Picture It: Drawing into Focus Our Participants' Bonds of Support

» Overview of the Benefits of Genograms, Ecomaps, and Care Connect Mapping

» Methods to Identify and Engage the Participant's Ecosystem

» Instructions For Facilitating Participant's Use of the Care Connect Mapping Tool

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Abstract: *Three culturally-affirmative network mapping techniques are described, with an example for each using the same identified participant example for each. The last section provides detailed instructions to implement the Care Connect Mapping Tool.*

Introduction: Network Ties and Care Delivery Innovation

Over the past few decades, there has been increasing recognition of the profound impact social conditions have on individual health and wellness, including traditional systems of care acknowledging the importance of participants' social environments. The introduction and implementation of CalAIM (California Advancing and Innovating Medi-Cal) exemplifies this shift in understanding. Nevertheless, challenges remain. Most providers lack of knowledge of important community resources or how to identify the supports in their participant's personal network. The effective use of Community Supports and similar CalAIM resources depends on service providers' ability to engage participants in ways that surface the resources available to them and that clear a path to accessing resources. Community Health Workers (CHWs), because of their unique qualities such as the trust and knowledge of the community in which the service population resides are well positioned to fulfill these opportunities.

"Our country's medical system is broken" is a common refrain among healthy well-resourced citizens. Public sector consumers with complex care needs, along with their concerned loved ones and their providers, experience even greater difficulties in accessing needed resources. Much of this inaccessibility can be mitigated if care providers open their aperture to include the participant's ecosystem; their household,

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loved ones, personal community supports, and social and clinical providers. By having a picture of these sources of support and stress and the qualities that bind them together, the totality of their personal and provider networks and the wells and gaps of support within the network emerge. Insight to the community and the mutual aid found within it is also enhanced. The strategies and tasks attendant to community brokerage and advocacy are second nature to CHWs who were themselves raised with an orientation to community that is common among public sector healthcare clientele. But these collective strategies and tasks are generally absent from standard workflows of our system of care delivery.

By taking what we describe as a **culturally affirmative**[1] approach and framing an ecological understanding, providers can bridge the gap between the way our systems of care operate, and the service needs and help seeking patterns of participants/ community. Culturally affirmative strategies identify social ties, appraise the quality of the bonds (durability at times of stress, concrete resources...) and consider how they are fashioned into a net of support through which the participant's concerned loved ones and providers cooperate and coordinate their care-taking efforts with each other in service to the participant's stated wants and needs. Identifying a participant's kin/friend and provider support networks is an excellent means of improving care coordination and is a hallmark of culturally affirmative care. This approach increases the plan's coherence, expands the continuum of care, and improves coordination of care delivery, all of which greatly improve health outcomes. It is not possible to provide culturally affirmative care without considering the participant in the context of their ecosystem.

Understanding the Usefulness of Support Networks

The community factor in individual wellness has long been the subject of study in public health, social work, medical anthropology, psychology and sociology. In these arenas it is commonly referred to as an ecosystem. **Ecosystem** refers to the living and inanimate elements of a participant's environment: the people for whom they feel love and belonging, their household, the natural environment (neighborhood cleanliness, greenery), surrounding amenities (easy access to transportation, healthy food) and their associations (work, school, faith institutions). Because the focus of our services is low/no income residents with complex needs, it is important also to include the care providers found in the ecosystem. Visualizing these elements as a web reveals the lived experience

[1] See Addendum page 28 for description of culturally affirmative approach.

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of the participant and their safety net of support.

> Identifying a participant's kin/friend and provider support networks is an excellent means of improving care coordination and is a hallmark of culturally affirmative care.

Unfortunately, despite the excellent benefits of diagram development, a minimal diagram (who to call in an emergency, or to pick them up at discharge, their other medication prescribers) is typically as far as providers go in understanding participants' relationships to elements in their ecosystem. Thus, they miss the opportunity to partner with valuable resources and enhance support network ties. For example, understanding how robust the tie is when under stress, the degree of warmth and positivity despite the stress, and if the tie is a conduit to important concrete resources (a couch to sleep on, childcare when working the night shift, drive to grocery store...) may make all the difference in saving the participant and their concerned loved ones from the deleterious side effects of a more acute intervention and also sparing the system unnecessary financial costs.

Even impoverished support networks usually have familial relationships which, though they may be fractured, can provide benefit from family resources, since families typically operate with a high "give-to-get" ratio. Strengthening the communication and cohesion of relationships important to participants in the longer-term decreases care costs while increasing positive health outcomes. An ecological review usually reveals resources in the participant's natural support system that are relevant to their provider care plan. It can help to identify where fragmented care efforts or interpersonal conflicts are blocking potential interventions. Often these and other loose ends in both provider and personal nets of support, if addressed, can strengthen the participant's safety net. This in turn decreases the impact of trauma and the cost of higher level care, and further integrates and stabilizes the participant in their community. CHW efforts to strengthen support networks can increase the elasticity of those bonds while under stress and can improve resource flow through the participant's network.

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Tools for Charting Participants' Support Network

Overview

Genograms, **ecomaps** and **care mapping** are three common methods to assess participants' ecosystems. When utilizing a culturally affirmative lens, each can be easily tailored to highlight important cultural features. So, to adequately understand the influences for behavior change (culture) and to meet the aims in the intervention plan, it is important to understand who the participant cares about and how their concerned loved ones can influence their commitment to improved health and wellness. These tools enable the care team to understand the participants in context and see the most enduring resources of their health and wellness, bringing into focus **who the participant cares for and who cares for them**, as well as their community. Diagrams, particularly genograms and ecomaps, offer a comprehensive view of the participants' priorities and motivations by allowing participants the opportunity to voice their own telling of their stories and define for providers their place within their communities.

An often overlooked benefit of ecosystem review is that it opens a vista to what future social challenges and benefits that may emerge. By considering the stages of the life cycles of individuals, community entities, and families in the ecosystem, the future needs of the participant can be anticipated. For example, a 15-year-old who has taken on parental functions and who is currently the engine for the household's daily functions—five years from now they may be a distance away from the household. Similarly, stable housing may tip to chronic housing insecurity for several family members when the elderly homeowner who is Head of Household moves to a nursing home. Using mapping to recognize and plan for the possibilities eases the transition and reduces the likelihood of the events precipitating acute crisis episodes.

Key facilitator functions:

1. Though there are times in which the participant may be highly motivated to track as much info as possible, most of the time it is not practical and often counterproductive to do so. The information that is most relevant to the participant's current circumstance Is the priority. Additional information can be added to the diagram, as it reveals itself in future encounters.

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2. Though it is not a difficult process, many people including providers tend to find the prospect of mapping intimidating. So, it is important to have a trained facilitator who is skilled in what is needed, and has the self-reflexive skills to follow, not lead, the participant's thoughts and feelings. The facilitator should see it as their job to display the information in a coherent orderly manner. The first drawing rarely looks that way. The facilitator should take as part of their responsibility to revise the drawing to make it easier to read, while respecting the participant's voice.
3. The facilitator should prompt the participant to note language preferred/used in the household and offer to find a facilitator who is fluent in their language if the current facilitator is not.
4. Have on hand a range of flesh color crayons. Many USA residents, more than ever before, are eager for recognition of parts of their racial/cultural identity that an acquaintance wouldn't conclude or even imagine by looking at them. Common examples are a grandparent, cousins, adoption, stepparent, children, spouse. And there are still many USA residents who are anxious about revealing race and/or have internalized colorism issues. It is delicate, but important, to keep the door open for the participant to declare their culture, ethnicity, or race as they experience it. The facilitator needs to focus on establishing and maintaining trust and engagement so the participant can feel free to express their ethnic identity as they see fit. This is an example in which the facilitator's self-reflexivity is most in demand.

To compare the strengths and drawbacks of each diagram, we will follow the story of Gerald and his orbit in each of the examples below.

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Genogram

A genogram is a multi-generational depiction most often used to identify relationship dynamics, health concerns, emotional ties, and behavioral patterns in a family. It typically surfaces loss and other trauma, health conditions and the consequences of interpersonal conflicts of subsequent estrangement and its impact. Of the three types of diagrams presented here, the genogram is the most complex to create but is the best one for clear and practical insight to the participant's priorities and values. It reveals much of what triggers them to make changes in their life, as well as where and from whom they seek help during trying times.

CHWs should first seek training and coaching to assist participants' genogram development in a manner that reinforces their pride in who they are, where they came from and what they have overcome, without triggering trauma response. The purpose of this description is to make clear how valuable the process of genogram development is to engagement and partnership in the therapeutic process and ultimately positive health outcomes.

Genograms As a Gateway to Intercultural Understanding

A culturally affirmative genogram underscores kinship, ethnicity, faith, migration history, gender expression, sexual orientation, pet guardianship, residency and other legal status. Though community and other communication channels have major roles in shaping culture, the first and primary transmitter of culture is the family of origin. The process of developing a genogram with a CHW or another provider serving as facilitator and thought partner is an excellent prompt for engagement and building shared understanding. For example, it can surface understanding of multiple ethnicities within a family, adding significant depth in understanding of the participant's cultural identity, thus furthering insight in their motivation for change and their design for wellness.

When the provider takes the time to methodically explore with their participants the family's intergenerational migration journey (ideally 3 generations), their perspective of their USA residency and how they internalize their cultural identity emerges through the participant's own telling of their story rather than filtered through the provider's perceptions.

The decision-making leading up to migration, especially immigration, is often the most consequential reveal to who we are. All relocation has difficulties. However, when it is

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dangerous to dare to leave, requires traversing perilous terrain and evading the terrorists hidden within it (which is common to immigrant experiences as well as for Black people moving away from the South throughout history until the 1960s), the experiences define lives down through generations. These choices reveal a person's agency, **which is the same capacity they draw on to pursue changes in health and wellness**. As migration scholar Isabel Wilkerson notes, migration is not simply about movement; it is about freedom and how far people are willing to go to achieve it.

In telling their migration story, the participant reflects on:

> *when and where they were born, raised, who was in their household during their childhood,... if/when they moved and why...did they have the luxury of careful planning or was it crisis or conflict driven... what had that to do with family means (both financial and social networks), homeland unrest...was the family fleeing from something...was a parent leading the family to something...what triggered "now is the time" (my father left so my mother decided we move back to California so she had the support of her family in raising us... my older brother turned eight, so my parents, determined none of us will be forced into militia, decided it was time to risk the dangers of migrating across regions) ...who was left behind...why others did not come with (my mother tried to convince her brother's family it was time but he was worried about leaving our parents. She told him he needs to think about his children) ...the simplicity (eight hour plane ride) or harshness of the journey (two years ago my mother carried my four year old sister for three days, we lived in three different countries before here) ...the time it took to go from the dream to where the family is now, what is/was the dream for the end of journey...and, for each generation, was the move thought of as sojourn or as a mission from which they would return...what are current connections to homeland... are there remittances ...what is the family dysphoria ...do they visit, how often...?*

From this exploration the provider gains understanding of the meaning the participant internalized from their experiences, the "lived experience." This includes the triumph, trauma, grit, resilience, as well as debilitation or trauma responses. This process is not only highly effective in building trust and revealing information about stress and support in the participant's current ecosystem, but it also surfaces innate cultural values, the kind that determine which potentially precipitating event will trigger people to act, to make a change—key features of positive health outcomes.

Partnering with participants to track their family story has a remarkably positive impact

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on the participants' trust and engagement with their provider. And the process typically has a positive, organizing impact on the thoughts and emotions of the participants. It produces a sense of accomplishment, identity, and pride about who they are and where they came from.

However, for the facilitator and other providers their empathic response may produce the inverse. It is not uncommon for providers to be emotionally stunned by their participant's firsthand graphic accounts of trauma on a scale they have not known personally or in their network. The provider's capacity for "self-reflexivity[2]" and other genogram development training is particularly important in instances like this. Studies of trauma point out that traumatic experience and trauma response are not equivalent. Trauma does not impact all individuals the same. Impact is a function of the response attributed to it and the meaning derived from it. And meaning is the purview of culture. Cultures that foster resiliency and provide shelter against the deleterious trauma response typically emphasize holding on to personal history, knowing who you are and where you are from as a people, a family and an individual. Many participants, due to their culture, mindset or both, possess significantly more coping capacity and a degree of grit that their providers may not have. It behooves providers to keep this in mind to avoid assumptions that deny their participants' ability to confront difficulties because of their providers' estimation of what they are capable of.[3]

There is an abundance of symbols to describe individuals and relationships on a genogram, as well as deep understanding and training on developing genograms, thanks to the prodigious work of Monica McGolderick, LCSW, PhD (h.c.)[4] and the Multicultural Family Institute she founded. She created a comprehensive set of genogram symbols available to the public.[5] There is also a treasure trove of literature that lends understanding of the family life of specific ethnicities on the Multicultural Family Institute website at multiculturalfamily.org.

[2] See Addendum page 30 for explanation of self-reflexivity.

[3] Denham AR. Rethinking Historical Trauma: Narratives of Resilience. *Transcultural Psychiatry*. 2008;45(3):391-414. doi:10.1177/1363461508094673

[4] "h.c." indicates honorary degree.

[5] McGoldrick, Monica. Standard Genogram Symbols 2023. Wikimedia, 9 Dec. 2023. https://commons.wikimedia.org/wiki/File:Genogram_symbols_2023.jpg. Also available on Addendum page 32.

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Genogram Example

The genogram example below is clearly missing a lot of information. It is drafted this way to make the point "a picture is worth a thousand words." A scant picture still communicates a lot and adds to shared understanding between participant and their care team. The opportunity for shared understanding is squandered if the provider's approach to collecting information is to ask formulaic, narrowly focused questions in order to check off boxes and collect data points or otherwise to mine for information. The greatest value of genograms and all mapping is the space that is created so the participant can explore the story, reflect on the journey, perhaps even be **self-reflexive** as they tell it, plus the opportunity to build connection between provider and participant. Without this relational approach, the outcome can easily become a traumatic re-telling awash with regret and sorrow and void of the recognition and pride of accomplishment found in their journey.

From the conversation that informs Gerald's genogram:

> *Gerald was born in San Francisco to parents who migrated from New Orleans and Gulfport Mississippi as children during the 40s. He left his parents' home at age 17, couch surfing at various Auntie/cousin's homes and doing odd jobs in the Bay Area until leaving with a cousin to Los Angeles. Once meeting Ximena he settled in Los Angeles for a total of 12 years during which they had two sons and Gerald worked in Ximena's family business. Seven years ago, after their separation, several DUI charges, losing his job and being diagnosed with heart and lung disease, Gerald moved in with his now elderly mother, Alma, in her home in Oakland.*

Rather than "do you have brothers and sisters?" the facilitator asked, "tell me about who lived with you while growing up." This shift reveals vital information on the degree of mutual aid in Gerald's network:

> *Gerald then revealed that a series of people lived with his family: relatives migrating from the South, an occasional displaced neighbor. Most notable was Dorothea (his "cool Auntie") who lived with them most of his childhood years. His adult family life includes two sons in their early teens, currently living with their mother in Los Angeles. His late sister's teenage daughter and son are part of the home in Oakland. Dorothea had moved in several years earlier as her health declined. She passed away from Lupus complicated by high blood pressure and kidney disease a year ago.*

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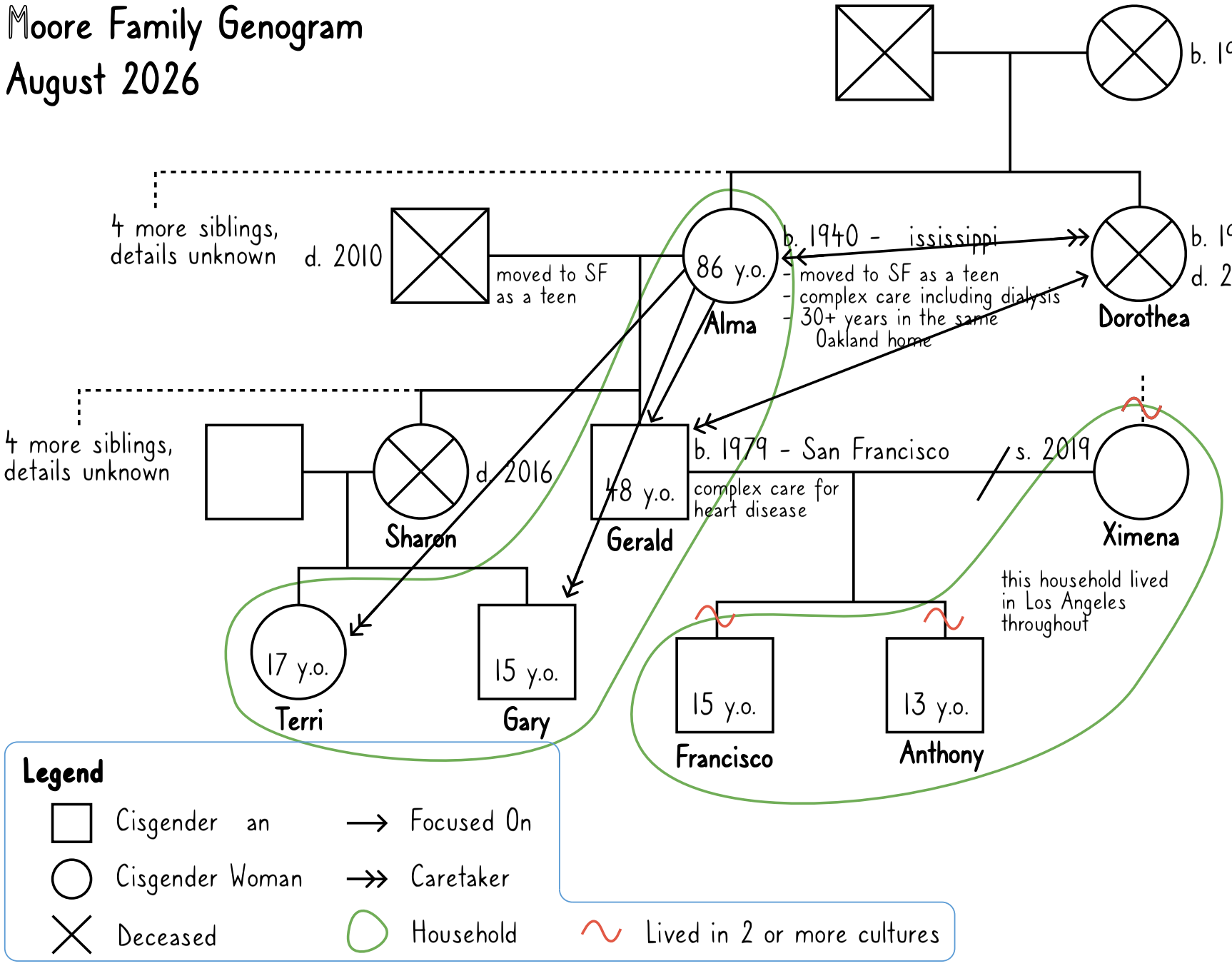
Initial impressions from developing Gerald's genogram:

- » Gerald's mother is the source of Gerald's housing security, so supporting this tie is a priority.
- » His mother also has complex care needs and declining health, and their communication is strained.
- » The teenagers in the home, particularly the son, have urgent education/ developmental concerns, adding to the grandmother's burden.
- » The whole household is grieving the loss of Dorothea—a second mother for Gerald and first daughter for Alma—who was the emotional and instrumental heart of the family. Gerald's genogram illustrates he is unusually rich with family members who expect to provide shelter and other care when it is needed. Further conversation likely will surface family support that can assist Gerald as new health and wellness needs emerge.

Much of what is learned when constructing a genogram also informs an ecomap. More of Gerald's situation is described in the following section.

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Moore Family Genogram
August 2026



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Ecomap

The ecomap is another mapping approach that can help both the provider and participant achieve a holistic view of the participant's home life and the relationships they have with groups, associations, organizations, family and individuals. Though many ecomap versions do not include this, symbols like the ones in genograms, detailing the quality (conflict, closeness) of bonds, provide insight to the kind of support that would help the family/individual/care provider advance the well-being of the participant. These symbols also show how outside demands can stress or support individuals in a household, and in turn how that stress or support impacts the individuals' relationships with each other. As with genograms, the ecomap notes the connection between individuals in the household. Unlike the genogram, it is situation-focused; it identifies and plots the bounds of support and conflict, nurturance and stress, at work, in school, and in faith institutions in their community.

The ecomap attends to:

» where the participant and their household live, work, attend school

» their health, including chronic care, psychiatric issues and wellness practices

» their faith practices and community, their aspirations and inspirations

» social connections, friends, regular activities and community associations

» typical modes of transportation and safety concerns related to it

As is true with genograms and care mapping, the relationship qualities are depicted with symbols. In ecomaps (and genograms) the bonds between the entities are described as:

» Thick line: Indicates a robust, resourceful relationship

» Series of plus signs (+++): Signifies a stressful or conflict-laden relationship

» Dashed line (- - -): Represents a tenuous, uncertain, or distant relationship

» Arrow: Shows the direction of energy or support invested in the relationship

Circles represent the identified participant, their household and all the other entities. A useful detail is to indicate the degree of influence of the entity by the size of the circle.

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Ecomap Example

This is Gerald's Ecomap based on his and his mother's account

> *Gerald's income is SSA/SSI. Both Gerald and his mother Alma say they often have disagreements. Gerald describes the bond with his mother as "speak when spoken to" but not much more. He has two sons in their early teens living with their mother in Los Angeles. He reports talking to them about once a month to catch up, and on occasions when he or his mother was hospitalized. He is engaged with the health system but has numerous complaints about his care.*
>
> *Gerald's teenage niece and nephew (Terri and Gary) are also in the household, and his mother is their guardian. They are the children of his sister who died 7 years ago secondary to alcoholism. The teens do not interact much with Gerald but he says "they're cool". Gerald's mother complains of frequent calls from her grandson's school but the granddaughter "gives me no problems, is my right hand". The mother has had a home church since moving into her current home thirty years ago. In addition to frequent calls, church members come by with ready to eat meals. A neighbor down the street brings food also and the children have had overnights with her during their grandmother's previous hospitalization.*

The ecomap is from Gerald's perspective in the context of his household, other family, friends, community resources and health providers. The ecomap highlights important community supports/stressors; here is a partial list:

» Both Gerald and his mother get their medical care at the community clinic. The care of each of them can be enhanced if the services are coupled.

→ [6] Should ensure that each understands their HIPAA privilege (to share as well as keep private).

» Alma goes to a dialysis station 2-3 days a week, which is a significant energy drain for her and the rest of the family.

» Gerald frequently attends 12-step meetings on Zoom and occasionally in person.

» Alma is frustrated (with the school and with Gary) by communications from school about Gary's behavior and missing class.

→ Link Alma and Gary to an education advocate.

[6] Arrow indicates a potential action for the care team to take, based on the ecomap findings.

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» There are indications that Terri and Gary get significantly less attention than is optimal from the adults in their family and the school professionals.

» Terri attends an after-school college prep program that she is very invested in, and they are invested in her.

→ Ensure, with Terri and Alma, that the prep program is an advocate at school.

» The church has a larger circle in the ecomap, indicating its importance in Alma's (and perhaps by extension the household's) life. Alma is a long-term member and for many years was a very active member of the church, and in recent years more often on zoom. Gerald's sons have a remote but loving relationship with their grandmother and respectful relationship with Gerald. Their mother facilitates her son's positive relationship with their father's family.

» Granddaughter Terri fulfills most domestic chores, her grandmother's personal needs, and the household needs.

» There is a neighbor who they rarely interact with, but who has helped by providing childcare and food when grandmother was taken away by ambulance.

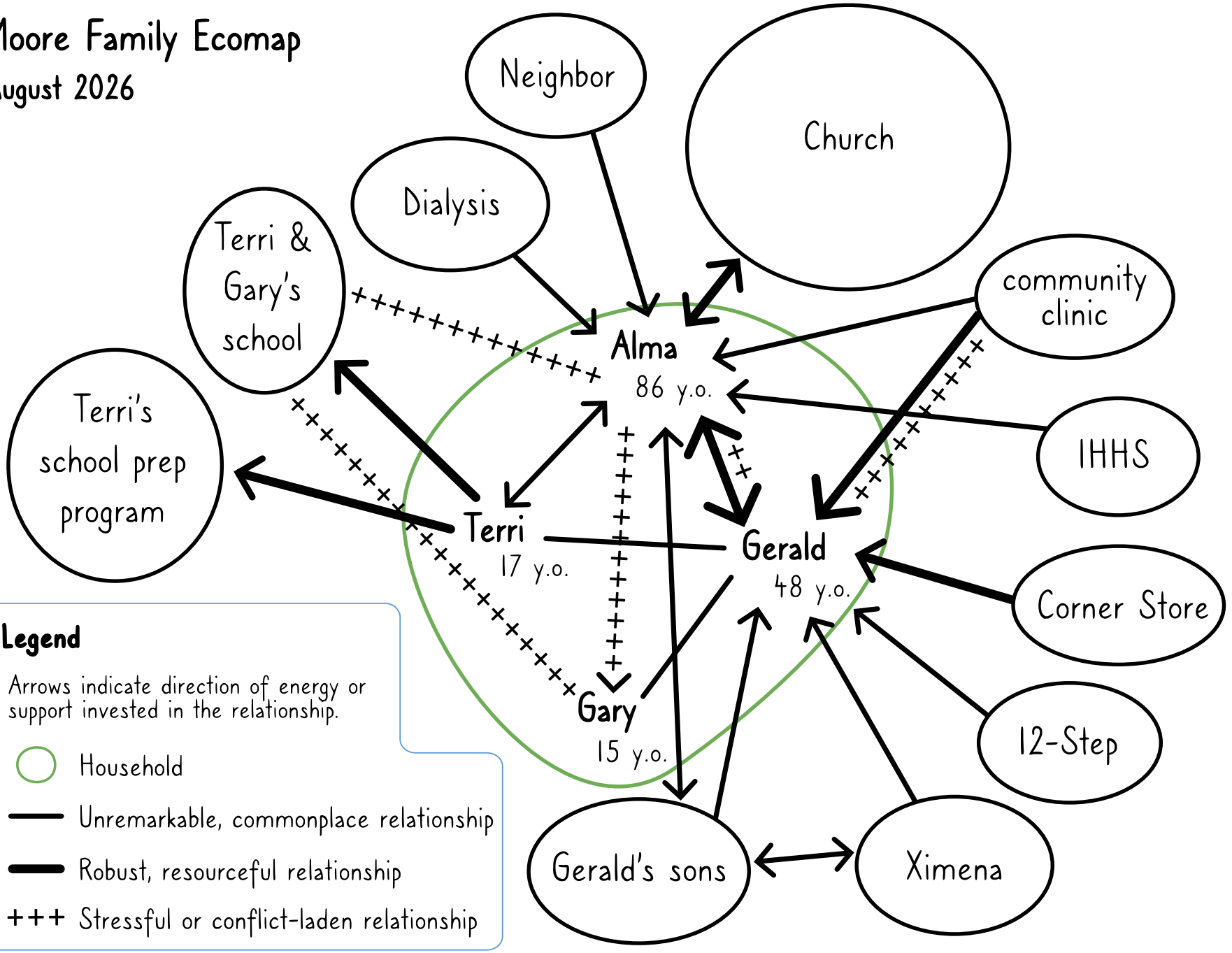
» The only caretaking responsibilities Gerald has is as In-Home Supportive Services (IHSS) worker for his mother. (In fact Terri is carrying out most of these duties, but she is too young to be listed as IHHS worker.)

» The corner store extends credit when family is short of funds.

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Moore Family Ecomap

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Care Connect Care Mapping

Care mapping is a method developed in the early 1980s to help families and providers visualize the details as well as the big picture of the services and burdens impacting children with complex care needs. The version of care mapping that was developed by Care Connect[7] in collaboration with Jennifer Reihm (Pearce) incorporates elements of both ecomaps and genograms. It aims to provide care teams with the insight and the opportunity to assess and engage their participants' personal and professional circles of support. This method was developed to assist CHWs to link to participant's personal support network individual providers in social and clinical care systems and to provide them a method for understanding, evaluating and fortifying the connections where needed. It is the most user friendly of the three diagrams.

The objective is to identify the participant's current and potential sources of care, understand how they experience the care they receive and what is needed to improve their experience and to identify holes to tighten in the participant's safety net. It attends to the needs of the participant. The needs of the people the participant cares about are not included in the Care Connect Map diagram. A culturally affirmative approach means creating a care map for each member in the household. The understanding gained from considering the maps together far surpasses reflecting on them individually.

The Care Connect Map is a picture of what the participant's personal safety net could be and optimizes the care system's care coordination. Unlike the ecomap it identifies the individual providers as well as the service centers. The Care Connect version of the tool has ecomap and genogram adaptations designed to help the participant and their providers visualize and understand the care and support surrounding them and what interventions can create and/or strengthen their net of support. It does not consider the needs of people the participant supports or cares about, in this case the people in Gerald's household and his sons. Nor does the scope of the Care Connect Map design lend itself to including how the stress of others (mother, niece nephew, his sons, their mother) impact him. Like ecomaps it notes elements of their ecosystem, facilitates care coordination, and pinpoints where in the participant's network the burden of illness and poverty is, how it can be relieved and what additional supports are needed to address stressors. The precise identification also enables higher closed loop communication.

[7] Alameda County Care Connect was a five-year initiative of Alameda County Health, funded by the State of California as part of the Whole Person Care Pilot project, a component of the MediCal waiver of 2015-2021.

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The Care Connect Map process is significantly less relational than the other two processes—more investigative, mining for information to analyze It does not surface as much information about relationships relevant to improving health and wellness habits and integrating and stabilizing in their community as genograms or ecomaps, but it does give actionable details of the participant's immediate opportunities for support, or risk for acute stress. It is the participant's report of their experience of stress and/or support (emotional as well as concrete), how the sources together form their support net, and it suggests the net's impact on their health and wellness. Participant and provider collaboratively create a plan for creating new, or enriching existing, ties to increase support quality and decrease the burden of poverty and illness for the participant. It improves communication between participants and their network and is a quicker and thus more effective method for providers to recognize the resource needs within the network.

These symbols are used to give a picture of the care provided:

- » Thick line: Indicates a robust, resourceful relationship
- » Series of plus signs (+++): Signifies a stressful or conflict-laden relationship
- » Dashed line (- - -): Represents a tenuous, uncertain, or distant relationship

In addition, colors and symbols are used to indicate the ease of access and quality of care in relation to the person on the Care Connect map.

- » An X is about how easy or hard it is to get care
  - › Green X is easy to get care
  - › Yellow X is a little of both
  - › Red X is hard to get care
- » A circle is about the quality of care
  - › Green circle is good care
  - › Yellow circle is Ok care
  - › Red circle is poor care

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Care Connect Map Example

The care map tracks the support provided by individuals. It provides details that would be likely to come up when developing an ecomap or genogram but would not be charted using those methods.

- » Though Gerald has significant dissatisfaction with his medical care, he is satisfied, even praising of the help he receives from most of the individuals:
  - › Medical receptionist is Gerald's favorite; she is always empathetic and links him to someone who can help him.
  - › The former CHW who referred him to his current care team responds to his calls, though it often takes her a few days; she helps him resolve clinic related problems the best she can.
  - › The care coordinator makes sure the transportation is always available and helps her mother when her transportation falls through.
  - › On the other hand, he has a very tense relationship with his MD, to point of yelling at each other. Gerald says the MD dismisses his concerns about pain and declining health.
  - › The nurse listens to the med complaints he expects the MD to resolve.
- » He has a friend from 12 Step—they have known each other and were close when they were both active in their addiction. They are strong supporters in each others' recovery.
- » The pharmacy treats him respectfully but often the medication is not in stock and sometimes their description of the medication action contradicts what Gerald heard from the MD.

The Care Connect Map approach pays particular attention to how neighbors can be of help:

- » Gerald is unacquainted with many of the people who work at the corner store, but the owner has had a long relationship with the family.
- » Neighbor Ruby has helped the family take care of the niece and nephew when Gerald's mother was hospitalized, has provided food, but though Gerald is grateful for her help, he does not consider her a support to him.

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Next steps:

» Detail out the declining health and pain concerns Gerald has been trying to resolve with his MD, identify the care team members best to assist with problem solving including facilitating communication with the MD.

› Trace and resolve the pharmacy hiccups.

» With Gerald, check in with former CHW for her perspective on the best support and plan for him.

» Since Terri is almost 18 and is providing tasks consider her as a possible IHSS worker for Gerald.

» With Gerald, consider asking if the corner store and/or Ruby would be someone nearby to reach out to if a crisis should arise.

In longer term:

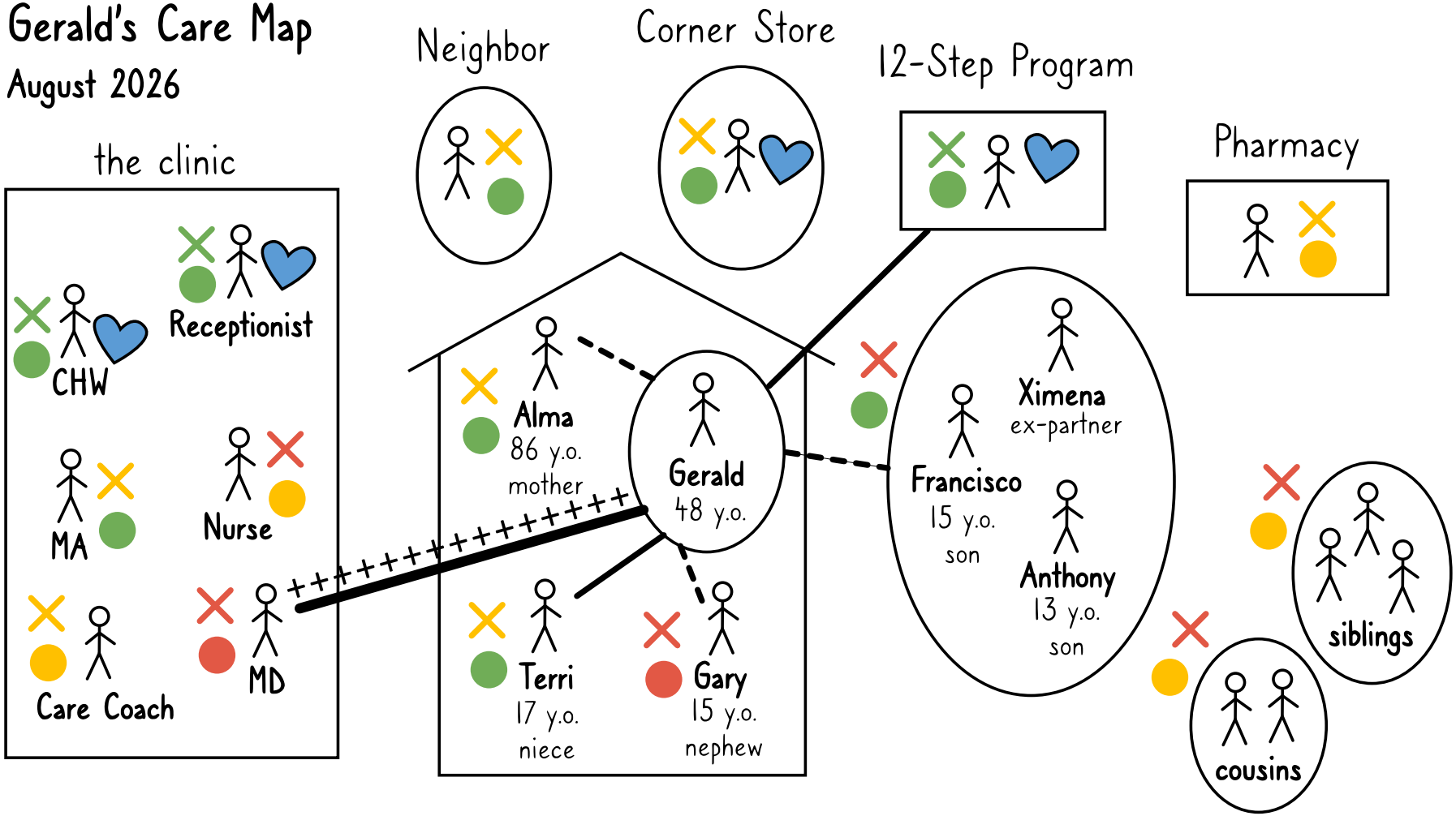
» Anticipating the upcoming developmental stages of current care takers, create a housing and assistance-in-daily-living plan for Gerald, for when his 86-year-old mother and his 17-year-old niece are not available. The people on the far-right bottom corner of the map are family members. So though Gerald currently dismisses them as possible helpers, keep them (e.g., his ex-partner and his sons) in mind as possible helpers if his mother and niece are no longer available.

» Consider Gerald's interest in establishing a closer relationship with his sons and the family members he noted in the far-right side of the chart.

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Gerald's Care Map

August 2026



Legend

- Invariably leave the conversation with greater agency, hope
- Difficult to get care
- A little of both
- Easy to get care
- Gives poor quality care
- Gives OK quality care
- Gives good quality care
- Friends & Family
- Paid Caregiver
- Support Groups
- ++ Robust, resourceful, but conflict-laden relationship
- Tenuous, uncertain, or distant relationship

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Summary

As the landscape of health and wellness continues to evolve, the value of these tools that CHWs can use to effectively map and strengthen the intricate web of participants' support networks becomes increasingly apparent. Network mapping not only helps service providers understand the interconnectedness of individuals and their communities but also facilitates targeted interventions that address barriers to care and promote holistic well-being. By leveraging these mapping tools, organizations can identify gaps and resources, reinforce existing ties, and foster cultural empathy for the burden of poverty and illness that participants experience.

The enhanced Care Connect Mapping tool presented here is a further refinement of the version developed at Care Connect during the Whole Person Care Pilot Program. This iteration incorporates additional ecomap and genogram features not found in earlier Care Connect Map versions, offering greater insight to the participant's strength and durability of support from their concerned loved ones, as well as identifying family and individuals who are part of their community and what resources are found within it.

Each of these network mapping tools is valuable for providing a visual assessment of a participant in their environment. Network mapping not only helps service providers know about and assist the participant in utilizing both their provider and personal safety net, but it also facilitates targeted interventions that address barriers to care and promote holistic well-being. As with any tool, the actual benefit realized depends on how well the tool is applied—what information is sought and how interactive and culturally affirmative the approach.

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Spreading the Use of Mapping Requires Managerial Leadership

CHWs' lived experience positions them to engage communities empathetically and to bridge system gaps. Advancing care delivery engagement strategies that draw on these insights can yield significant improvements in health outcomes. Communication, relationship-building, assessment, and cultural mediation are the key competencies built with care mapping training. The learning objectives for care mapping, as with most trainings that incorporate a culturally affirmative gaze, need to emphasize recognizing support system strengths, developing interviewing skills, understanding family migration histories, and diversifying information gathering and other communication. The possible outcomes include improved collaboration between providers and participants, incorporating cultural protective factors in problem solving and applying intergenerational perspectives. In addition, the increased knowledge and skills foster professional growth among CHWs. Success, however, requires line supervision and leadership that are knowledgeable, skillful, and meaningfully involved in building the CHW workforce. This includes providing resources to ensure timely, community driven, and data informed introductory training and continuing education.

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Care Connect Mapping Tool Instructions

Below are instructions for developing a Care Connect Map.[8] Mapping is best done with a trained provider or Peer facilitating the process. The instructions are written for the facilitator to use to guide the participant through the process. An example of a completed Care Connect Map is included at the end of these instructions.

Step 1: Begin Your Care Connect Map

Start by drawing a small circle in the middle of a blank piece of paper; this represents you.

Step 2: Identify Individuals Who are a Help to You

Think about all the people, those you interact with daily or who you may have contact with just a few times a year but are a significant source of care (love, belonging, significant kindness or help) for you. Begin with friends and family and include your pets. Include people who may not fall into a typical category but make life easier at critical times. For example, a storekeeper who extends food credit until your check comes, a former provider who responds when you reach out. Next, consider who helps you with your health, housing, and other daily needs, as well as any places that you receive help such as clinics and hospitals.

For each person who cares for you, draw a stick figure. It may help to label each figure, such as “sister,” “son,” or “MD’s medical assistant.”

Step 3: Categorize Your Support

» Draw a circle around friends and family members.

» Draw a square around professional caregivers, such as doctors, nurses, social workers, and therapists.

» Draw a rectangle to represent teams of caregivers at places like clinics, hospitals, or emergency rooms.

» Draw a house shape around those who live in your home.

[8] Adapted from a model developed by Jennifer Reihm (Pearce). See Addendum page 31.

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» Draw a triangle to represent locations in the community or on Zoom, FaceTime, What's App or other virtual platform where you gather with others such as faith-based entities or support group meetings.

» Draw a heart next to those who, when you are around them, the experience leaves you feeling hopeful—that you got this and they got you.

Step 4: Review and Add Missing Connections

Consider if anyone is missing from your map. Are there people others assume you would add but you haven't added? For those whom you are reluctant to include, list them in a corner of the page.

Step 5: Evaluate the Importance and Comfort of the Relationship

» Think about how easy or difficult it is to engage each member of your care network. Consider whether they are reachable in person or by text or phone and how responsive they are to your needs.

» Identify the most important people in your care network.

Step 6: Illustrate Relationships and Interactions

Reflect on how much care each person or group provides. Use arrows to show the direction and strength of each relationship:

» Thick line: Indicates a robust, resourceful relationship.

» Series of plus signs (+++): Signifies a stressful or conflict-laden relationship.

» Dashed line (- - -): Represents a tenuous, uncertain, or distant relationship.

» Arrow: Shows the direction of positive energy or support in the relationship.

Note that these lines are not mutually exclusive. For example, with Gerald and his mother there is essential daily support (thick line) but also have a high-energy, conflict-laden relationship (plus signs), with energy moving in both directions. Include all lines that apply to each relationship.

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Step 7: Look Again at the Map You Created. Reflect Out Loud on What You See

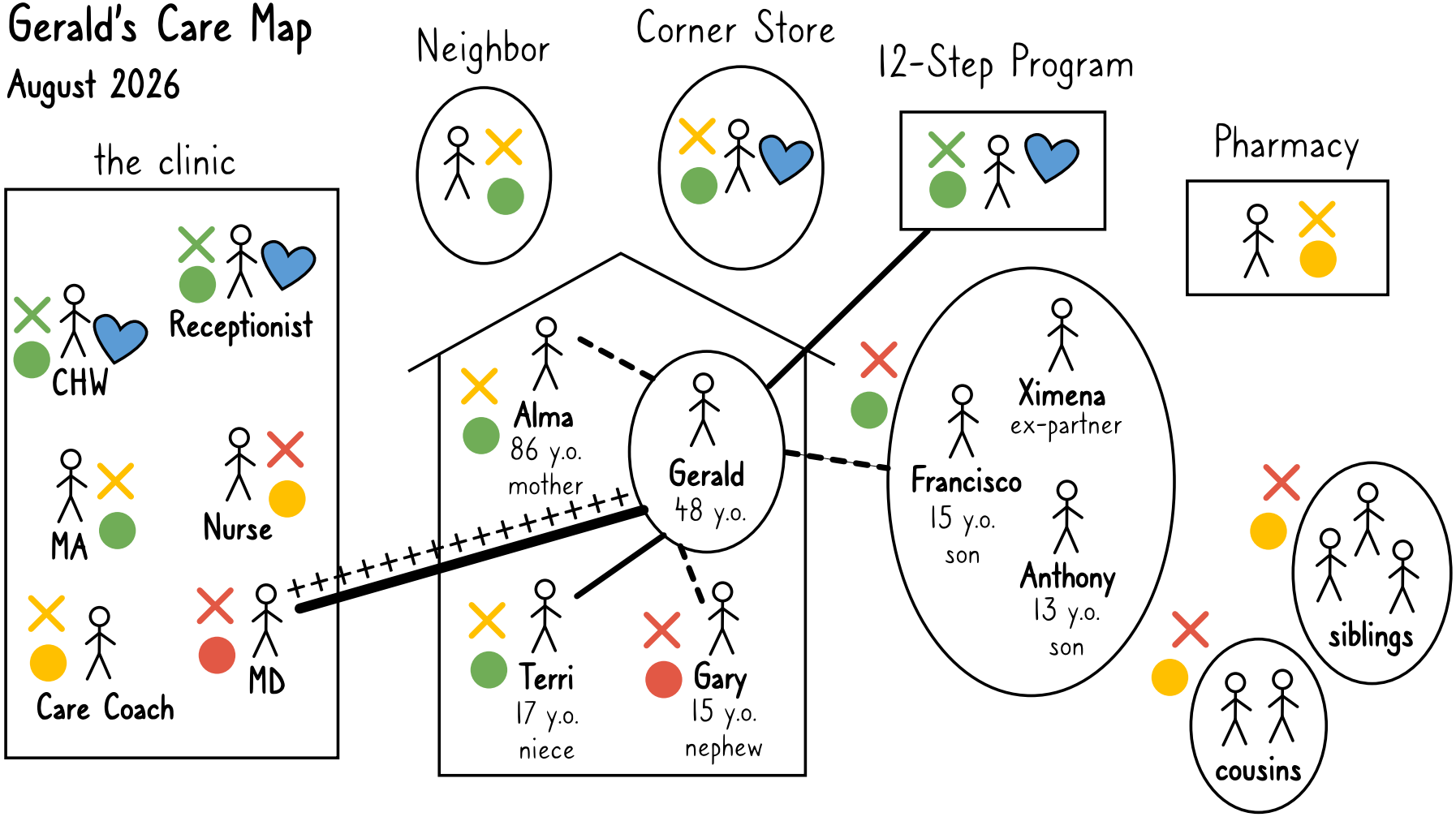
The questions below are for your consideration, prompts to maximize your reflection. For the ones you identify as most important - describe your relationship.

- » Do you have any caretaker responsibilities in these relationships?
- » Are there other friends or family who you wish were available to support you?
- » Are there professionals or services that are missing and needed?
- » What places in the community are you and/or your loved ones part of?
- » What places that you visit are missing from the map?
- » How would describe your relationship with your neighbors?
  - › Do you have any of their phone numbers?
- » Who is your go-to person when you need help?
- » For those that you listed in the lower right corner of the page: Can we think together who they are to you, reflect on what it means to include or not to include them?
- » For those whom others would assume that you would include but you haven't:
  - › What happens if or what does it mean to include them? What happens/what does it mean if you don't?
  - › How would you like your relationship with them to change?
- » How would you want this map to change twelve months from now? three years from now?
  - › What, if any, ways would you like to change to help make this happen?
  - › What do you want more of, less of, or changed?
  - › Are there relationships you want to improve, or others that you want to distance yourself from?
  - › How can we help?

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Gerald's Care Map

August 2026



Legend

- Invariably leave the conversation with greater agency, hope
- Difficult to get care
- A little of both
- Easy to get care
- Gives poor quality care
- Gives OK quality care
- Gives good quality care
- Friends & Family
- Paid Caregiver
- Support Groups
- ++ Robust, resourceful, but conflict-laden relationship
- Tenuous, uncertain, or distant relationship

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Addendum

Rationale for Culturally Affirmative Practice

People, particularly of the African diaspora and other BIPOC populations, need interventions that are both transactional (e.g., how many steps to get into the consumer's home, what are their transportation needs) and relational (both the concrete and intangible support of those who they care for and who care about them). Even when food and shelter needs are satisfied, if emotional connection is lacking, people are more likely to succumb to acute illness and early death.

Typically, cultural dynamics are attended to only when the provider and/or their consumer perceives ethnic difference as a problem between them. Standard provider response to such predicaments is to assure respect, express humility and then, unfortunately, disengage from the exchange that surfaced the cultural gap. While humility and respect are the basis for all cultural competency, to realize health equity objectives, communities, especially our indigent and medically fragile residents, require an affirmative, intellectually grounded, and culturally proficient approach to care. Culturally affirming service delivery is not simply the absence of bias, but the intentional (affirmative) inclusion of the meaning and purpose the individual and family find in their daily lives. These strategies focus on developing shared meanings needed for cultural empathy, gaining essential knowledge and skills, moving out of our assigned workspaces to enter the places where our participants live and that they frequent, to understand participants within the context of concerned loved ones. "Affirmative" means it is a proactive approach recognizing and welcoming culture, used consistently throughout our work to build knowledge and understanding of the situations we encounter alongside our participants and co-workers.

It is our default assumption that there are important differences between us as providers and those with whom we work—in how we gather knowledge, in what we deem to be evidence, in what we infer from situations, in help-seeking patterns, in health beliefs and many other understandings. Rather than treating culture as an obstacle to be overcome, we can consider culture a gateway to exploring the values and beliefs of participants and to align with them to better assess, problem solve, and transfer skills to improve participants' health and wellness. Culture centers on the individual's network and community, particularly on the quality of the network bonds. It accounts for their daily concerns, habits, and help-seeking behaviors. For providers and

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care teams, including cultural understanding in assessment means a shift in our gaze, a change to the observation skills attendant to provider care, in which culture's protective factors are recognized, including its role in alleviating the hardships of poverty and disease.

By increasing deliberation, proactive problem-solving, and outreach—especially for those who are detached from care—and by broadening our attention to include the ties that bind participants to family and community, we add coherence to care delivery across provider and personal support networks. Ultimately, this will decrease contention amongst the provider community, and they will experience more fruitful and cost-effective partnerships with participants and their concerned loved ones.

Many other hurdles will emerge once culture is recognized as within the sphere of influence. But they are worth the climb and relatively easy to solve once people involved are willing and aware. Training in conflict resolution is a key tool, as most trained mediators will agree; whether within families or between nations, all conflicts are cultural.[9]

Definitions of Key Concepts

Culture

"...is a pattern of shared basic assumptions...learned by members of a group in solving their **eternal problems** of survival **in the environment** and their **internal problems** of integration that work well enough to be taught to new group members as the correct way to perceive, think about, and feel about all aspects of their daily life. Once shared assumptions exist, they function to provide meaning to daily events, make life predictable, and therefore reduce anxiety." (emphasis in original)[10]

Basic Assumptions That Shape Culture

"The worlds people create for themselves are distinctive worlds, not the same worlds others occupy. They fashion from all incidents whatever meanings fit their own private

[9] Written by Valerie Roxanne Edwards, LCSW, rev. 2026.

[10] Schein, E. H, "Process Consultation, Culture and Organizational Therapy." Handout. Cape Cod Institute, 16 - 20 July 2001.

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biases. These biases, taken together, constitute what has been called the 'assumptive world of the individual.' The worlds people get inside their heads are the only worlds they know. And these symbolic worlds, not the real world, are what people talk about, argue about, laugh about, fight about."[11]

Cultural Iceberg

A metaphor introduced by Edward T. Hall and further defined by Edgar Schein, to explain how we experience culture. Hall sought to highlight cross cultural communications and differences in management of time and space across cultures. He explained that, like an iceberg, only 10% of the impact of culture is visible; most cultural dynamics are below the surface. The internal aspects are largely unconscious beliefs, values and attitudes which, taken together, determine for the beholder what they conclude to be what is right or best.

Schein, who studied culture in the context of organizations, further developed the metaphor by creating two tiers to describe what is below the surface. Just below the waterline are espoused values and beliefs that are taught (formally or informally, maybe excellently executed, maybe poorly), creating social norms, "the way to do things", or their mission. This shallower section occasionally bobs up to visibility but is mostly hidden. Think of it as the understanding that is revealed as relationships develop as we acculturate to a school, workplace, or residential community for example. The espoused values that may be sorted out in the workplace include continuums of individual vs. collective, autocratic vs. participative, criticism vs. diplomacy.

The deepest level are the underlying basic assumptions that are not only hidden from others but are often unconscious for the subject. Nevertheless, these represent what the person actually believes, holds faith in—the unwritten rules, the source of decision making and life's governance, and thus are harder to change.

Cultural Humility

A lifelong process—engaged in with patients, communities, colleagues and oneself—of self-reflection, self-critique, and commitment to understanding and respecting different points of view, and engaging humbly, authentically, and from a place of learning. It is a

[11] Barnlund, D. (1998). "Communication in a Global Village." In Bennett, M. J. *Basic concepts of intercultural communication*. Yarmouth, ME: Intercultural Press. pp. 35-54.

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process that requires respectful partnerships that recognize power imbalances that exist in the dynamic of patient-physician communication by using patient focused communication and care.[12]

Reflexivity

It is typical for helpers to reflect regularly on their direct service experiences. Generally, this attention is focused solely on participants and their environment—spotting patterns, gleaning what can be learned to inform their next interventions. Reflexivity is what is usually termed reflective, but with the added dimension of "critical reflection" – the practice of questioning one's assumptions including how one's assumptive view (their "self") influences others in the environment, as well as their own decisions and interventions (for example when one speaks, to whom, what questions one asks, in what order). All this can impact the outcome and affect others in the environment. Thus, reflexivity is a practice important for teams and systems as well as individuals to employ. **Self-reflexivity** is applying that attention inward only to oneself. A participant, supervisee or supervisor who gains insights and holds themselves accountable for their role in an outcome is an example of self-reflexivity.

Aversive or "Modern Racism"

Used to describe people who sympathize with the victims of past injustice; support public policies that, in principle, promote racial equality and ameliorate the consequences of racism; and identify more generally with a liberal political agenda. They regard themselves as non-prejudiced and nondiscriminatory, but almost unavoidably possess unacknowledged negative feelings and beliefs. There are structural as well as interpersonal dimensions of this. These negative feelings are not hostility or hate, rather discomfort, uneasiness, disgust, at times fear. They are motivated to maintain a non-prejudiced self-image and project this "face". They maintain this by avoiding open, 'outside the script' discourse.[13] As a consequence, critical workplace conversations are avoided, only furthering the social distance and lack of shared understanding and collaboration.

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[12] Tervalon, M, and J Murray-García. "Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education." *Journal of Health Care for the Poor and Underserved* vol. 9,2 (1998): 117-25. doi:10.1353/hpu.2010.0233

[13] Adapted from Gaertner, S. L., & Dovidio, J. F. (1986). The aversive form of racism. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 61–89). Academic Press.

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Background

The Care Connect Mapping tool evolved out of Alameda County Care Connect, Alameda County's Whole Person Care Project, which was led by then Alameda County Health (ACH) Director Colleen Chawla and ACH Medical Director and Executive Director of Care Connect Dr. Kathleen Clanon. The Care Connect Peer-to-Peer Advisors (P2P) component recruited and trained Black and Mam-speaking Guatemalan residents of Oakland who had lived experience to serve as P2Ps. In this role, they connected Medicaid-eligible individuals who faced health and housing challenges to needed services. Through its P2P program Care Connect invested in strengthening county service systems by exploring culturally affirmative engagement tools and practices aimed at fostering meaningful partnerships between health care providers and consumers.

Jennifer Reihm (Pierce), Health Literacy Specialist, introduced Care Mapping to Care Connect. She has over twenty years of experience collaborating with consumers, providers and professionals to co-produce content and design experiences that are easy to understand and act on. She is skilled at designing interventions grounded in behavioral science and plain language principles, engaging diverse stakeholders in co-design efforts, and qualitative research and evaluation.

Building on these insights, Partners for Health Equity (PHE), which comprises Care Connect alumni, is focused on recruiting and supporting Black and other BIPOC CHW candidates through an approach that honors community leadership and team belonging.[14] PHE is developing a unique CHW / CHW supervisor training curriculum, building on resources developed in an early phase of the California Health Care Foundation (CHCF) project entitled Community Health Worker and Promotor Workforce: Capacity-Building Collaborative[15]. A grant from CHCF, held by Alameda County Health (ACH), funded these activities. This included the further development of the Care Connect Mapping resource described here.

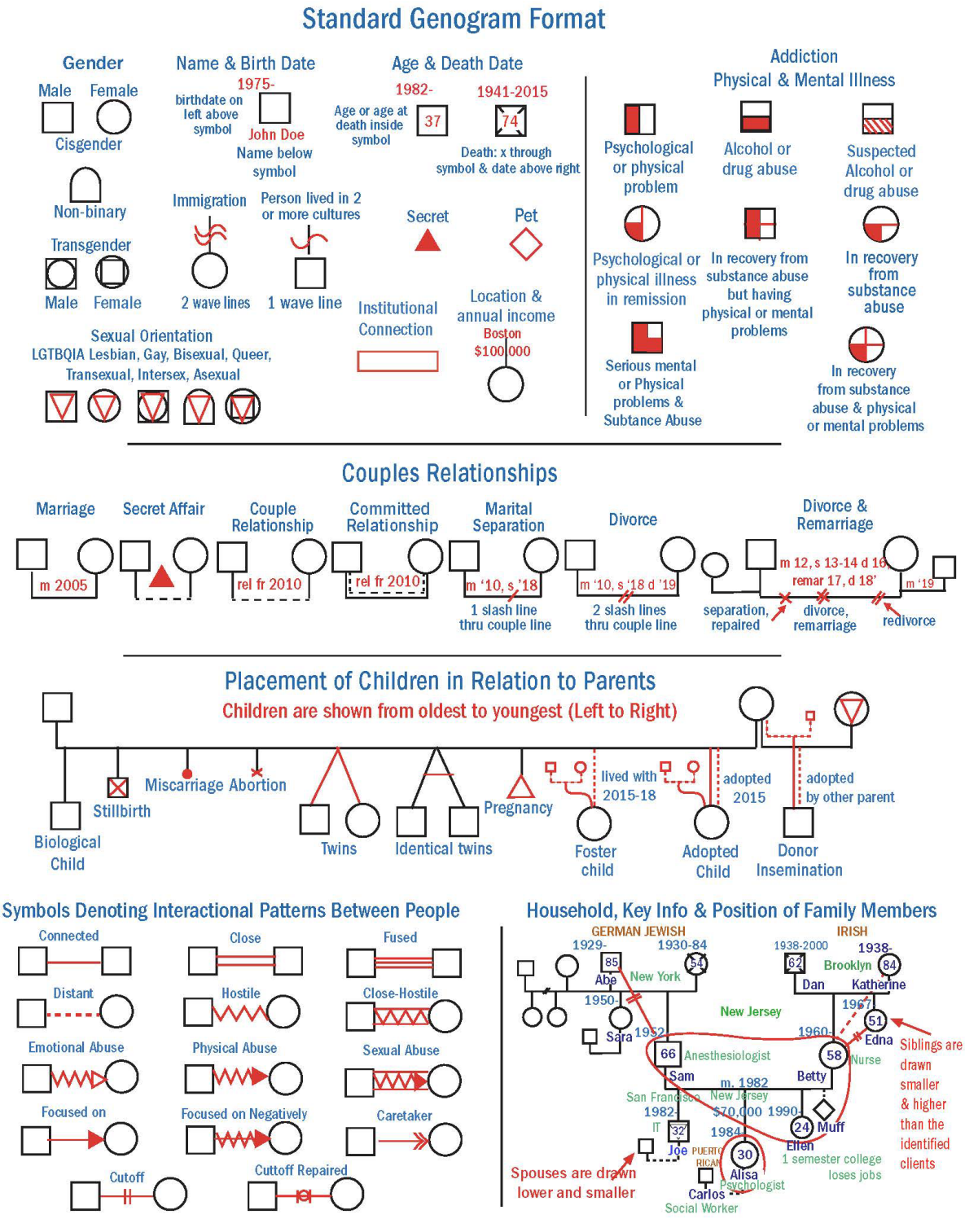
[14] For more information about PHE, contact vedwards@berkeley.edu.

[15] "Community Health Worker & Promotor Workforce Capacity Building Collaborative." California Health Care Foundation, published 13 May 2023. https://www.chcf.org/resource/2023/05/16/community-health-worker-promotor-workforce-capacity-building-collaborative/.

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Genogram Symbols

McGoldrick, Monica. Standard Genogram Symbols 2023. Wikimedia, 9 Dec. 2023. https://commons.wikimedia.org/wiki/File:Genogram_symbols_2023.jpg. Accessed 28 Sept. 2026.



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