary capacity of CBOs and community health workers to lead public health efforts during the pandemic. When many public health efforts and messages on COVID-19 were met with mistrust and overshadowed by mis- and disinformation, community-led outreach efforts played an essential role.

The Black Boston COVID-19 Coalition formed to advocate for a mass vaccination site in the heart of the Black community in Boston, Massachusetts, and ensured that community members were employed to support the effort.[1] The Arkansas Coalition of Marshallese effectively focused outreach on mothers, knowing that the Marshallese culture is traditionally matriarchal.[2] La Unión del Pueblo Entero reached residents of Texas *colonias*—unincorporated border towns without local health departments—with community health workers who canvassed and organized house meetings.[2] The Asian Community Development Council joined forces with the Thai Culture Foundation and Immunize Nevada to host a vaccination clinic at a Nevadan Thai temple, where community members felt safe and understood.[3] The Navajo and Hopi Fam-

ilies COVID-19 Relief Fund created flyers in Navajo, featuring images of Navajo people, about COVID-19, handwashing, and what people should do if they got sick.[4]

These CBOs combined science with culturally and locally resonant messages, personal relationships, and an understanding of people's lives. They shared learnings with hundreds of other organizations around the country. They represented their communities at meetings with local, state, and federal health officials, voicing concerns, articulating unmet needs, and shaping strategy.

As the pandemic recedes, there is a risk of losing hard-won partnerships and funding for community-led programs that should be expanded to address ongoing public health challenges.

In response to this, several efforts are under way at the CDC Foundation, the Alliance for Disease Prevention and Response, other philanthropies, and public health agencies to avoid backtracking on public health and community partnerships and to develop a common understanding of best practices and resource needs. These efforts benefit from long-standing work that has provided an evidence basis for such engagement, including community-based participatory research (a validated conceptual model for increasing equity through community-academic partnerships that prioritize community-originated research questions and community-designed program evaluations)[5] and the Community Guide[6] (evidence-based public health interventions).

However, policy change is needed to facilitate this transformation, particularly in building capacity and strengthening partnerships between public health agencies and CBOs and community health workers. CBOs are nonprofit organizations led by community residents who set priorities and design, implement, and evaluate programs.[7] They are generally small and often rely on volunteers. Many have served their communities for decades. The people who do the work are often community health workers "who are trusted members of and/or have an unusually close understanding of the community served,"[8] including professionals with dozens of titles such as community health representatives, *promotoras*, and peers.[9]

Understanding Barriers In Public Health And Community Partnership

To better understand the barriers to effective partnership between public health and communities, in November and December 2023, we conducted online surveys of public health departments and CBOs. We present survey results and make policy recommendations based on those results and our own experience.

One survey was sent to the health directors of the thirty-five largest US metropolitan communities. Twenty health directors (57 percent) responded. A second survey was sent to email lists of several hundred CBOs. Fifty-two CBOs based in twenty-two states across the US responded. Many of these CBOs were small: 50 percent had ten or fewer staff members, and 44 percent reported budgets of less than $1 million. Details on the surveys, including respondent characteristics, are in online appendix A.[10] The survey results combined with the public health and community experience of the authors to outline three intersecting barriers to strong partnership and collaboration.

MISTRUST One overarching barrier is mistrust. In our CBO survey, only 18 percent of respondents reported a high level of trust between their community and the public health department; 28 percent felt that the level of trust, although mixed, has been improving. Details of the CBO survey are in appendix B.[10] In our public health department survey, only 11 percent cited a high level of trust, although 47 percent noted that the level of trust was mixed but that progress had been made. All (100 percent) of the public health departments indicated that partnerships with community residents and CBOs were a high priority (ranked 4 or 5 on a five-point scale); 79 percent listed them as "most important." Details of the public health department survey are in appendix C, and a graph of survey results on trust is in appendix D.[10]

Mistrust felt by marginalized communities results from many factors, including structural inequities and historical and current disparities in health status and social determinants of health, which have been unevenly addressed by the public health sector in the past. Improving trust requires addressing these factors and improving authentic community collaboration.

SILOED WORK AND FUNDING A second barrier is that public health is too often seen as the sole purview of the public health department, rather than an all-of-society effort, which results in siloed work and funding. The COVID-19 pandemic brought into stark relief what has been hidden in plain sight: Public health has a significant impact on education; work; and physical, mental, and social well-being, especially in historically marginalized communities. And schools, workplaces, faith organizations, and other community institutions have a significant impact on public health. In response to COVID-19, new linkages were established between public health and other sectors, including CBOs and community health workers, who straddled clinical, public

health, and community organizations and services, helping affected communities navigate gaps and enroll in safety-net programs.

The National Association of Community Health Workers has gathered examples of many community health worker–led organizational members that demonstrate the effectiveness of public health as an all-of-society effort. The Florida Community Health Worker Coalition responded to members' needs by creating a COVID-19 infection prevention curriculum in April 2020. In one month, they trained more than 450 community health workers in English and Spanish.[11] The Kaʻū Rural Health Community Association, in Hawaii, vaccinated Native Hawaiian–, Marshallese- and Filipino-speaking populations in rural fishing villages, urban centers, and homeless encampments while collecting vital data to inform and improve the National COVID-19 Resiliency Network.[12]

Finances contribute here, too. Chronically underfunded local public health departments often have limited staff for community relationship building.[13] In addition, models that restrict and prevent directly funding community organizations erode trust, relationship building, and community capacity. As one public health official noted in our survey, "Not being able to guarantee funding in the future and having to tie funding to specific activities has had a negative effect on the trust we have built with grassroots organizations."

Moreover, given the interwoven nature of health, the predominance of disease-specific public funding presents a mismatch for CBOs. Seventy-four percent of CBOs in our survey said that "flexibility in use of the funding to address community needs" would make it easier to obtain funding from public health agencies, and 67 percent recommended having "dedicated funding for CBOs [and community health workers]" (appendix B).[10] Health department survey respondents named disease-specific funding as the second-highest barrier to funding CBOs, at 70 percent, second only to inadequate overall funding, at 85 percent (appendix C).[10]

INSUFFICIENT SHARED DECISION MAKING A third barrier is that communities have insufficient decision-making roles in public health planning, program implementation, and funding. Among CBO survey respondents, although 91 percent reported that their health department had asked for input on community concerns in the past year, only 29 percent had been formally engaged in deciding priorities and policies, and only 15 percent had been involved in funding decisions.[1] The health department survey had similar findings: Although 65 percent hold regular meetings (at least four times a year) with community organizations to share information and solicit input, only 20 percent reported community members advising on specific priorities or policies, and a mere 15 percent formally involved community members in deciding agency policies, priorities, or funding allocation (see appendix C).[10]

Further, smaller CBOs tended to be less likely to have funding from health departments: Of the unfunded CBOs, 48 percent reported budgets of less than $500,000, and 68 percent had ten or fewer staff members. In contrast, of the funded CBOs, 18 percent reported budgets of less than $500,000, and 33 percent had ten or fewer staff members (see appendix E).[10] This all reaffirms that too often, affected communities have at best a secondary role in public health leadership.

Policy Recommendations

We offer the following policy recommendations to address these barriers and build strong partnerships between public health and communities. These interventions should be established and then evaluated and refined through community-engaged research to ensure continued progress. Many require action at the federal level, often by Congress, but much progress can also be made by action in the executive branch of the government, as well as at the state, local, and territorial levels. A chart summarizing these recommendations is in appendix F.[10]

ESTABLISH COMMUNITY COUNCILS First, we recommend that the Centers for Disease Control and Prevention (CDC) and other federal agencies require state and local public health agencies to establish community councils with a formal role in public health decision making. Community councils would create new infrastructure for building and strengthening partnerships and understanding between public health and communities. They should be involved in the selection, design, prioritization, implementation, and assessment of public health projects. Community councils should also be engaged in participatory budgeting to promote shared power over resource allocation.[14] They should have significant representation from historically underfunded, underrepresented, and marginalized local communities and populations, and they should bring together the different and important perspectives and expertise of community members, practitioners, administrators, and policy makers at a shared decision-making table.

Similar councils have been established in various settings and are examples that health departments can build on to ensure the effective representation of underrepresented community members to increase equity. For example, feder-

ally qualified health centers are required to have a majority of board members who are "individuals who are or will be served by the center and who, as a group, represent the individuals being or to be served in terms of demographic factors."[15] The Ryan White HIV/AIDS Program Part A HIV Planning Councils assess service needs, specify the types of services required to meet those needs, and allocate Part A funding.[16] At least 33 percent of planning council voting members must be people who receive Ryan White HIV/AIDS Program Part A services. Other members of the councils come from health and public health, government, and other federal HIV program grantees. The councils provide for orientation and ongoing training of members, with particular attention paid to the needs of community members and consumers. Also, West Side United, an independent nonprofit organization in Chicago, Illinois, convenes people and organizations to work together to improve health in a community with relatively low life expectancy.[17] Guided by councils with strong community representation, it has set priorities and implemented programs to address them.

We support efforts by other local health departments in establishing 501(c)(3) organizations to bring together community coalitions to support the departments and their partners in advancing health.[18]

DEDICATED FUNDING FOR COMMUNITY-BASED ORGANIZATIONS Second, we recommend that Congress, federal agencies, and state and local governments dedicate funding specifically for CBOs. There is no prohibition against identifying funding that is exclusively for CBOs. Such dedicated resources could be through direct funding or to the organization as a subcontractor of a larger non-CBO organization. Multiple grant opportunities specify a particular type of organization, such as public health agencies, schools, and nonprofit groups, as the preferred or only eligible entity.

In the CDC's Strengthening US Public Health Infrastructure, Workforce, and Data Systems grant's notice of funding opportunity, state health agencies were required to distribute no less than 40 percent of their funded awards to local jurisdictions not already funded by the grant. Moreover, the CDC stated, "All recipients should demonstrate how they will reduce or eliminate the administrative requirements and reporting burden put upon local health departments and nonprofit organizations supporting grant activities."[19] A similar approach could be applied to CBO funding.

Although the examples we offer are from the CDC, this targeted funding approach could also apply to other federal agencies such as the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration for Community Living. The National Institutes of Health's (NIH's) new Community Partnerships to Advance Science for Society Program offers a noteworthy example, with its more flexible and streamlined grant requirements that allow for direct grants to community organizations to work collaboratively with researchers in all phases of the research process.[20]

Public health is too often seen as the sole purview of the public health department, rather than an all-of-society effort.

If certain funding opportunities were exclusively for CBOs, that would help reduce the competitive disadvantages that CBOs currently face, because of their size and lack of infrastructure, when they are allowed to bid on grants. Additional attention would be needed to ensure that smaller CBOs have an opportunity for funding in such bids. And as was indicated in the CDC grant referenced above, funders can require that administrative requirements be reduced or eliminated, particularly when the CBO funding is as a subcontract to a larger organization.

FUNDING NOT LIMITED TO A SPECIFIC DISEASE OR CONDITION Third, we recommend that Congress, federal agencies, and state and local governments provide CBOs with funding that is not tied to a specific disease or condition. CBO funding should be flexible whenever possible, so that it can address local priorities. Flexibility would better empower the community and reflect the reality on the ground of the interconnectedness of public health interventions across conditions, recognizing the impact of the interwoven social determinants on health outcomes.[21] This could be done by creating new line items or by strengthening promising efforts that already exist.

Good Health and Wellness in Indian Country at the CDC works to support a "coordinated and holistic approach to healthy living and chronic disease prevention" across a variety of goals around diabetes, high blood pressure, high cho-

lesterol, tobacco use, healthy eating, physical activity, and breast-feeding.[22] The program was created with guidance from Tribal nations and combines understanding of Western science with the lived experience and expertise of Tribal nations. Also, the CDC's Racial and Ethnic Approaches to Community Health Program focuses on reducing racial and ethnic health disparities by providing grants to state and local health departments, tribes, universities, and community-based organizations. The program has produced many local successes—for example, the DeKalb Mobile Farmers' Market, a program in DeKalb County, Georgia, that converted an old prison bus into a mobile farmers market that goes to food deserts with live on-site food demonstrations, nutrition education, and fresh food for sale.[23] Congress should expand these two programs, with prioritization of funding for CBOs.

Federal, state, and local public health agencies should also adapt procurement practices to make it easier to blend and braid different funding sources to create greater community flexibility. The Rhode Island Department of Health braided multiple federal funding sources to create health equity zones that allowed each community council to choose its priorities.[24] However, this required significant negotiation with the CDC and other agencies and has not yet been replicated by another state, although some cities have undertaken similar efforts.

In communications with one of the authors (Alice Chen) in 2021 and 2022, CBO leaders shared examples of the additive impact of flexibility in meeting community needs on multiple fronts. The International Mayan League, based in the Washington, D.C., area, received a call from a family that had questions about the COVID-19 vaccine. The family trusted the International Mayan League as a source of information because the organization had helped them enroll their child in school. Medical volunteers with Project H.E.L.P., based in Birmingham, Alabama, have helped community members for years during natural disasters and by providing blood pressure screenings. During the pandemic, long-standing trust meant that these volunteers were well positioned to help people keep themselves safe. Finally, when Hurricane Ida hit New Orleans, Louisiana, in August 2021, resulting in a boil water advisory, the Power Coalition for Equity and Justice shifted temporarily from vaccine promotion to distributing bottled water. In each of these instances, focusing on acute needs built trust for long-term work.

SIMPLIFIED PROCUREMENT AND REPORTING

Fourth, we recommend that federal, state, and local agencies develop simplified procurement and reporting processes to lower the obstacles to small community organizations applying for and being awarded grants. Federal agencies, and often state and local ones as well, have procurement rules that make it difficult to fund small organizations because of eligibility requirements related to organizational capacity, financial stability, and experience, as well as extensive reporting and compliance requirements.

In our CBO survey, 65 percent of respondents reported that it would be easier for them to obtain funding from public health departments with "simplified application processes and reporting requirements." Others noted challenges in procurement, including a need for "funding upfront, instead of by reimbursement" (57 percent) and for "funding for infrastructure (e.g., staff to handle finance, reporting, and fundraising)" (appendix B).[10] In our public health department survey, 65 percent of respondents reported that a primary barrier to funding CBOs was "procurement rules" that had certain eligibility criteria, such as budgetary size. Most health department survey respondents (65 percent) funded larger organizations with the specific intention of having them subcontract with smaller CBOs, often to provide infrastructure support to the smaller organizations and to handle the reporting requirements (appendix C).[10] One potential solution to allow more CBOs to apply for grants directly is to have dedicated funding that specifically allows only small CBOs to apply and waives certain procurement restrictions.

Another funding challenge is that many small organizations cannot afford the usual reimbursement practices of public grants. More than half (57 percent) of respondents to our CBO survey expressed a need for up-front funding (appendix B).[10] Dia De La Mujer Latina, a subgrantee for a federal vaccine promotion program, ran a bilingual call center that received thousands of calls a month. However, the reimbursement model and delays in payments put the program at risk of having to lay off call center employees.[25]

In response to this challenge, Colorado passed a law in 2021 allowing up to 25 percent of grant funding to be paid up front to nonprofits receiving public funding.[26] The Boston Public Health Commission similarly established the Community Health Equity Empowerment Fund with 25 percent up-front funding for small CBO–led chronic disease initiatives.[27] The program also offered technical assistance and administrative support to recipient organizations to ensure that reporting requirements were met.

Made to Save, a campaign of the nonprofit organization Civic Nation, tailored a grant program specifically for CBOs conducting COVID-19 vaccine outreach and education in communities

of color.[28] With funding from foundations and other philanthropy, it supported 110 community-based grantees, the vast majority of which were led by executive directors of color, and many of which were mostly staffed by community members. Prospective grantees were recommended as organizations that were trusted and had a track record of being able to connect with members of target communities. Staff then worked with potential grantees to develop project plans and write applications. Projects and goal metrics were tailored to fit the priorities and needs of each community, including both the capacity-building needs of the CBOs for COVID-19 vaccine work and their longer-term priorities. Funding was provided up front to allow these small organizations to hire community health workers and do their outreach work. When frequent quantitative metrics reporting was taking significant staff time away from community outreach and programming, the reporting process was adjusted to allow for more qualitative reporting. This provided a richer understanding of the organizations' accomplishments while reducing administrative burden.

Many of the community-based examples cited in this article were Made to Save grantees. This nongovernmental effort demonstrated how grant making could be tailored to small organizations. A report from the Strong, Prosperous, and Resilient Communities Challenge includes several similar recommendations for more effective grant making at the federal and local levels.[29]

TECHNICAL ASSISTANCE AND TRAINING Fifth, we recommend that Congress support and federal agencies create a technical assistance and training program for community capacity building and best practices for working with the community. We propose the creation of a centralized technical assistance program to supplement the more narrowly focused and limited technical assistance efforts embedded in individual grant programs. The program should be led by staff with significant experience working in and with communities. Program components would include foundational community capacity building for CBOs, community coalitions, and community health worker associations, and best practices in community partnership for public health agencies and organizations seeking to subgrant to communities. The program could also include shared financial management support for smaller organizations. Notably, at this time, CDC-supported specialized training and technical assistance for smaller CBOs is rare. The development of such work should be informed by efforts under way in other federal agencies such as HRSA, SAMHSA, and NIH and should incorporate and fund existing high-quality national and local technical assistance efforts.

Communities must be treated as experts in the lived experiences and local assets and barriers that can so deeply affect health.

A centralized program would allow for more state and local agencies to offer technical assistance and training. Forty percent of public health department survey respondents reported funding other organizations to provide specialized technical assistance and training to CBOs when they directly funded the CBOs. A slightly smaller portion of agencies (25 percent) have their own staff provide specialized training to CBOs (appendix C).[10]

Technical assistance and training are powerful ways to build long-term capacity while achieving grant goals. Made to Save provided grantees with capacity-building support such as coaching on grant writing; media training and press outreach; shared tools for outreach; and multisector coalition calls that featured CBOs sharing their successes, resources, learnings, and gaps. This type of approach has recently been endorsed by White House's U.S. Playbook to Address Social Determinants of Health.[30]

BOLSTER COMMUNITY HEALTH WORKERS Sixth, we recommend that federal, state, and local governments increase diversity across the public health workforce, including sustained funding for community health worker employment, career advancement, and professional organizations. All of the aforementioned recommendations would benefit from a public health workforce that more closely reflects the community, and particularly underserved populations. Community health workers came to prominence as an evidence-based, cost-effective, and versatile workforce[31] during the COVID-19 pandemic and in the community-based programs cited in this article. Congress allocated funding for community health worker training and deployment through the Coronavirus Aid, Relief, and Economic Security Act of 2020 and the American Rescue Plan Act of 2021.[32] However, this funding has already expired for many awardees, and thousands of community health workers have

lost their jobs.[33] Community health workers are typically employed by health care organizations and CBOs through time-limited, narrowly focused grants. Such short-term funding limits the workers' ability to pursue long-term careers and hampers their full integration into the public health and health care workforce.[34]

For these reasons, the National Association of Community Health Workers developed a set of recommendations on long-term financing of community health workers that calls for incorporating the workers into Medicaid and Medicare program benefits and paying for their services through a "per member per month" or "shared risk" model, rather than fee-for-service.[35] The association further calls for sustained grant funding through federal agencies such as HRSA, the CDC, and the Indian Health Service.

Beyond community health workers, federal, state, and local training programs for community members to enter careers in public health are worthy of support and expansion. These include the CDC's Public Health Associate Program and Public Health AmeriCorps.

Conclusion

Public health in the twenty-first century can become more powerful and effective in addressing health disparities, and in improving health status broadly, by building on lessons of the COVID-19 pandemic and engaging the creativity, resourcefulness, and wisdom of communities throughout the US. The diversity of US society represents one of the nation's greatest strengths. Communities, especially those experiencing the greatest health disparities, must be supported in working alongside public health departments to identify priorities and design, implement, and evaluate programs to address the multifactorial causes of poor health. They must be treated as experts in the lived experiences and local assets and barriers that can so deeply affect health. Policy makers at the federal, state, and local levels have an important role to play in facilitating this transformation through policies that support CBOs and community health workers with funding, technical assistance, and formal roles in decision making that build the trust and community capacity needed for the US to become a healthier, thriving, and more just society. ■

The authors thank the survey respondents and community-based organizations and community health workers across the country for their important work. They also thank Lauren Smith, Angela McGowan, Steve Greeley, and Susan Farrell for their input. The authors are solely responsible for the accuracy of the information presented in this article. Any views or opinions expressed in this article are solely those of the authors, and no endorsement of these views or opinions by the authors' institutions is expressed or implied.

NOTES

1 Ojikutu BO, Bogart LM, Dong L. Mistrust, empowerment, and structural change: lessons we should be learning from COVID-19. Am J Public Health. 2022;112(3):401–4.

2 Made to Save/Civic Nation. Vaccine Equity Panel: implementing community-informed strategies to increase vaccine confidence and access. Facebook [video on the Internet]. 2022 Apr 27 [cited 2024 Apr 17]. Available from: https://www.facebook.com/itsmadetosave/videos/1429006384195749

3 Miller S. Southern Nevada's new AAPI medical center seeks to bridge the gap. Las Vegas Weekly [serial on the Internet]. 2022 May 26 [cited 2024 Apr 17]. Available from: https://lasvegasweekly.com/news/2022/may/26/southern-nevada-new-aapi-medical-center-bridge-gap/

4 Yee Ha'ólníi Doo. Navajo educational flyers [Internet]. Flagstaff (AZ): Yee Ha'ólníi Doo; c 2024 [cited 2024 May 1]. Available for download from: https://navajohopisolidarity.org/educational-flyers

5 Wallerstein N, Duran B, Oetzel JG, Minkler M, editors. Community-based participatory research for health: advancing social and health equity. 3rd ed. San Francisco (CA): Jossey-Bass; 2017.

6 Community Guide [home page on the Internet]. Atlanta (GA): Community Guide; [cited 2024 Apr 17]. Available from: https://www.thecommunityguide.org/index.html

7 National Community-Based Organization Network. What is a CBO? [Internet]. Ann Arbor (MI): University of Michigan, School of Public Health; c 2024 [cited 2024 May 1]. Available from: https://sph.umich.edu/ncbon/about/whatis.html

8 American Public Health Association. Support for community health workers to increase health access and to reduce health inequities [Internet]. Washington (DC): APHA; 2009 Nov 10 [cited 2024 Apr 17]. Available from: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities%C2%A0

9 National Association of Community Health Workers. Community health worker professional roles and titles [Internet]. Boston (MA): NACHW; [cited 2024 Apr 17]. Available from: https://nachw.org/wp-content/uploads/2023/06/CHW_prt.pdf

10 To access the appendix, click on the Details tab of the article online.

11 National Association of Community Health Workers. CHW networks respond to COVID-19: insights from Ohio, Florida, and Massachusetts. YouTube [video on the Internet]. 2020 May 29 [cited 2024 May 1]. Available from: https://www.youtube.com/watch?v=cIiaIS9bEc4

12 Kaʻū Calendar. Kaʻū News Briefs, Monday, March 1, 2021. The Kaʻū Calendar News Briefs, Hawaiʻi Island [blog on the Internet]. 2021 Mar 1

[cited 2024 May 1]. Available from: https://kaunewsbriefs.blogspot.com/2021_03_01_archive.html
13 Schoch-Spana M, Sell TK, Morhard R. Local health department capacity for community engagement and its implications for disaster resilience. Biosecur Bioterror. 2013;11(2):118–29.
14 Bittle BB. Sharing power to improve population health: participatory budgeting and policy making. J Public Health Manag Pract. 2022;28(4, Suppl 4):S143–50.
15 Public Health Service, 42 C.F.R., Section 51c.304, Governing board (2023 Oct 1).
16 Health Resources and Services Administration, Ryan White HIV/AIDS Program. Part A: grants to eligible metropolitan and transitional areas [Internet]. Rockville (MD): HRSA; [last reviewed 2022 Nov; cited 2024 May 1]. Available from: https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-a
17 West Side United [home page on the Internet]. Chicago (IL): West Side United; c 2021 [cited 2024 May 1]. Available from: https://westsideunited.org/
18 Island A, Clayton A. The 501(c)(3) decision guide for local health departments in community health coalitions [Internet]. Washington (DC): National Association of County and City Health Officials; 2022 Aug [cited 2024 Apr 17]. Available from: https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/501c3-Decision-Guide-for-LHDs-FINAL.pdf
19 Centers for Disease Control and Prevention, Center for Surveillance, Epidemiology, and Laboratory Services. Strengthening US Public Health Infrastructure, Workforce, and Data Systems, CDC-RFA-OE22-2203 [Internet]. Atlanta (GA): CDC; 2022 Jun 23 [last updated 2022 Jul 22; cited 2024 May 1]. Available for download ("Related documents") from: https://www.grants.gov/search-results-detail/340034
20 National Institutes of Health, Office of Strategic Coordination—The Common Fund. Community Partnerships to Advance Science for Society (ComPASS) [Internet]. Bethesda (MD): NIH; [last reviewed 2024 Apr 24; cited 2024 May 1]. Available from: https://commonfund.nih.gov/compass
21 Brown AF, Ma GX, Miranda J, Eng E, Castille D, Brockie T, et al. Structural interventions to reduce and eliminate health disparities. Am J Public Health. 2019;109(S1):S72–8.
22 Centers for Disease Control and Prevention, Healthy Tribes. Good Health and Wellness in Indian Country [Internet]. Atlanta (GA): CDC; [last reviewed 2020 Jun 23; cited 2024 May 1]. Available from: https://www.cdc.gov/healthytribes/ghwic.htm
23 Davis D. From prison bus to mobile market: driving out obesity in DeKalb County, GA [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; [cited 2024 Apr 17]. Available from: https://nccd.cdc.gov/nccdsuccessstories/TemplateThree.aspx?s=2757&ds=1
24 Glass P, Wendelken S, Zongol C. Health equity zones: a toolkit for building healthy and resilient communities [Internet]. Providence (RI): Rhode Island Department of Health; 2021 [cited 2024 Apr 17]. Available from: https://health.ri.gov/publications/toolkits/health-equity-zones.pdf
25 Cohen E, Mascarenhas L. NIH needed help reaching communities of color about COVID-19, but grassroots groups say they were not paid properly. CNN [serial on the Internet]. 2022 Mar 6 [cited 2024 Apr 17]. Available from: https://www.cnn.com/2022/03/06/health/nih-ceal-covid-outreach-payment/index.html
26 HB21-1247, Colorado Department of Public Health and Environment Contract Pay to Grantees Up Front (2021 Jun 7).
27 Boston Public Health Commission Executive Office. Request for proposal: Community Health Equity Empowerment Fund [Internet]. Boston (MA): The Commission; 2023 Summer [cited 2024 May 1]. Available from: https://www.boston.gov/sites/default/files/file/2023/07/Community%20Health%20Equity%20Empowerment%20Fund.pdf
28 Civic Nation. Made to Save impact report: lessons learned from a national, equity-centered campaign to increase COVID-19 vaccination rates [Internet]. Washington (DC): Civic Nation; [cited 2024 May 1]. Available from: https://madetosave.org/wp-content/uploads/2022/05/Made-to-Save_Impact_Report_FINAL.pdf
29 Strong Prosperous, and Resilient Communities Challenge. Increasing federal funding to community-based organizations [Internet]. SPARCC; 2022 Mar [cited 2024 May 1]. Available from: https://www.sparcchub.org/wp-content/uploads/2022/03/Final-CBO-Memo-March-2022.pdf
30 White House, Domestic Policy Council, Office of Science and Technology Policy. The U.S. playbook to address social determinants of health [Internet]. Washington (DC): White House; 2023 Nov [cited 2024 Apr 17]. Available from: https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf
31 Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. Health Aff (Millwood). 2020;39(2):207–13.
32 Lawson N. As pandemic-era funding of community health workers is dwindling, states can turn to Medicaid for sustainability [Internet]. Washington (DC): Georgetown University, McCourt School of Public Policy, Center for Children and Families; 2023 May 19 [cited 2024 Apr 17]. Available from: https://ccf.georgetown.edu/2023/05/19/as-pandemic-era-funding-of-community-health-workers-is-dwindling-states-can-turn-to-medicaid-for-sustainability/
33 Payne D. Covid brought a community health worker boom. Now come the layoffs. PoliticoPro [serial on the Internet]. 2023 May 8 [cited 2024 Apr 17]. Available [subscription required] from: https://subscriber.politicopro.com/article/2023/05/covid-brought-a-community-health-worker-boom-now-come-the-layoffs-00095626
34 Kumar N, Jones S, Marshall M, Ostrom S. A hard day's work: promoting sustainable funding for community health workers [Internet]. Washington (DC): FamiliesUSA; 2022 Sep [cited 2024 May 1]. (Whitepaper). Available from: https://familiesusa.org/wp-content/uploads/2022/09/CHW-Sustainable-Financing.pdf
35 Rush C, Mason T. Sustainable financing of community health worker employment: key options for states to consider [Internet]. Washington (DC): National Association of Community Health Workers; 2023 Dec [cited 2024 Apr 17]. Available from: https://nachw.org/wp-content/uploads/2023/12/sustainable-financing-of-community-health-worker-employment.pdf