The Role of Community Health Weavers in the Micro-geographies

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The young field of community health work is moving into adolescence with all the promise and ambiguity of that tumultuous passage into maturity. Although the certification of the community health worker is recent, health has always been born and sustained in the community, particularly at micro-geography levels.

Introduction

Community health workers (CHWs) are a relatively recent phenomenon in terms of how medicine and public health view the development of the field and its credentialing. CHWs' work on the ground to enhance health was truly invented in, and by, community. Their intelligence and efforts span health systems (e.g., hospitals, public health, social service agencies) and the broad expanse of community. Their nimble and flexible work, particularly in the micro-geographies of health (e.g., census tracts, small blocks in a neighborhood) focuses on community strengths and goals at an individual level and allows them to be both efficient and effective. CHWs show value in terms of decreasing costs; providing return on investment for those enrolled in Medicaid; dealing with chronic diseases; helping people access needed supplies such as food, transportation, and protective gear; and providing vaccines to vulnerable populations. As such, hiring, supervision, resourcing, and daily support of CHWs requires leaders who possess a humble spirit, fresh eyes to see and better understand the community context in which CHWs work, and a deep respect for the generativity and life- and health-enhancing work of these vital and often underappreciated community-based practitioners.

Community Health Weavers in the Micro-geographies

Although the certification of CHWs is recent, health has been born and sustained in the community since long before either hospitals or public health were invented... by the community. As adolescents like to adopt new names, it may be time for us to think of CHWs as community health *weavers*—a more accurate description of their generative function in the lives of individuals and community structures. These weavers make it possible for health to move from previously distant health science structures into the subtle complexities of neighborhoods and social structures. And they blend community intelligence into the strategy and tactics of health organizations. Adolescent power is not entirely predictable—ask any parent. The maturing of CHWs marks the end of the simple phase of social determinants, which operationally involved titrating small bits of socially relevant services, and the beginning of a new phase, in which social systems also change health systems.

CHWs are only effective if the community sees them as their agents, connecting them to resources and processes they value. Ironically, the more closely integrated CHWs are into the culture and identity of the hospital or public health system, the less likely they are to achieve an effect on systems that think they can purchase CHWs by funding them. Like a keystone in an arch, the CHW holds the tension between the two systems, allowing safe passage from one side to the other. Most keystones are, in fact, in the center of the bridge over the most troublesome water.

There are other roles within health systems that also depend on dual credibility in order to be effective. Professional chaplains emerged seven decades ago, reflecting dual capacities that must be credentialled in order to be board certified and employed inside the clinical system. Professional chaplains are both religiously and clinically credentialled; it is not enough to be clinically competent and vaguely religious, or fully ordained and vaguely clinical. Hospitals must show that these dually credentialed competencies are part of their structure. A hospital need not fully grasp the intricacies of the religious endorsement, but it needs to have confidence that a religious body has vouched for that side of the role. Anyone hiring a CHW should have similar confidence that the community side of the CHW's identity has passed review by a relevant community body.

The challenge of this dual standing is that the hospital person hiring and supervising the CHW may not have actually even driven through the neighborhoods in which the CHW is expected to function, and may have no idea who or

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what network the CHW would need to relate to in order to achieve the outcomes the health system desires. The hiring person should first pause with some humility and show some curiosity about the neighborhoods in which one imagines placing a particular CHW. A clue that more humility is needed is when the neighborhood is only identified in terms of its deficiencies, disparities, diseases, or its residents' predominant health insurance status. A CHW weaves the

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strengths of both clinical and neighborhood systems, just as an arch is supported by rock on both sides of the river. If you don't know anything about the community strengths, pause until you hire someone who does.

Some facets of health are advanced through standardization of best practices that make it easy for providers to make good choices for their patients. Such health system processes try to extend analytics into the social factors, often ending with deployment of providers to make phone contact or, perhaps, a CHW to go knock on a door. These

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strategies work surprisingly well with people who have reason to trust the intelligence and intentions of the health system. But social factors have social properties. The more frayed and traumatized the social reality of the person, the less likely the standardized deployments will work. Social phenomena function at social scale and speed. CHWs tend to be deployed into the most problematic social spaces; they must be nimble and wise in the micro-geographies, such as census tracks or a sliver of neighborhood. It is in the micro-geographies that health is found, if at all.

CHWs are usually present because of some negative condition and funded because they promise to ameliorate its worst effects. However, their success depends on finding, marshalling, and aligning the *strengths and goals* of the individual, those who love them, and neighborhood systems. The health system may think the patient is being "managed," but what is actually happening is more like liberation. A CHW is generative, not just therapeutic. Sometimes the CHW weaves a net of supports underneath the person and family so they can find peace enough to recover. Sometimes they weave a protective garment against stresses such as noncompliant insurance systems or invasive helping professionals. Sometimes they weave a rope ladder so others can climb out of their distress and back to normal life.

The complex opportunities of CHWs hold the tension between what ReThink Health Director Bobby Milstein calls the "adversity industry" that has grown up to fix things, including disease conditions, and the "well-being" economy,

which includes education, church, and most civic life [1]. In Minneapolis, for example, community networks have grown for several decades between health, faith, social, and community organizations, exemplified by the East Side Health and Well-Being Collaborative. Amid COVID-19, these high-trust networks were obviously critical to reaching neighbors reluctant to trust a novel vaccine. As it happened, the coordinating office of this group was 10 blocks from the sidewalk where George Floyd was murdered in 2020. If the networks—including CHWs—had not shared the community's outrage, they would not have the credibility to be relevant to COVID. They see the whole bruised neighborhood at risk of risks. Sometimes the CHWs do heal one condition in one person at a time. But they have the capacity to do this because they are seen as relevant to the healing of the social body.

As we have seen in the tough neighborhoods of Memphis and Winston-Salem, CHWs usually have a primary identity as a person of faith or compassion, with their formal health skills being a supporting credential. They are useful to the health science agency that employs them precisely because their lived experiences offer more to work with than health science. They are able to carry health science into places and lives otherwise unreachable, because they are known for what faith calls "fruits of the spirit: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control" [2]. These are not decorative or inspirational traits; they are essential characteristics of someone in the business of weaving webs of trust in troubled lives and neighborhoods—the positive side of the negative social drivers.

CHW Competencies and Roles

CHWs represent a new body of competencies required of the organized systems of public or population health. They are not merely new roles hired to implement discrete

interventions on the far reaches of data-driven management strategies. They are visible signs of a new ecology of capacities that change the definition of work for all health care practitioners, from clinicians and data analysts to practice managers and financial policy designers. CHWs live and work in between the providers of social services, health, and government systems. All of these complex systems are marked by different languages and mental models about what matters when, and the conditions in which their services are available. Part of what makes CHWs so vitally important is that they bring to view the perverse and counterproductive policies affecting the lives of the people for whom they care. They hold tension in the social architecture.

CHWs represent more than a linear role or position. They work in a field of practice just like nursing, social work, or public health strategy. There is not just one CHW job description because there are a variety of nuanced roles and responsibilities based on the goals to be achieved and the people and communities involved [3]. These nuances have a profound impact on how systems approach CHWs.

Before CHWs' work begins on the ground, the job description, interview process, knowledge of communities and systems, and training (both didactic and experiential learning) are critically important. Who one decides to hire, contract, or partner with, and whether that organization will respect CHWs as colleagues (and educators), are key decisions. Additionally, clarifying whose role it is to supervise CHWs requires thoughtfulness and respect. Health systems may be guilty of dumping social drivers on CHWs to address for clients or for the overall community without providing resources and support for the advocacy necessary to change the underlying policies and conditions. On the front lines, CHWs report that it is still very difficult to weave when there are very few threads and needles with which to

do so. The most mature CHWs and structures that support them create that change agent role, moving beyond a solely service-based one.

Place-based Micro-geographies of Health

The work done by people in CHW-type roles in both Tennessee and North Carolina yields the best health outcomes and decreases costs when it is based in our most underserved ZIP codes and census tracts [4, 5]. Recent reporting showed that North Carolina had 162 distressed census tracts or micro-geographies, where the majority of residents lived at a level of 24% or more of the poverty level [6]. What if health systems, public health departments, community-based organizations, and even congregations placed some variant of CHWs in those most distressed areas to navigate persons to care, improve access, provide for social determinants of health, and more? Engaging these micro-geographies in a nimble manner, via the trusted liaisons represented by CHWs, is a critical step toward getting the most vulnerable persons to community-based care, clinical care, and all types of resources they may need. But CHWs do not just channel resources from outside into the vacancy of an "underserved" place. CHWs teach the community about its own strength and possibilities; a healthy community owns its own healing, confident of its own agency. Full health is more like liberation.

Conclusion

CHWs' efforts have consistently been shown to positively impact: costs [7], return on investment for Medicaid payers [8], health outcomes, and quality of life of our most vulnerable populations, particularly those experiencing chronic disease [9] and the sharpest edge of poverty and racism, most recently during the COVID-19 pandemic [10]. There is no need to continue to prove that CHWs are valuable in the ecology of health that exists between the clinical space of health systems and our most distressed communities. Health systems should honor the work of our CHW colleagues, give them the resources and tools they need to bring *all* of our people to their most optimal health status, and then connect those micro-geographies of health to the landscapes where those assets exist and can be easily accessed.

Those with the title of CHW cannot achieve this new relationship between health and community systems by themselves. Their success depends on supervisors and senior leaders who understand the fundamental recentering of the whole enterprise of health.

Community is no longer just a venue of needs waiting to be acute enough to cross over into the appropriate clinical space, nor the empty space in which we discharge or jettison patients after doing something reimbursable to them. Community is where healing happens, if those relevant to the healing process find proper relationship and alignment guided by both science and social values. CHWs are a keystone to the arch, without which the bridge collapses. But the keystone has no value without all the other parts of the bridge and without the energy to make the journey from disparity to equity. NCMJ

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