DEPARTMENT OF HEALTH

# Community Health Workers in Minnesota – Intersections with Housing and Health

**ENVIRONMENTAL SCAN BRIEF - 2026**

## Homelessness in Minnesota

In 2025, there were over 8,300 individuals experiencing homelessness in Minnesota on a single night in January.[1] The connection between homelessness and health is significant, as individuals living in shelters or on the streets often face a range of health challenges.[2] Without stable housing, individuals may not be able to access necessary healthcare, may delay treatment or lose access to insurance. This cycle can result in worse health outcomes and increased risk of illness. Addressing these disparities requires a comprehensive approach that includes housing solutions, healthcare access, and support services for those experiencing homelessness.[3]

### Health disparities among Minnesotans experiencing homelessness

Compared to the general population, Minnesotans experiencing homelessness are far more likely to have chronic health conditions like asthma and diabetes. The mortality rate of Minnesotans experiencing homelessness is three times higher than the general population.[4] The Minnesota Homeless Mortality Report showed that mortality across each racial and ethnic groups is higher among people experiencing homelessness than in the general Minnesota population.[5]

## CHWs build trust and connect people to care

Community Health Workers can bridge organizations and services in a manageable way for people experiencing homelessness and can change health and housing outcomes. Community Health Workers (CHWs) are frontline health workers who are trusted members of or have an unusually close understanding of the community served, which enables them to serve as a liaison between communities and health and social service systems, facilitating access to services, and improving the quality and cultural competence of service delivery. The CHW scope of practice[6] includes helping individuals navigate health and human services systems, advocating for individual and community needs, providing direct services, and building individual, community, and clinic capacity. In the context of housing, these skills often align with the community's needs.

CHWs can bridge organizations and services in a manageable way for people experiencing homelessness.[7] There are also similar roles with different titles like peer support specialist, care coordinator, outreach worker or peer navigator, but the CHW scope of practice is what differentiates the CHW position. Lived experience and community connection allows CHWs to effectively support people experiencing homelessness within the defined scope of practice.[8]

## CHWs working across Minnesota

In 2024, CHWs in Minnesota supported people with housing concerns to access services for rental assistance, immediate shelter needs, food access, harm reduction services, and medical care.[9] CHWs work in a variety of clinical and community locations where they support people with housing related needs. In 2026, in Minnesota there are nine community-based organizations that focus specifically on serving people experiencing homelessness or housing instability that either employ CHWs or are exploring the CHW role as a part of their workforce. These organizations are primarily located in larger population centers like the Twin Cities, Duluth and Rochester, and there is one rural location in Northern Minnesota.

CHWs focused on serving people experiencing homelessness or housing instability work in shelters, housing-focused community organizations, clinics, local public health, or other community-based organizations that conduct outreach into housing and homelessness service settings. The primary role of the CHW in organizations focused on serving people experiencing homelessness or housing instability is building trust with people and helping them navigate complex systems.

## Building skills for stable housing

CHWs offer one-on-one or group sessions building skills to help with planning and navigating systems like healthcare, insurance, or housing support. Several programs focus on working with the client to build and support skills that prepare someone for housing readiness and maintaining housing. Examples of those skills include understanding lease agreements and tenant rights and responsibilities; developing skills for daily living such as grocery shopping, meal preparation, laundry, and budgeting; self-management of diagnosed conditions and health literacy; and behavioral routines that reduce the risk of housing instability. There is a focus on executive functions such as decision making, organization, communication with landlords or healthcare team members and routines to support taking medication consistently; and coping skills to respond to stress and conflicts with appropriate boundaries and supports.

## Connecting people to health and community resources

CHWs in community-based organizations focused on housing have been able to support community members with connections to:

- Food access
- Harm reduction and substance use disorder treatment
- Health insurance and other benefit enrollment
- Transportation to clinics for healthcare or medication pickup
- Professionals serving in housing support roles or other social services
- Health and parenting education through home visiting
- Skill building for self-management of chronic conditions.

## Improving health and housing outcomes

Nationally, evidence shows that CHWs working in shelter or supportive housing settings can play a critical role in improving health outcomes for people experiencing homelessness or unstable housing.[10] The literature highlights measurable impacts such as reducing housing instability, successfully completed referrals to medical care, behavioral health or social service benefits, completed treatment plans (e.g., adherence to medications for opioid use disorder), and reduced use of crisis options (Emergency Department visits, law enforcement calls). Upstream support includes longer term relationships with CHWs to detect early risk identification, health or legal crises that impact employment or ability to pay rent.[11]

# Training and employing CHWs in housing and homeless settings

CHWs play an important part in Crossroads to Justice, Minnesota's strategic plan to prevent and end homelessness.[12] Training and employing CHWs in settings like shelters and supportive housing programs is a key strategy under the plan's goal: *Homelessness is treated as a crucial health and public health crisis wherever it occurs.* The Crossroads to Justice strategic plan includes the following actions:

- 5.2.2a Increase the availability of **culturally responsive health care professionals** (e.g., peer specialists, nurses, psychiatrists, Licensed Alcohol and Drug Counselors) **trained to work in community settings** with people facing homelessness, through expanding peer navigators/educators, Justice Consultants, and community health workers in homeless settings.
- 5.2.2b Expand peer navigators/educators/certified specialists, Justice Consultants and **community health workers placed in homeless settings** to improve access to care and build trust in public health.

## CHWs working with people experiencing homelessness

As part of a statewide landscape analysis, MDH has been tracking the number of CHWs working in housing and homelessness organizational settings. From September 2023-March 31, 2026, there were 154 CHW Certificate Program graduates who participated in a Health Resources and Services Administration (HRSA) CHW Training Program grant. Fifty of 154 total graduates noted in their original application that homeless individuals were included in the population served. Available data from the CHW training program students, at three, six, and 12 months post-graduation, showed that 38 of the 154 graduates noted working with people experiencing homelessness and five graduates described themselves as working in housing settings six or 12 months post-graduation. A variety of job titles, settings and locations for these roles include the following:

- CHW job titles: Community health worker, community health worker (lead), care coordinator, community connector

- CHW employment settings: homeless shelter, housing stabilization services provider, Tribal Nation, non-profit organization serving people managing mental health or substance use disorder
- CHW employment locations: Bemidji, Minneapolis, Winona, Moorhead

# Building and sustaining CHW programs in housing settings

Through meetings with organizations that employ or are interested in employing CHWs in shelters and supportive housing settings, both progress and persistent challenges were identified related to financing and sustainability.

## Barriers to implementation and sustainability

Key informant interviews highlighted several recurring barriers to CHW program development, employment, and long-term sustainability. These included organizational readiness, training, supervision, retention, and funding. A common barrier was lack of awareness of the CHW role, the CHW scope of practice, training options, and billing mechanisms.[9]

Across organizations, common concerns centered on limited funding options for CHW positions and supervisory staff to support the CHW roles in housing support settings. Lack of funding can result in lower salary levels and limited availability of full-time positions. Another concern is lack of staff capacity for supportive supervision and ongoing support to help CHWs navigate internal and external organizational dynamics. A consistently reported challenge was the lack of medical records and billing infrastructure needed to support financing for CHW services. Many housing and social services organizations serving people experiencing homelessness do not provide billable healthcare services and therefore lack the systems required to bill for CHW services.

Barriers to implementing apprenticeship (on-the-job training model) included limited supervisor and administrative capacity, as well as constraints related to time, funding, and awareness of the model itself. More broadly, unstable and insufficient financing continues to affect retention, with many noting that current reimbursement rates do not cover the full cost of sustaining CHW positions.

## Progress supporting employers and the CHW workforce

Progress has been made in supporting employers with billing, supervision, and training all with a lens on team integration and CHW retention.

- In 2025, MDH developed an employer CHW Billing toolkit and provided training and technical assistance.[13]
- Opportunities for supervisor support are available through the Minnesota CHW Alliance Supervisor Roundtable.
- Through the HRSA grant, financial and student support was provided for CHW Certificate Program Completion and Registered Apprenticeship Program training.

- Minnesota CHW Alliance is now an Apprenticeship Program sponsor, which supports employers with administrative and training aspects of on-the-job training in the first year of employment.[14]

## Sustainable Funding and Partnership Strategies

Organizations will need to find blended funding sources, formalize partnerships, and prove value of the role across systems to sustain CHW positions that connect with people in need of support for housing or chronic health conditions. Like many settings where CHW are hired, a variety of funding sources are needed to sustain the positions.[14] Medical billing through Medicaid and Medicare for CHW Education and Community Health Integration services is one funding source available if an organization is set up to bill for medical services and the CHW has their Minnesota CHW Certificate program completed. Additionally, public health dollars and state grant funds could be directed, alongside local government (county funds) and community grants.

To get a CHW position started, it could be helpful for organizations serving people experiencing homelessness or housing instability to work with organizations that are already set up to bill Medicaid or Medicare, like a healthcare or community organization that provides CHW services but work together on specific clients or housing access topics. Co-locating positions embedded in community settings can be a source of access and trust building, leading to meaningful engagement with a variety of programs.

# Key learnings

Key informant interviews and conversations held with CHWs and CHW employers who work in settings that support people who are unhoused identified the following key insights:

- Community organizations can partner with CHW employers for outreach to increase access to care and navigation of services for clients that could be served by both organizations for different reasons.
- Barriers described to improve health outcomes for people experiencing homelessness include limited or inconsistent phone and internet access, lack of reliable transportation, lack of consistent healthcare access, and limited access to pharmacies.
- Flexibility and creative problem solving between the CHW, people experiencing homelessness, and community organization can impact successful outcomes.
- To sustain CHW positions that connect with people in need of support for housing or chronic health conditions, organizations will need to find blended funding sources, formalize partnerships, and prove value of the role across systems.
- One data point to measure impact of a CHWs work with a patient over time could be the change in social determinant of health (SDOH) screening responses over time, helping assess whether patients experience improvements in access to basic, social, and healthcare needs over time.

# Impact stories: Navigation supported by CHWs in homeless settings

Below are two impact stories about CHWs interfacing with housing and chronic disease. They showcase community efforts to develop, refine, and implement CHW services for patients experiencing housing insecurity or homelessness.

## Open Cities Health Center (OCHC)

> *"People often feel nervous and scared and don't know where to start."*
> - A CHW from Open Cities Health Center

Open Cities Health Center is a Federally Qualified Health Center (FQHC) with clinics in St. Paul that provides comprehensive primary care and integrated health services to diverse communities across the Twin Cities. As of May 2026, Open Cities has two CHWs conducting regular rotations at affordable housing properties including CommonBond Communities and Catholic Charities in St. Paul. They are funded under a state funded cardiovascular health grant and an overdose prevention grant. Their outreach does not have a specific emphasis on housing, but they encounter and support people in those locations.

The CHWs conduct outreach in the community multiple times a week to share information about the Open Cities clinic, and resources and support options for basic needs including food, housing, transportation, harm reduction items, or access to medications through a pharmacy. CHWs connect patients who screen positive for food insecurity to food options in their community and work on providing medically tailored meals to Open Cities Clinic patients. CHWs refer people with health-related needs to Open Cities clinic and make appropriate referrals and warm handoffs to other community-based organizations.


*Image: Open Cities Health Center CHW outreach table at the Partners in Prevention Clinic at Hallie Q. Brown displays flyers and other educational materials.*

Transportation was named as a major barrier to care and accessing SDoH resources. Two examples were described involving phone or internet access and its connection to transportation.

- CHW patients reported having trouble paying their phone bill. The patient was familiar with the bus lines and how to take the bus, but when the CHW connected the patient to a new food pantry location, the biggest barrier was how to find out the new bus route when their phone didn't work or did not have access to internet. The CHW printed bus line maps (at a big enough size) and walked them through until they felt confident.
- CHW patients report medical ride services can take too long, are inconsistent, or do not wait for the patient to get to the pickup location. CHW recommendations to manage these challenges are to start scheduling earlier in the week in advance of the appointment and in enough time for the delay that may come.

In addition to providing outreach at housing partner locations CHWs also provide outreach, in-person visits and telephone visit options from Open Cities clinic. CHWs describe acting as a bridge to help people know where to start, set up a medical, optometry or behavioral health appointment on the spot, and follow up with them to be sure they understand next steps.

CHWs describe many ways of staying connected to patients or potential patients, especially when people do not have reliable phone access or consistent locations. CHWs share their business cards with their clinic contact information, take patient contact information, and often use alternative contacts, such as a friend with active phone service, or the phone number of an organization that the person visits regularly and where messages can be left for them. Open Cities Health Center's CHWs also have a bilingual resource book they provide that people can use to access services in the community.

> *"People see the resource book and love it for a starting point and a way to share the help with their friends."*
> - A CHW from Open Cities Health Center

## CHUM shelter

Located in Duluth, CHUM is a drop-in shelter with a clinic that provides stabilization services to individuals that do not have housing. CHUM employs both a Peer Recovery Specialist and a CHW paid out of Substance Abuse and Mental Health Services Administration (SAMHSA) grant funds. The CHW position is supported by a subcontract with Lake Superior Community Health Center. The CHW interviewed from CHUM has a background in social work and is looking into enrolling into the CHW Certificate Program for fall of 2026.

The CHW roles at the CHUM shelter include coordinating rides and medication pickups, scheduling medical appointments, assisting with paperwork for insurance or county services, and connecting with staff at a local detox location. His work is primarily one-on-one with people who visit the shelter. He receives some referrals from the shelter nurse. People generally present with a form of chronic disease including mental health or substance use disorder along with diabetes or cardiovascular health concerns. CHUM staff described the unhoused

population at their shelter as older with severe medical comorbidities. Frostbite also continues to be an issue for people they serve.

The CHW sees between six and ten people per day at the shelter. Although many come and go with frequency, people work with him off and on until they are housed. He also collaborates often with partners that include medical clinics, county staff, detox staff, and non-profit program staff. There are baseline and exit assessments of people who work with the CHW at CHUM. Documentation is primarily on a private online communication channel hosted by the county social services. The CHW has paper documentation, and for the grant population of unhoused people he tracks data in a secure online database.

The CHW reports spending about 60% of his time transporting clients to medical appointments and was recently approved for a work vehicle to help with transportation medical appointments or medication pick up rides. Transportation provided through insurance in this area, also known as medical rides, has been difficult to use for patients. Initiating the ride and sending reminders can be burdensome, and at times the ride does not show up for the patient. There are individual challenges with people getting to medical appointments that circle around addiction, disorganization, mental health challenges, the need to maintain access to chemicals, and persistent fear of the medical care or medical care team. The CHW uses his time transporting people or working together on paperwork to build trust and learn more about them as individuals and what might make their experiences with services better.

> *"It can be difficult to get people going, getting them to be willing to go to care and just to set them all up. They are always welcome to visit the shelter and ask for care"*
> - A CHUM Shelter staff member

CHUM plans to continue supporting the CHW position after the grant funding ends and would like to expand the CHW role to include more outreach.

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