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Community Health Workers in Time of Crisis: A COVID-19 Case Study

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Abstract

This article focuses on the lived experiences of those implementing community health worker (CHW) programs during the COVID-19 pandemic. Based in an upper mid-west state, this qualitative case study is bounded by the state-level context and two distinct local case sites—one rural and one urban—and includes the experiences of five CHWs, two program directors, and a state-level administrator. The acute crisis response galvanized the ongoing need for CHWs, not only because they are trusted health messengers, but because they advocate for—and organize with—communities to address inequalities and inform public health institutions. Author-practitioners described personal and community identity as intertwined, a perspective in solidarity with decolonized approaches to humanistic psychology. Highlights

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discussed include: (a) Personal relationships motivated author-practitioners to join the pandemic response; (b) All pandemic response efforts were interconnected with social determinants of health; (c) The pandemic was as an opportunity to do things differently with more flexibility, personally and organizationally; and (d) Privately funded opportunities enabled local areas to implement quick responses, which influenced eventual state-level responses. All authors described structural racism as a constant context of this work. This article fills gaps in the literature related to the implementation of crisis responses and CHW programs.

Keywords
collaboration, community, cultural competence, diversity, global crisis, personal narratives, qualitative research, racism, social justice

> *"Kuv ntshai tsha yog kuv mus txhaj tshuaj, es kuv ho mob lossi tag siv neej, yuav tsis muaj leej twg saib kuv thiab pab ku.v" "I'm scared that If I get vaccinated, and I was to be sick or pass away, there will be no one to take care of me or help me."*
>
> –Hmong elder to a CHW

Globally, community health workers (CHWs) implement on-the-ground solutions to improve community health through their close connections to the realities communities face and their ability to cultivate trust. This grassroots approach to supporting community health and well-being resonates with the perspective in humanistic psychology that "the community is a force for therapeutic change" (Jaffe, 1976, p. 16). This perspective compels us to consider how social institutions such as public health agencies might function in a more democratic, community-based, and community-responsive way, and to nurture spaces where people take charge of their own personal development for social justice. Considering how CHW programs were implemented during the COVID-19 pandemic as part of a public health system, it is an opportunity to "interrogate the systems and environments within which people live" (Karter et al., 2019) to identify possibilities for living better, collectively and individually.

This article summarizes some of the history and recent evolution of CHWs during the pandemic, and captures the experiences of how CHWs, program directors, and a state health administrator implemented community solutions, highlighting the sensemaking process of the author-practitioners as they

reflected on this work. In-depth case descriptions are provided for the state-level activities, as well as the two local case sites in an urban and rural area.

Background

The title "community health worker" or CHW, describes frontline public health workers who are close to and serve members of a community by helping them adopt healthier behaviors, advocate for health needs, and serve as a bridge to the medical establishment (U.S. Department of Labor, Bureau of Labor Statistics, 2021). Based on the premise of community empowerment, CHWs often advocate for their community and propose solutions to policy makers (Cherrington et al., 2010; Israel, 1985). They usually share the same race and ethnicity, language, socioeconomic status, and life experiences with communities, and have firsthand knowledge of the community problems they attempt to solve. A common characteristic of CHWs is that they conduct their work *outside* of health facilities and instead work directly with people in their homes, neighborhoods, and communities. Research indicates that CHWs have contributed to improvements in health, social, and economic outcomes for individuals (Kangovi et al., 2020) and communities (Minkler et al., 2020).

Role of Community Health Workers

For millennia, communities around the world have had individuals they turn to as healers; westernized health care has sometimes sought to provide complementary care in partnership with grassroots health leaders and traditional healers, particularly in hard-to-reach regions. The origins of CHWs can be traced to rural China in the 1920s, where agricultural workers received training on hygiene and sanitation practices and conducted immunization campaigns that were funded in part by the Rockefeller Foundation (Perry et al., 2014; Taylor-Ide & Taylor, 2002). In the 1960s, this frontline health practice was adopted in different parts of Asia and the world, such as Latin America (Pérez & Martinez, 2008). Formalized CHW programs were developed more broadly in the 1970s and were implemented in low-, middle-, and high-income countries to improve health systems (Perry et al., 2014). In high-income countries, such as the United States, CHWs have been employed to reduce health disparities and support disease-specific care. During the 1980s and 1990s, funding decreased for CHW initiatives due to downturns in the economy and mixed reviews of program efficacy. However, these programs experienced a resurgence in recent years to overcome persistent health disparities. The Patient Protection and Affordable Care Act of 2010 included

CHWs as a critical component of the public health system (Allen et al., 2015; Shah et al., 2014).

In the United States, about three quarters of CHWs are in paid positions, employed by some branch of state or local health systems or community agencies targeted to improve outcomes related to specific diseases. The remainder are volunteers. Cherrington et al. (2010) found that paid CHWs usually prioritize objectives defined by them, whereas volunteer CHWs are more likely to conduct activities defined by community members. CHWs have described conflicted loyalties between the health institutions that employ them and community needs (Cherrington et al., 2010; Ingram et al., 2008; May & Contreras, 2007; Pérez & Martinez, 2008), and this is more likely to occur when the sources of funding that define job requirements are geographically remote from project sites (May & Contreras, 2007).

The COVID-19 pandemic accelerated the use of existing CHWs and inspired the development of new programs (e.g., Bhaumik et al., 2020). CHWs play a critical role in frontline health information outreach, trust-building, and contact tracing with the most vulnerable populations. It was noted that the CHW roles changed significantly during the pandemic, and there was a need for role clarity. The most common additional activities during pandemics were building community awareness, dispelling myths, and contact tracing. Most of the published research on CHWs during the COVID-19 pandemic comes from low- and middle-income nations and not from higher income countries, such as the United States (e.g., Cherrington et al., 2010).

Implementing Health Interventions Such as CHW Programs During Acute Crises

Barbero et al. (2021) and Cherrington et al. (2010) report that the implementation and coordination of CHW programs with public health systems is an understudied area. Implementation of crisis responses during public health disasters is another persistent gap (e.g., Lurie et al., 2013; Macnamara, 2021), and disaster researchers emphasize that research conducted during and immediately after public emergencies builds capacity to prepare for future adverse events (De Groeve, 2020). Reflecting on both of these topics, Bhaumik et al. (2020) state there is a need for more research on how CHW programs are implemented during the COVID-19 pandemic and recommend paying special attention to "equity, gender, and economic evaluation" (p. 1). They note there is not much evidence of *new* CHW programs initiated during crises.

Methodology

This embedded case study (Flyvbjerg, 2011; Yin, 2017) is bounded by statewide context and two geographically distinct "local" case sites—one midsize metropolitan area and one more rurally based—located in the same upper-midwestern state. Both case sites engaged faculty affiliated with the same medical college that has a statewide presence and has strategically invested in both urban and rural community sites with both clinical and other infrastructures. Key personnel in both the urban and rural sites came to realize they were running similar projects that involved CHWs during the pandemic while attending a statewide meeting. They recognized it was important to highlight that institutional civic engagement can occur simultaneously in very different ways and in very different communities. In keeping with the ethos of honoring community voice, this article draws on collaborative autoethnographic and ethnographic storytelling (Acosta et al., 2015; Anderson, 2006; Holman Jones, 2021), and participatory research techniques (Franco et al., 2021; Stringer, 2013; Wood, 2017) to democratize the research and authorship process. The case study is authored by five CHWs, two local project directors, and one state administrator. This emic approach enables us to access the "insider" perspective, allowing us to capture some of the "backstage" of this phenomenon (Goffman, 1966) and present narratives typically absent from mainstream literature.

The methodological orientation of the article is infused with an ethos to generate useful, phronetic (Flyvbjerg, 2001, 2011) context-dependent knowledge designed to improve local practice and inform practitioners more broadly. Flyvbjerg (2011) and Peattie (2001) assert that detailed case studies are a useful methodology for practice because expertise is developed through knowledge of and experience with many cases. This study included key criteria for case studies described by Flyvbjerg, including: (a) in-depth description, (b) an explanation of how each example "evolved over time," and (c) a focus on how they were related to the broader context.

Each local case has similar characteristics, including: (a) the same state-level infrastructure; (b) implementing new CHW programs during the pandemic; and (c) receiving initial short-term funding from philanthropic organizations. The sites served different geographic locations, populations, and had different affiliations with local public health agencies, making them unique enough to serve as separate exemplars. They became peripherally aware of one another a year and a half into the pandemic.

Four members of the author team, including the two program directors, the state administrator, and the academic-based researcher drafted initial points of inquiry. Then the local cases were written separately, and involved

conversations and sensemaking (Herda, 1999; Weick, 1995) among CHWs and project directors. The state administrator reflected on the state context and authored this narrative in collaboration with the author team. After this process, reflections and highlights were further refined in a series of weekly meetings for authors over a 2-month span. This paper includes multiple authors and, as such, is not written in one voice. Authors did not always agree with every point included but valued the presentation of diverse viewpoints. This collective work provides a comprehensive description of this bound case.

The State-Level Story and Context for the Local Cases

Located in the upper mid-west, this state's population is approximately 5.8 million. The urban case is located in the largest and most demographically diverse city in the state and has had one of the nation's greatest COVID-19 death disparities by race (Johnson & Buford, 2020). The rural case serves a seven-county region with the largest per capita population of Southeast Asian residents in the state and a growing Hispanic population. The state features a decentralized public health governance structure, or "home rule," where local governmental and tribal health agencies have authority over public health services rather than a central state agency. There are no specific state laws related to CHWs (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2021), and although CHWs were a small part of the total public health workforce prior to the pandemic, state staff were intentional about promoting the CHW model as an effective intervention for chronic disease prevention.

Early State-Level Response

The Department of Health Services was the lead agency for the COVID-19 state-level response. Similar to other institutions across the country, the onset of the pandemic led to severe disruptions in day-to-day operations. Staff were often unclear on how their everyday work fit with the needs of the response. Selected staff were reassigned to meet the evolving needs, and those not selected did not necessarily know why. It did not appear that there was a systematic way to reassign staff, but inclusion in these efforts was prestigious and career-building.

The department was constantly restructured during a fast and evolving situation. During the first 3 months, the state formed a community resilience

and response task force that included staff members who were advocates of CHWs and had experience with these programs. In collaboration with internal and community partners, the task force drafted an early proposal to department leadership encouraging the use of CHWs, which influenced later efforts to integrate CHWs in the COVID-19 response.

Later State-Level Responses

The temporary response was restructured multiple times, with increasing numbers of staff reassigned to support the COVID-19 response. By the Fall of 2020, the state leveraged federal flu prevention dollars to set up infrastructure that would later support COVID-19 related efforts. By the time federal COVID-19 resources arrived in the state, the pandemic response had settled into a more consistent structure. Federal resources meant the department could be more innovative and support hyper-local response initiatives to increase vaccination rates. In April 2021, the agency developed a COVID-19 outreach grant program with federal resources. One goal of the program was to streamline normal bureaucratic processes so initiatives could be implemented quickly, and smaller organizations could apply. The state wanted to ensure the success of first-time applicants by including a simplified application process, more flexibility for spending and reporting, and additional support for grantees through dedicated community liaisons.

A year later, the outreach grant program expanded and diversified the network of public health organizations the state funded. Ongoing communication with CHW program staff enabled the state to obtain timely feedback, allowing them to adjust interventions to address unintended consequences and bureaucratic hurdles. The efforts to prioritize CHWs and assign state staff as community liaisons were replicated in other state grant programs. State-level staff now serve as advocates for community partners in internal decision-making spaces.

Integrating CHW programming in state-funded vaccination efforts improved the reach and quality of vaccination services for communities the government does not typically reach. CHWs also informed broader planning and decision-making that affected the whole state. Marginalized communities often experience trends and challenges before they become widespread across the general population. Listening to CHWs and other community partners enabled the state to address those issues promptly and be better prepared to help everyone.

Local Urban Case Example

In March 2020, a local endowment issued a statewide call to fund projects focused on COVID-19 prevention. The city health department, in partnership with the county and faculty from a statewide medical college, responded to the statewide call and was awarded a 6-month, $500,000 grant. One goal of the grant was to train and deploy CHWs to disseminate messaging and support households disproportionately impacted by COVID-19. The health department received a no-cost extension and leveraged federal COVID-19 resources to extend it another 3 months. Additional federal resources were used to employ CHWs on vaccine outreach through August 2021. Although partner agencies worked together in the past, most of the project-based relationships were developed specifically for this project. The partners were originally working on separate grant applications but submitted one application to align efforts and maximize impact. The health department had not worked with CHWs prior to the pandemic, but the funding and the partnership with faculty from the medical college helped integrate CHWs into their COVID-19 response.

The grant was written a few weeks after the first COVID-19 case was identified in the United States and knowledge about the virus was rapidly changing. Masks were not recommended when the grant was written and a stay at home order had not been implemented. The partners designed the project to be nimble; however, the partners did not write the grant with the intention that it would be a long-term, multi-year project. Although there was uncertainty about the trajectory of the virus and emerging community needs, it was clear that the virus was disproportionately impacting communities of color (Johnson & Buford, 2020).

The irony of three large, bureaucratic organizations implementing a short-term project to respond to an emerging pandemic was not lost on the partners. It was difficult to move through bureaucratic systems quickly to negotiate contracts with subcontractors, hire staff, and purchase supplies. To reduce a several-month hiring process to a couple weeks, the health department utilized an existing contract the city had with a temporary employment agency to hire and onboard CHWs, rather than hiring the CHWs as city employees. The partners recruited the CHWs, but the CHWs were compensated through the temporary agency. In total, 12 part-time CHWs were hired to support the response, including four team leads. Four CHWs served the African American community, two served the Hispanic community, four served the Southeast Asian community, and two served the Native American community. Project CHWs had a range of professional experiences. Some were trained CHWs,

while others were seasoned community leaders that came into CHW work due to pandemic related job changes.

Project leadership met weekly with lead CHWs to learn about community needs, identify opportunities for training, and learn how other members of their team were doing. Although the four teams of CHWs served different communities and worked independently, weekly meetings allowed CHWs to see commonalities between communities and solve problems together. As trust grew between team leads, CHWs supported each other at community events, made referrals to agencies in another CHW's network, and worked together to secure shared resources.

CHWs worked independently and had the autonomy to prioritize their community needs, which required trust between the CHWs and the health department. This trust allowed CHWs to provide honest and timely feedback that strengthened the response. For example, CHWs told the health department when families were not receiving timely contact tracing or when there were not adequate translation services at COVID-19 testing sites. The health department could not address all the feedback offered by CHWs, but they valued the trust on the ground perspective.

Meeting People Where They Were for COVID-19 Outreach and Education

Early in the pandemic, there was a shortage of disposable masks and a local manufacturer of hospital grade-disinfectant wipes donated hospital-grade fabric and rubber bands that were assembled into masks through an initiative called MaskUpMKE (Image 1). The CHWs assembled tens of thousands of masks and distributed them at community events, door-to-door in neighborhoods, and to local businesses. One CHW put a sign on his truck indicating that he had free masks available. CHWs also provided education on when to wear a mask and how to properly wear and store one. The health department eventually purchased cloth masks and distributed those in addition to disposable masks. Many cloth masks were still being worn a year after distribution, reflecting the depth of the CHWs' outreach.

A local mask ordinance passed in July 2020. The health department printed thousands of flyers for businesses to display to promote the ordinance but did not have the capacity to distribute them. CHWs observed that businesses were not enforcing the ordinance and decided to distribute the posters, answer business' questions about the ordinance, and provide free masks. One CHW reflected, "The businesses are important. Why? Because the communities are

Image 1. Disposable Masks Were Difficult to Find Early in the Pandemic
Note. CHWs assembled tens of thousands of disposable masks from hospital-grade fabric and rubber bands through an initiative called MaskUpMKE. CHWs distributed masks at outreach events along with COVID-19 education and guidance on how to properly wear a mask. CHW = community health worker; COVID-19 = coronavirus disease.

coming into the shops. . . if businesses support our program, we have more access to people."

CHWs were not part of the formal contact tracing team but completed online contact tracing training. This training helped CHWs work with individuals who had COVID-19 but did not engage with the health department because of their immigration status or because they did not trust the government. CHWs encouraged participation in formal contact tracing, but provided guidance on isolation, advised individuals to follow up with close contacts, and made sure they had resources (e.g., food) to isolate safely if they did not feel comfortable.

Each CHW identified strategies to meet people where they were to provide COVID-19 education (e.g., handwashing, mask wearing, physical distancing, testing information), distribute masks, and make referrals to services (Image 2). For example, CHWs distributed masks, hand sanitizer, and educational materials at a Native American community event and at a Hmong New Year celebration. One CHW assembled hygiene kits (i.e., education materials, cloth masks, hand sanitizer, toothbrushes, soap, shampoo, razers, etc.) to engage individuals in the community through door-to-door outreach. CHWs used outreach events to counter misinformation about the virus and respond to the unique needs of their community. For example, the Hmong community was uniquely impacted by stay-at-home orders and gathering restrictions.

Image 2. CHWs at an Outreach Event Where They Provided Free Masks, Education on How to Prevent the Spread of COVID-19, and Hygiene Kits
Note. CHWs are wearing masks that were purchased by the health department and distributed throughout the community. CHW = community health worker; COVID-19 = coronavirus disease.

Gathering restrictions meant that cultural ceremonies and celebrations—marriages, deaths, holidays—could not be planned in accordance with tradition. One CHW reflected,

> Traditional funeral rites must be accurately performed in order for the deceased to travel back to their home or to the Land of the Ancestors. . . [COVID-19] meant the inability of families bathing and grooming their deceased loved ones before the funeral. With hospital morgues and funeral homes overwhelmed, this meant prolonging the journey and ultimately the unsuccessful passageway for the recently deceased. Not only did Hmong families fear COVID-19, but we feared how this would impact the afterlife as well.

For Hmong elders, quarantining at home also resurfaced historical trauma from when they lived in refugee camps. Targeted outreach helped CHWs respond to unique community needs.

In addition to providing direct outreach, CHWs were innovative in how they disseminated public health messaging. One CHW sewed cloth masks using traditional Hmong textiles and imagery to promote mask wearing in the Hmong community. Images of the masks were printed on posters and bus shelters to promote mask wearing. Another CHW made masks with caring words (e.g., respect) in the language of each of the state's tribal nations. The masks were mailed to tribal representatives, photos were taken of tribal members wearing the masks, and the photos were put in a music video to promote mask wearing.

When vaccines were approved, CHWs provided health education about vaccine safety and countered misinformation with facts. As vaccine eligibility criteria expanded, CHWs partnered with the health department to organize vaccine clinics in their neighborhoods.

Navigating the Economic Challenges of the Pandemic

CHWs witnessed the significant economic challenges families faced due to pandemic-related job losses. One CHW reflected, "Everyone has a lot of stress because [they had] no money, no food . . . we say you can't come outside but they don't have no food." CHWs served individuals/families who were isolated at home but were not engaging with the health department due to a lack of trust in government. At first, the health department provided a 2-week supply of food to isolated families who could not secure food. As COVID-19 cases increased and demand for food grew, the department could not keep up. Recognizing the unique needs of families CHWs served, the project team purchased groceries from retailers so families could get through the weekend. Eventually, one CHW leveraged his relationship with a local food bank to acquire and distribute tens of thousands of pounds of food. In addition to food, CHWs responded to requests for diapers. The health department purchased diapers for CHWs to distribute, but the supply could not keep up with demand. One CHW secured diaper donations from retail stores, but again, supply could not keep up with demand.

CHWs also worked with families that could not pay their rent. As federal relief funds were distributed, millions were allocated to rental assistance programs. The CHWs referred and provided high-touch support to eligible families. As the demand for these programs grew, CHWs followed up with the rental assistance programs to check on application status. One CHW used his personal relationship to invite leadership from the rental assistance program to a weekly team meeting to talk about eligibility and challenges CHWs were experiencing with enrollment.

During the holidays, the CHWs organized a holiday toy drive to support families who were experiencing economic hardship from the pandemic. The toy drive recognizes how committed CHWs were to their community and how CHWs recognized the full range of needs families had during the pandemic, with one CHW sharing, "I feel how these families feel."

Local Rural Case

A public policy institute in the community had a reputation for bringing people and organizations from diverse perspectives together for civil discourse and to achieve common goals. In response to existing communication barriers with Hmong and Hispanic communities, a faculty member with a joint appointment at the statewide medical college and the policy institute convened a network of partners in March 2020 to apply for a grant from a local endowment to support COVID-19 response initiatives. The network included Hmong and Hispanic community leaders, a medical college, health systems, resource agencies, and health departments. The goal was to strengthen communication channels and facilitate regular information exchanges between community agencies and people in Hmong and Hispanic communities. A project director reflected on the need for the project,

> Anchor institutions and local governments were not prepared or equipped to reach immigrant communities to prevent and mitigate the spread of COVID-19. Health departments and systems were ill-prepared to communicate with people who did not speak English, read, listen to local TV stations, or visit public health or health system websites. They were not prepared to deal with the historical trauma of refugees or religious/cultural disease constructs that do not include viruses. They were not prepared for people afraid to answer their phone when a strange number appears or fearful that they could lose their home immediately if they do not go to work. They were not prepared to face businesses willing to treat employees as less than human.

During these network meetings, participants noted there was distrust of health agencies on the part of community agencies and Hispanic and Hmong communities. For example, Hmong community leaders experienced health systems "wanting to work with" them, only to later feel abandoned or that their voices were not truly heard. Because of potential immigration consequences, people in Hispanic communities feared most anchor institutions. This networking group envisioned bidirectional communication not only for the pandemic, but as part of a longer-term solution to address health equity.

CHWs were identified as a solution that could help build trust, even though prior to the pandemic, CHWs did not exist in a formal way in the region.

Although the initial grant proposal was not funded, partners continued to identify alternative funding sources to move the CHW model forward, and eventually received a small grant for "things not people." Given rural internet access issues, the partners purchased iPads and cellular data so CHWs could access information and meet virtually with community members. Subsequently, the first CHWs were hired in May 2020 by patching together a variety of local funding sources, mostly in the $1,000 to $5,000 range. In addition to COVID-19 outreach activities, partners explored funding opportunities for non-COVID-19 activities to give CHWs more tools to serve their communities. For example, the partners received funds to educate Hispanic and Hmong communities about health insurance enrollment and to raise awareness of the 211 helpline, with the funder using CHW insights to foster inclusivity for immigrant callers.

In Fall 2020, partners received state funding for influenza vaccination outreach. In April 2021, a state COVID-19 vaccine outreach grant was awarded. Securing further financial support was highly relational, and the program snowballed in unforeseen ways, much as the pandemic did. Key actors at state, local, and national levels saw the success of the project and provided additional financial support. In Fall 2021, the state extended the initiative's COVID-19 outreach funding through June 2024. Partners raised over $2 million dollars since the project's inception.

The Hmong and Hispanic Communication Network (H2N)

The partners eventually called the initiative the Hmong and Hispanic Communication Network (H2N). Hmong and Hispanic Community Coordinators, original project planners, were each tasked with finding four part-time CHWs representing a variety of geographic locations and social circles within local Hmong and Hispanic communities. Some CHWs had previous experience working in the health field or doing community organizing or education, but others had not. One said, "Nobody set out to be a CHW but it is the kind of work that we do." CHWs participated in COVID-19 prevention and mitigation training, including modeling prevention strategies, such as wearing masks, physical distancing, and hand washing/sanitizing. CHWs were also "trainers" and shared community concerns, information gaps, social networks and platforms preferred in their communities, and types of messaging that might be most helpful.

Transparency, establishing relationships and maintaining trust are important during an evolving health emergency, and the leadership structure of

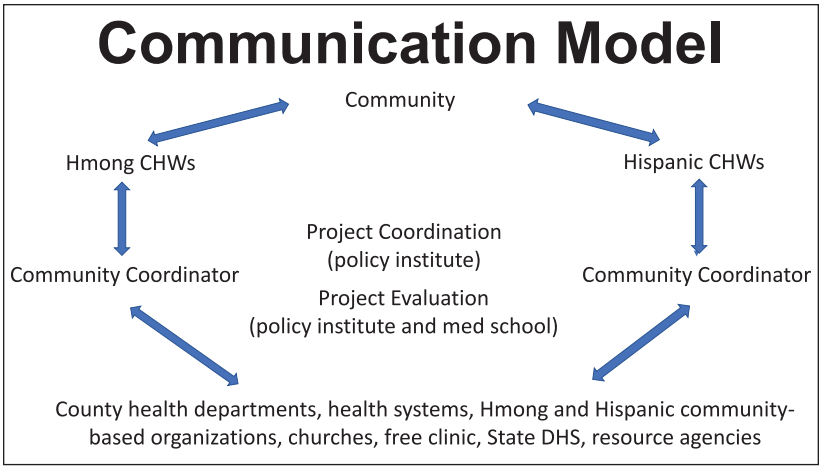

Figure 1. Organizational and communication model for the H2N Program.
Note. DHS = Department of Human Services.

H2N was intentionally flat to reflect those values. Community Coordinators meet weekly with their CHWs. Community Coordinators also met weekly with the policy institute and had biweekly meetings with a larger group of community collaborators that included public health, a medical college, health systems, and local resource agencies. CHWs educated the project team, community collaborators, the state, and other funders by sharing on-the-ground observations, concerns, and ideas. As trust was established between CHWs and partner agencies, including the state, CHWs emphasized that they felt like community voices were being heard. Grant writing, tracking and reporting, building local and state partnerships, collating information, and H2N marketing were led by the institute.

Health, educational, and economic disparities were exacerbated by the pandemic, and CHWs were sensitive to community-identified needs. CHWs were the eyes, ears, and mouths for their communities. In many ways, they also became the hands, delivering USDA food boxes to quarantined families, accessing rent and housing assistance, connecting people with health insurance and/or health care, and helping families seek immigration legal support. One CHW said, "CHWs get questions about everything. Community members may be undocumented and need food, immigration, or rent assistance" (Image 3).

Image 3. Meeting Basic Needs Was Crucial in Building Trust
Note. CHWs orchestrated a drive-thru food distribution event to bring together food donations from the Hunger Coalition and locally owned Hispanic grocery stores. CHWs and volunteers packed food bags with healthy, culturally responsive foods and distributed the bags in a familiar and safe location. CHW = community health worker.

Tailoring Pandemic-Related Health Education, Outreach, and Vaccine Distribution

Hispanic outreach focused on dairy farm and food processing workers and their families, many of whom are undocumented, do not speak English, and cannot read or write in Spanish. Transportation and distances in rural areas are significant barriers. There is often a lack of basic understanding about health systems and access to care. Health insurance is not offered through work, and they are not eligible for most services due to a lack of a Social Security Number. Mistrust fueled rumors, such as microchip insertion with vaccinations.

As in the Hispanic population, language and literacy barriers in the Hmong community keep some isolated. Many Hmong grandparents are unable to communicate with their grandchildren, and many speak but do not read Hmong. There is mistrust of western medicine, and the Hmong community has a long, tragic history of being persecuted by their government. Because of this and the rise in violent crimes against Asian Americans, many felt the vaccination effort was an attempt to exterminate the Hmong community.

One-on-one conversations with trusted messengers were critical for health education and outreach. CHWs had conversations within their extended families and social circles. They also talked with people at food distribution events, farms, churches, festivals, community centers, ethnic grocery stores, and food processing plants. CHWs met with small town community leaders and farm and business owners to gain access to people they were trying to reach. CHWs had over 8,000 conversations in their communities between May 2020 and January 2022.

CHWs also recorded public service announcements and podcasts on Hmong and Hispanic radio and developed messaging for YouTube and social media that incorporated current health and resource information and community stories in Spanish and Hmong. These communication strategies addressed myths and answered common questions. A multi-generational photo and video campaign featured area families. A one-minute video featuring diverse local young people reached 70,000 people after being broadcast by a local TV station.

CHWs were trained for influenza vaccination outreach in late 2020. In partnership with a free clinic, CHWs organized five pop-up influenza clinics, recruiting and welcoming participants, answering questions and reassuring people in their own language in a culturally sensitive way. These experiences prepared CHWs for COVID-19 vaccination outreach.

COVID-19 vaccination inequities abounded in early 2021, underscoring the need for CHWs. H2N and a local Hmong community-based organization were persistent in advocating for vaccine slots designated for Hmong elders by the health department. Even after vaccine eligibility expanded to include people with chronic illnesses, health department vaccines were only allocated for seniors. With a generally younger population, this meant that few Hispanic people were vaccinated. It was also apparent that health systems were geared to serve their paying patient population, and many vulnerable people were not established patients.

Initially, CHWs assisted elders and others eligible for the COVID-19 vaccine in finding and registering for vaccines. When vaccine eligibility opened, H2N organized pop-up clinics in the community with partners in safe, convenient locations at times amenable to work schedules. Between December 2020 and December 2021, H2N held pop-up vaccination clinics in over 30 locations, including farms, community centers, schools, churches, and festivals, giving over 1,000 COVID-19 and over 600 influenza vaccinations to underserved communities (Image 4). The Southeast Asian population was the highest vaccinated ethnic group in the state, and Hispanic vaccine rates exceeded non-Hispanic rates in several counties (Wisconsin Department of Health Services, 2022).

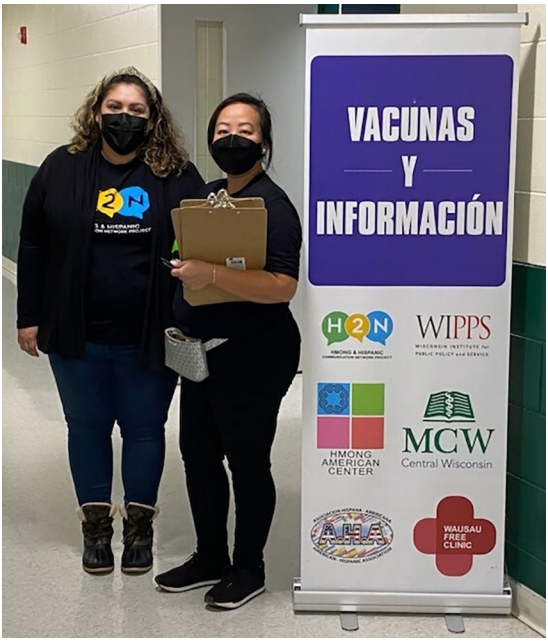

Image 4. A Pop-Up Vaccination Clinic Held in a High-School Fieldhouse, a Community-Trusted Site

Note. Bilingual Hmong and Hispanic CHWs worked with COVID-19 and influenza vaccinator partners to promote and staff this clinic. Over 250 vaccinations were given within several hours. CHW = community health worker; COVID-19 = coronavirus disease.

Prioritizing Health Equity Through Strengthening Community-Based Organizations

Although partners originally convened to respond to a local endowment's call for proposals to respond to COVID-19, they envisioned that CHWs could serve as trusted health messengers in the community to promote health equity beyond COVID-19. H2N has funding for two full-time coordinators and 12 part-time CHWs through summer 2024. Partners had longer-term aspirations to empower and invest in community-based organizations so that they are better prepared to handle future adverse health events or disasters in their community.

H2N had important consequences for local organizations and the influx of funding helped stabilize some organizations. A Hmong community-based

organization had a smaller footprint in recent years due to the loss of refugee resettlement funding and a sense that the welfare of the Hmong community had stabilized. In 2019, its Board recommended filing for bankruptcy. When the fiscal agency of the H2N project was transferred from the policy institute to this organization in Spring 2021, however, this organization was able to sustain funding for key staff positions. At the current time, the policy institute continues program management and project direction with the intention of gradually handing these pieces off as Hmong and Hispanic community-based organization capacity grows so that these organizations can carry on the work into the future.

"Opening" the Case

Flyvbjerg (2011) stresses that much of the value of a case can be lost with oversimplification of hard-to-summarize narratives and high-level generalizations because "the case study itself is the result" (p. 312). He recommends keeping a case open by allowing stories to unfold in their diversity. Rather than a summary, this section includes highlights from collective sensemaking events (Weick, 1995). They include: (a) personal relationships; (b) social determinants of health; (c) personal as intertwined with collective identity; (d) utilizing personal and political power differently; (e) financial support; and (f) structural racism.

Personal Relationships Initiate and Sustain Action

The community leaders hired as CHWs had previous experience working with partner agencies and had time to do the work; relying on these personal relationships enabled programs to start quickly. The strength of CHW work itself rested on personal ties to their communities, and those relationships grew stronger over the course of the pandemic. These enduring relationships outlasted the funding structures in one case. Even when the urban-based CHW project ended, requests for assistance did not, and CHWs were put in a difficult position to support their community with no compensation or access to program resources.

While relying on personal relationships led to increased diversity at the local level because of employed CHWs, reliance on personal relationships *decreased* the numbers of people of color in decision-making positions at the state level. The diversity of entry and mid-level staff either stayed the same or increased slightly during this time, but key leadership became more dominated by white males than before the pandemic. While this was accidental—a common result of rushed decision-making during crises—practitioners are

still responsible for reconciling unintended consequences. Macnamara (2021) wrote, "lack of intentionality . . . do[es] not provide inoculation from a responsibility and potential reputational damage" (p. 251).

Social Determinants of Health Are Intertwined With COVID-19 Prevention and Mitigation

COVID-19 interventions were deeply intertwined with activities related to other social determinants of health and help build trust. Here is one example of a CHW recalled:

> A CHW visited a Hispanic family that was in isolation/quarantine due to two cases of COVID-19 in a household of six. The two parents tested positive, and the father required medical care. His recovery took over two weeks. His work was the family's only source of income. The family was very overwhelmed because at baseline, they live month to month. The CHW brought food boxes to their doorstep for several weeks and helped them apply for rental assistance. Later on, they got vaccinated at a pop-up clinic.

The influx of federal resources expanded these possibilities, although there were restrictions on aid to undocumented persons. For the urban case, it meant that funds could be used to purchase food, diapers, and meet other community needs. The rental assistance programs that CHWs referred clients to used federal relief funds. Federal funds also meant the urban case could continue employing CHWs for vaccine distribution. The rural case explicitly integrated all of their pandemic work with programming related to the social determinants of health because they assumed—as most funding sources did—that the pandemic would be short-term. They now intentionally deepen *and* diffuse health equity activities by supporting community-based organizations. Their assertion is supported in the disaster preparedness literature (e.g., Braun & Lampel, 2020; Comfort, 2002), which calls for robust community-based organizations that are positioned to link with public and private agencies as needs arise.

Personal Transformation Integrated in Community Transformation Efforts

These community leaders were all involved with work related to diversity, equity, and inclusion before the pandemic. Their description of their sense of social responsibilities with their life purpose were intertwined in ways that resonate with the African Unbutu worldview of "seeing oneself through others" (Chigangaidze et al., 2021, p. 1). One CHW reflected, "I'm 65 years old,

ok? A lot of this stuff for me is about helping people. That's your purpose, that's what you're doing." The willingness and ability to contribute to their communities went beyond any particular task or job, even when they were no longer employed in that role. "You're still a community health worker, you know, almost like how can you not be it?" While Cherrington et al. (2010) found distinctions between paid and unpaid CHWs in terms of allegiance to the missions of the organizations funding them or to the community, these CHWs did not.

Through this experience, CHWs described becoming more effective and powerful advocates; having a greater understanding of social problems and intercultural awareness; and appreciating the role of art in social change. One author-practitioner described the impact of doing this work on his advocacy efforts,

> In my personal experience, I've learned to be more of an advocate, not just for myself but for my organization, and also for my community as well. Oftentimes, before this whole pandemic, there were times when I myself personally would say, 'you know, I'll wait my turn.' But during this whole pandemic, I learned to be more assertive and learned to be more persistent with what we need.

Several CHWs discussed their deepening understanding of health disparities and structural inequality. An author-practitioner reflected,

> "It also taught me a lot about generational trauma, and the trouble our parents and grandparents face. And then how the pandemic kind of focuses on those historical moments that they went through. Then mental health was also huge for me."

The local sites drew on the many skills and talents of the CHWs, and art emerged as a way to generate culturally appropriate messaging. A CHW reflected, "I was able to create these art mask pieces with a few others on the team. And before that, I just never thought that art was something that could be powerful, and it actually is." CHWs learned about strategies from each other and were enriched by those connections. This was particularly the case in the highly segregated urban case. One CHW emphasized, "This pandemic did a lot of good in terms of solidifying some relations to different communities. The intercultural stuff was important."

Power to Act Differently Individually and Collectively

Authors navigated power differently during the pandemic because the normal rules did not always apply. They described "doing a dance" to find ways to

operate that were in-bounds with established rules and flexible enough to address the situation. Sometimes state and local-level staff and directors bypassed traditional decision-making channels by going to the "top" and occasionally made judgments that suspended some rules. For example, when all public gatherings were banned, CHWs often knew when traditional funerals were going to take place. They worked with program directors to provide masks and hand sanitizer for these large events to keep people as safe as possible. CHWs drew regularly on code-switching, such as bringing out the "health department affiliation" when working with businesses, and downplaying officialdom when working with populations with low trust of institutions.

Opportunities arose for actors within institutions to design innovations and use them as a catalyst for ongoing change, a phenomenon seen in other large-scale crises (Braun & Lampel, 2020; Macnamara, 2021). Both the local endowment that initially funded the urban site and the state Department of Health Services streamlined application and reporting processes to make funding opportunities more accessible. The state changed its funding priorities to prioritize CHWs and added more in-house liaisons with CHW programs.

The authors hope that some of the flexible processes put in place during the pandemic continue. One author notes, "A lot of our really hard rules were softening. The system was doing everything possible to get us back to the 'hard rules.'" Staff wanted to make sure the "give" in the system would continue to be there, which reflects what Macnamara (2021) described as the "tension between normalization and innovation in the face of disruptions and crisis" (p. 255). The "new ways" are not without challenges. As one author said, "there was probably more pain on the part of the finance people. Easier is not necessarily the right thing to do." These leaders prioritized flexibility, and some recommended practices for CHW programs, such as standard definitions and certification (e.g., Agarwal et al., 2019; Barbero et al., 2021), were not met with enthusiasm. One said, "If you require a credential for CHWs, we'll call it something else."

Structurally, the two local sites took different approaches to organizing their pandemic response, existing on an organizational continuum common during large-scale crises (Braun & Lampel, 2020). On one end of the continuum is the urban case where temporary project activities were tied to permanent bureaucratic structures, in this case, the local health department. On the other end is the development of new independent organization structures, the rural case example's enduring health coalition (H2N) that was "incubated" at a policy institute, and whose activities are now housed at a community-based organization. These two sites interacted with state-level actors in

various ways, and over the course of the pandemic, one grew "co-dependent" (Braun & Lampel, 2020; Comfort, 2002) through the multi-directional flow of information and, eventually, disbursement of financial support. The greater intimacy as a result of this co-dependency may protect against funding priorities growing out of touch with local needs, a problem commonly found in other CHW programs (e.g., Acosta et al., 2015).

Financial Support Structures

Private philanthropic entities, with greater flexibility to act without going through a legislative process, played an essential role in supporting the early pandemic response before state or federal COVID-19 resources were available. Partners in the urban case would likely not have convened without the initial large grant. This same funding opportunity allowed partners in the rural case to create a shared vision. Access to resources also resulted in projects scaling at different rates. The urban program, with its large start-up funding, was running by summer 2020, while the rural-based effort initially worked "month-to-month," piecing together small grants to cautiously expand. The state-level response was influenced by these earlier innovations.

Racism as a Public Health Issue

The role of racism, structural and interpersonal, was a reoccurring theme in the authors' reflections. Many of the mitigation strategies and interventions, seemingly "neutral," were designed for impact on the general population and often disregarded the multiple barriers historically marginalized communities face. Authors described the need for immigration reform and public action to address racism and poverty. Historical distrust of institutions in the African American community (Eiser & Ellis, 2007) and the increase in anti-Asian discrimination and assaults fueled fears in the Hmong community, which led many to distrust vaccination efforts. Authors discussed the importance of adequate compensation for CHWs, who are often expected by "officials" to represent their communities and provide services for free.

An important point to consider is that the CHWs, all members of racial and ethnic groups at greater risk of complications from COVID-19 infection, took more risks than people who stayed at home during the pandemic. In many ways, health care systems transferred risk to individuals with the lowest pay and least job security in the public health system. CHWs described their worry about the risk to elderly family members living with them, their children, and themselves. CHWs were eligible for the vaccines early as

essential health care workers, but several CHWs contracted COVID-19 prior to the authorization of the vaccines. All the CHWs agreed to serve in this capacity despite the risks, and felt they made important, immediate impacts on the people they served. But they gave mixed responses about perceptions of the long-term impact. One CHW noted that one place to start was in the institutions themselves, "there is a need to diversify the message bearers within institutions." Enabling CHWs and program directors to garner a seat at the table is considered important progress.

Conclusion

The state-level context and two local cases represent an example of how entirely new CHW initiatives were implemented during a public health crisis by providing pandemic relief while addressing the social determinants of health and nurturing trust. Personal relationships among those who valued listening to and acting with community leaders catalyzed innovations in public health practice. Authors described ways in which personal identity and moments of transformation were intertwined with their commitment to social justice, providing another opportunity to consider how community-based approaches to humanistic psychology may be imagined (Saleem et al., 2021). Local efforts of the two local sites complemented and informed the eventual state-level efforts, which supports the assertion of Braun and Lampel (2020) that local (micro) organizing during crises is often complimentary with larger (macro) bureaucratic structures. These authors consider feedback loops and the flexibility to do things differently key to their success. They hope the concrete, context-dependent case knowledge presented will benefit others to consider applications to other settings.

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Supplemental Material

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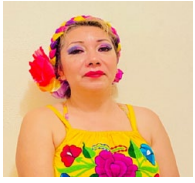

Cecilia Garcia is of Mexican nationality and has lived in the city of Milwaukee for 18 years. She is a community health worker and has worked for the Latino community for more than 9 years, seeking basic resources and direct connection with organizations that can provide services to low-income families.

Otis Winstead is a Vietnam Era Army Veteran; Otis has served as a Veteran peer support specialist along with servicing the community in the same capacity for the past 10 years. There is no greater a God's gift than giving one's time, empathy, and compassion to help their fellow man. What counts in life is not the mere fact that we lived. It is what difference we have made to the lives of others that will determine the significance of the life we lead.

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