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NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

LEADERS IN COMMUNITY HEALTH

An Environmental Scan to Inform Community Health Worker Strategies within the Morehouse National COVID-19 Resiliency Network

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The National Association of Community Health Workers (NACHW) unifies the voices of Community Health Workers to support communities in achieving health equity and social justice.

Table of Contents

Executive Summary 1

Background 13

The Morehouse School of Medicine's National COVID-19 Resiliency Network (NCRN) 14

Environmental Scan 16

State Specific Descriptions 28

Listening Sessions 42

Key Informant Perspectives on Challenges and Strategies to Partner & Engage Populations of Focus 48

Appendix 55

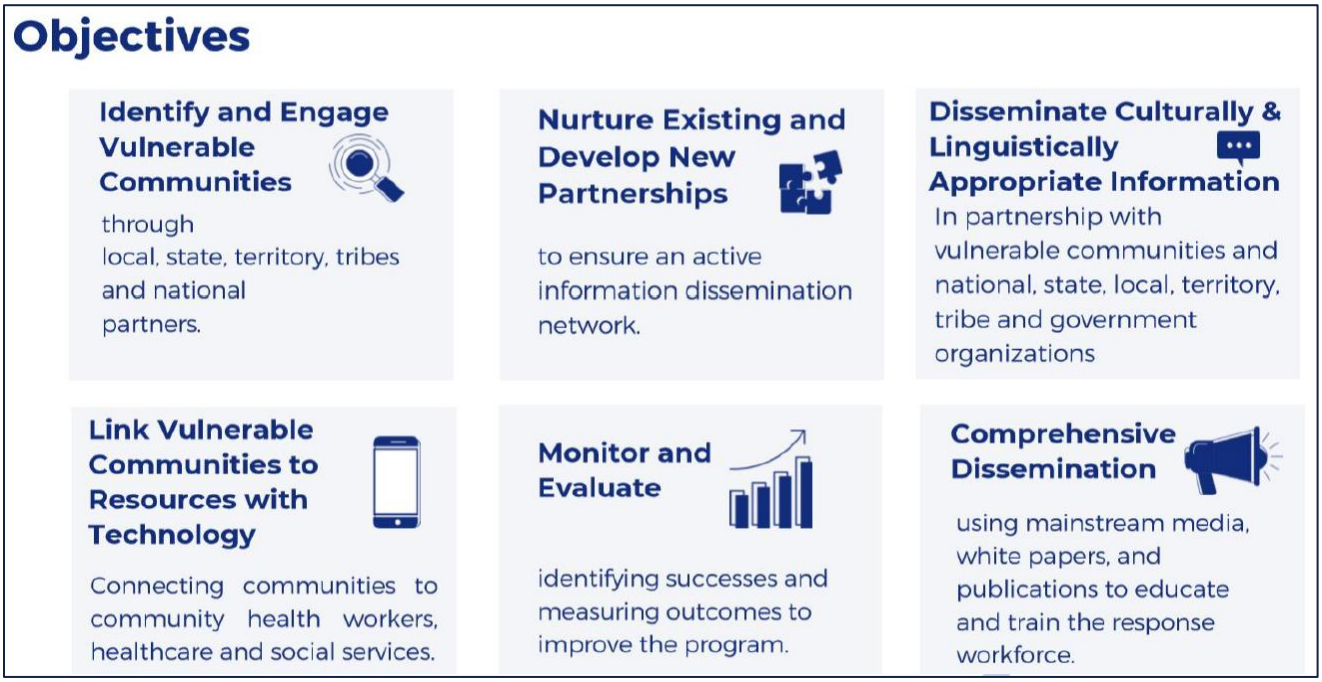
An Environmental Scan to Inform Community Health Worker Strategies within the Morehouse National COVID-19 Resiliency Network: Executive Summary

On December 12, 2020 the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices voted to recommend that persons over the age of 16 receive the Pfizer coronavirus (SARS COV-2) vaccine in the United States, one day after the Food and Drug Administration approved emergency use authorization of the same. While hailed as the beginning of the end of a pandemic that has infected over 17 million and taken the lives of over 308,000 people in the US, this announcement does not overshadow predictions of a dark winter with tens of thousands of more lives at risk. Nor does it drown out the pleas from local and state leaders, including bipartisan governors in the COVID Collaborative-- calling on the public to maintain public health measures: avoid crowds, social distance, wash hands frequently and wear masks - currently the only effective tactics to general infection and protect those with increased risk of contracting or becoming ill from the virus.

Since the first US diagnosis of COVID-19 in January 2020, this infectious disease has threatened the health, safety and economic vitality of the persons living and working in the United States and has disproportionately impacted the elderly, communities of color, lower income and rural communities, frontline workers and those without easy access to health care.

The Morehouse National COVID-19 Resiliency Network

To mitigate the impact of the COVID-19 pandemic on marginalized communities in the US, the Office of Minority Health awarded funding to the Morehouse School of Medicine National COVID-19 Resilience Network (NCRN) to collaborate with community-based nonprofits and associations, tribal nations and territories, academic institutions, health centers, faith-based organizations, and local, state and federal agencies to achieve six key objectives:



Community Health Workers Roles in COVID-19 Response

In this national effort to support populations at increased risk for adverse outcomes including members of Indigenous Tribal Nations, Black and LatinX populations, persons with disabilities, limited English language skills, justice-involved populations, people with limited health literacy, members of the lesbian, gay, bisexual, and transgender (LGBT) community, immunocompromised persons, and others, there has been broad based support-- from providers, legislators, policy makers and funders--- for integrating Community Health Workers (CHWs) into local and state COVID-19 response plans. Community Health Workers (CHW) and their CHW Networks have critical roles to play in:

- building community trust and strengthening public health response
- increasing capacity for testing, contact tracing and community rebuilding
- facilitating health system access, addressing social needs and providing psychosocial support and
- ensuring racial equity in COVID-19 vaccine development, confidence-building, and distribution

The value of engaging CHWs and their networks in the COVID-19 response was confirmed on March 19, 2020 when the U.S. Department of Homeland Security CISA issued guidance that classified CHWs as essential critical infrastructure workers during COVID-19. Since that time providers already working with CHWs to achieve equity in health service access, delivery and outcomes, have called for CHW engagement in COVID-19 response efforts. However, most COVID-19 response efforts are not incorporating CHWs into their response efforts and CHWs are not being engaged in their fullest capacity to scale-up COVID-19 response. While there are a few examples of health actors who are actively recruiting CHW expertise and participation, they tend to be organized at a local level, lacking in sustainable funding and infrastructure, and in general are not engaging CHWs according to the CHW Core Consensus project's defined CHW roles and competencies. This issue of leaning on the CHW workforce for support during this time without proper consideration of funding or sustainability will only become greater: as the pandemic approaches its one-year milestone, tens of millions of Americans' are now being victimized by the COVID-19 recession (hunger, housing and employment hardships), governors are calling for increased testing, contact tracing and public health measures, and pressure is mounting for racial equity in vaccine development and distribution. In each challenge, CHWs continue to be identified as a trusted and skilled workforce to join the fight against this pandemic and to scale readiness for future pandemics. It is crucial, then, that we capitalize on this moment to highlight the indispensable work CHWs are doing and to secure a sustainable future for the workforce.

At the time of this report's release, federal legislation is being considered to develop an ever-ready workforce for public health and social needs response and the incoming Biden administration has confirmed an interest in hiring 150,000 CHWs as part of a Build Back Better plan. However, some plans, including the Mapping the New Politics of Care project cited in this report, say that up to one million community health workers are needed for testing, contact tracing, social needs navigation and to address the increase in economic, medical and mental health needs resulting from the pandemic and centuries of health disparities. Comparatively, the US Department of Labor reported there were 58,950 CHWs employed in the US as of May 2019. Those numbers emphasize the findings of the New Politics of Care data that the current numbers of CHWs are not nearly enough to address the multitude of public health issues stemming from the current pandemic. Additionally, reported numbers of CHWs may be misrepresentative because CHWs work under many different titles and are employed or funded through various and often disparate means. As this report highlights, not only should the number of CHWs employed increase greatly to match the

needs of vulnerable communities during this pandemic, but the workforce requires sustainable funding and proper recognition in order to effectively participate in alleviating the burden of COVID-19.

About This Report

An Environmental Scan to Inform Community Health Worker Strategies within the Morehouse National COVID-19 Resiliency Network was developed by the National Association of Community Health Workers (NACHW) and a consultant from the Community Health Acceleration Partnership (CHAP) to examine key factors within the United States landscape that create challenges or opportunities to integrate the CHW workforce into COVID-19 responses. The methods, participants and geographic locations engaged in the development of the report are filtered by the Morehouse NCRN Five Priority Communities impacted by COVID-19 (Phase 1) as shown in the table below:

Methods

This report was developed using a multi-method approach which centered the voices and experiences of Community Health Workers (CHWs), CHW Networks, and their multi-sector allies (employers, nonprofits, community-based and cultural organizations, public health, primary care, government, etc.). CHWs are frontline public health workers whose trusted and/or unusually close relationship to the community they serve builds bridges, and improves clinical, behavioral and social service access, delivery, quality, and care system performance, while fulfilling at least ten core roles in over 50 job titles. Members of the CHW workforce often belong to communities disproportionately affected by inequities, CHWs are unique stakeholders in system transformation, representing both provider and patient/community members' voices. NACHW defines CHW Networks as community-based organizations (including CHW Associations and Coalitions) with leadership and/or membership that consists of 50% or more of CHWs, and whose mission

National COVID-19 Resiliency Network Five Priority Communities Impacted by COVID 19 (Phase 1)

State/Territory	Priority Areas	Vulnerable Communities	Reasoning (all communities touch HPSAs)
Florida Georgia	Entire states	African American Hispanic Migrant Workers	Rising COVID-19 infection rates among African Americans and Migrant Farm Workers
Louisiana	Orleans, Jefferson, East Baton Rouge Parishes	African American Incarcerated	Quick rise in cases and deaths, 2nd highest incarcerated population in US, need for culturally appropriate approach for African Americans
Navajo Nation	Reservation touches Arizona, New Mexico, Utah	Native Indian	Largest American Indian population with the highest infection rate and most deaths; Need for additional culturally relevant resources
California Hawaii	Los Angeles Hawaii, all counties	African American Asian Pacific Islanders Hispanic	CA has Highest cases in US Asian Pacific Islanders highly impacted in CA and HI
Rural consortium Texas Alaska	El Paso, Moore County Anchorage	Hispanic Migrant workers • Meat Packing • Farmers Alaskan Native	Migrant Meat Packing and Farmer industry highly impacted Alaskan Natives at higher risk for COVID-19 related morbidity and mortality

and activities focus on workforce development, mentoring, member mobilization, and advocacy.

Authors used the NCRN objectives and Five Priority Communities to filter and analyze publicly available secondary sources and investigations (census data, Social Vulnerability Index (SVI), County Health Rankings, CHW workforce capacity and allocation data, COVID-19 rates, etc.) into an environmental scan. Listening session and key informant interview data was also collected from September 2020 to December 2020. National Listening Sessions were conducted virtually with CHWs, CHW Network leaders and allies (both NACHW members and non-members). Virtual key informant interviews were implemented with national leaders whose primary focus was COVID-19 pandemic response at the time of engagement. Both were used to contextualize environmental scan data, deepen report perspectives and amplify trusted voices and culturally relevant recommendations. The Environmental Scan, Listening Session, and Key Informant Interview sections of this report are organized by NCRN Five Priority Communities and populations of focus, and the summary findings and recommendations of this report are organized by NCRN objectives.

Who Should Read this Report

Primary audiences for this report are the Morehouse School of Medicine and the Office of Minority Health National COVID-19 Resiliency Network leadership and its stakeholders, Community Health Workers, their Networks and training sites, CHW employers, program managers and partners, and local, state and federal COVID-19 response task forces and initiatives who seek to understand CHWs and their roles and capacity to strengthen COVID-19 responses. The report will additionally help readers understand the impact of COVID-19 on CHW programs and on the communities they support, and provide strategies to integrate CHW leadership and innovation into response efforts.

About the National Association of Community Health Workers

The National Association of Community Health Workers (NACHW) is uniquely positioned to develop this report. NACHW was founded in April 2019 after several years of planning and organizing by CHWs and allies to establish a membership driven organization with a mission to unify Community Health Workers to support communities to achieve health, equity and social justice. NACHW is a national voice for CHWs, CHRs, Promotores de Salud, and other workforce members promoting values of self-determination, integrity and social justice, facilitating policy discussions and advancing CHW professional identity and best practices, and amplifying CHW leadership and capacity building. NACHW is led by an Executive Director who is also a CHW, and enjoys governance from an advisory board of predominately CHWs and allies with decades of research and practice expertise in CHW training and workforce development, community organizing and engagement, intervention design, equity and social justice advocacy, research and policy leadership.

NACHW launched a national CHW COVID-19 poll on March 16, 2020, to understand the information, resource, and self-care needs of CHWs. NACHW used the perspectives from CHW state leaders in our national Ambassador program to launch a national campaign with global and U.S. partners to amplify CHW roles and leadership potential, advocate for funding to scale up CHW Network capacity, and help operationalize CHWs and Network engagement in the COVID-19 response.

Using data from our first national poll, NACHW launched a national campaign to amplify the roles and leadership of community health workers and the capacity of CHW Networks during COVID-19. Highlights of our messaging, engagements, advocacy, research and impact include:

- Three Ways for Public and Private Institutions to Amplify CHWs during COVID-19
- Nine national town hall calls with over 30 CHW Networks from 27 states to disseminate and collect information, facilitate networking and unify national messaging on CHW roles during COVID-19
- A webpage on March 16, 2020 with curated and original COVID-19 resources for CHWs.
- A webinar and webcast in April 2020 with the CDC and ADA on the roles of CHWs during COVID-19 with a combined initial reach of over 4000 English and Spanish speakers
- Launching the Community-Based Workforce Alliance with Health Begins, Health Leads, the WHO Community Health Acceleration Project, Partners in Health, Last Mile Health and others intended to strengthen advocacy, communications, technical assistance, and monitoring
- A Health Affairs Blog in May 2020 articulating the ways CHWs can help Strengthen Public Health Response during the pandemic
- Published research on the insights from CHW State Leaders on the impact of COVID-19
- A web page listing CHW Networks, Associations, Coalitions and CHW training sites to promote membership in local Networks, training and career advancement and help facilitate partnerships with public and private institutions
- Presentation of Community Centered Solutions for Addressing COVID-19 among Racial and Ethnic Populations - Meeting Community Members Where They Are for over 400 attendees of the Sept 17, 2020 HHS OMH Advancing the Response to COVID-19: Sharing Promising Programs and Practices for Racial and Ethnic Minority Communities virtual symposium

"The National Association for CHWs (NACHW) is an essential convening body and connection point for community health workers across America. With support from NACHW and local partners across America, CHWs can play a critical role in responding to COVID and in continuing to help vulnerable Americans manage chronic conditions. CHWs – and NACHW – should be front and center as federal and state leaders seek to move out of the pandemic and re-open society."
- Claire Qureshi, Community Health Acceleration Partnership at WHO

Findings and Recommendations Summary:

A successful COVID-19 response, including vaccination distribution, will depend on establishing an authentic feedback loop, and equitable engagement with communities to design, implement and monitor culturally relevant and effective strategies that invest in existing community assets, build trust and expand access to ensure public participation, partnership and accountability.

This section offers the following findings and recommendations organized by the six NCRN Objectives.

NCRN Objective One: Identify and Engage Vulnerable Communities **(through local, state, territory, tribe and national partners)**

All counties identified within the NCRN Five Priority Communities impacted by COVID-19 (PC) have at least one section with very high Social Vulnerability Index scores. In addition, each PC has a strong proportion of African Americans, LatinX, and/or Indigenous communities. All counties have struggled to provide proper care and support to vulnerable communities during the pandemic, and minority communities have

had an undue burden of COVID-19 cases in each PC. Pacific Islander communities experience a disproportionate amount of cases in almost every PC when adjusting to population. States including Florida, Hawai'i, Louisiana, and Texas do not even collect data or disaggregate data on COVID-19 cases and deaths according to race and ethnicity demographics, which erases the vast range of diversity within communities and erases the ability of PCs to track the burden of COVID-19 on minority communities.

CHWs are lower wage public health workers who are predominantly women of color and persons who shared lived experience with the under-resourced and historically marginalized communities where they are serving. This creates additional risk for CHWs as a frontline workforce and a demographic during the pandemic.

CHWs we spoke with said that they were largely overlooked in the engagement with COVID-19 testing and tracing. Often COVID-19 related job announcements failed to identify CHWs as eligible candidates or distribute announcements through CHW Networks or employers. Many Hawai'i CHWs and their allies reported that even when they completed required contact tracing training programs, they were not hired.

Most CHWs services have been significantly disrupted by the pandemic. Many have had to stop in person and community-located service delivery, including home visits, visits to shelters, soup kitchens and faith-based sites. CHWs who have been re-assigned to COVID-19 activities report being overburdened during the pandemic response because of increased community needs but lack administrative and professional development support. NACHW members and CHW leaders in our national Ambassador program report having to respond to their own health concerns and those of their family while trying to maintain and adapt their community-based services.

The struggle for CHWs to maintain their normal service delivery and not become overburdened with pandemic response ties directly to workforce capacity: CHWs have been historically under-resourced while taking on a large workload, and the difficulty in maintaining capacity has only increased during COVID-19 as communities across the US rely on CHWs but are increasingly lacking in funding to sustain the workforce. According to the Department of Labor statistics collected in 2019, each PC, with the exception of the Navajo Nation, employs at least several hundred CHWs. It is evident from the allocations of CHWs suggested by the Mapping the New Politics of Care project, however, that each PC will require many more CHWs if they hope to effectively respond to community needs during COVID-19. The data from Mapping the New Politics of Care reveals that without an infusion of CHWs into each PC, current CHWs lack the capacity to respond to the ever-growing number of COVID-19 cases, deaths, and related health concerns.

Recommendations:

- Collect disaggregated demographic data across all states, tribal nations and territories to improve identification of COVID-19 impact and advance health equity in response efforts
- Provide sustainable funding for CHW integration into current and future pandemic response by allocating funding to CHW Networks and community-based organizations
- Understand and respond to CHW professional development, training and personal support needs
- Recruit, train and hire CHWs in COVID-19 testing, tracing, and vaccine distribution efforts, giving consideration to the suggested number of CHWs delineated by the Mapping the New Politics of Care project and enlisting partners to reach those numbers
- Engage CHW Networks and training sites in your workforce development and public health response advisory, planning and implementation boards

NCRN Objective Two: Nurture existing and develop new partnerships **(to ensure an active information dissemination network)**

NACHW along with many US institutions have been increasingly prioritizing the roles of CHWs in the pandemic response. Along with the focus and amplification of the CHW workforce, there has been federal momentum in proposed legislation, state level and foundation funded initiatives, and within the Community Based Workforce Alliance to articulate a community based response. The opportunity exists for COVID-19 response to initiate and expand on authentic partnerships with CHWs and their networks/association/coalitions to establish a multi-sector infrastructure to address community information, resource and coordination needs and preferences.

With a few exceptions (Alaska, the Navajo Nation), a majority of the Five Priority Communities do not have robust state engagement of CHWs, meaning state health apparti are uninvolved in matters concerning the CHW workforce and do not seek out CHW participation or expertise in decision making. CHWs are funded through disparate and disconnected organizations, and funding is typically short term grant funding focused on programmatic work and services, not capacity building of the workforce. In every NCRN PC, the CHW workforce lacks sustainable funding and planning. Thus, in most cases, CHWs and their partners have been left to organize funding, certification, and other concerns of the workforce on their own.

For this reason, many states have organized CHW networks/associations/ coalitions. CHW networks, associations, and coalitions are run by and for CHWs and advocate for CHW workforce needs, which is why they should be authentically engaged. Each state in the Five PCs except for Hawai'i has a statewide CHW network/association/ coalition that convenes meetings of CHWs across the state and organizes efforts based on workforce capacity, engagement, and placement within public health infrastructure. While states like Alaska and Texas have statewide coalitions established by state legislation, most of the CHWs workforces in the five PCs have established networks/associations/coalitions on their own, and face challenges in obtaining funding and pursuing changes for the benefit of the workforce. There has been a trend in recent years of state actors enlisting CHW networks/associations/ coalitions to make recommendations and participate in advisory boards to further the capacity of the workforce, but despite such efforts, CHW networks still struggle to gather their own funding and advocate for themselves and their work.

CHWs and their networks have stressed the importance of identifying, partnering, and/or funding existing community COVID-19 responses. However, many report a lack of communication, coordination and integration between community/local initiatives and state initiatives. This gap is magnified for rural communities in places like Georgia, Texas, Louisiana and the Navajo Nation, who are not receiving resources and information at the same rate as urban communities. During the pandemic, CHW associations/networks have made recommendations to local and state actors, offering their leadership to scale up the contact tracing workforce, innovate and adapt CHW services, and incorporate their locally-sourced strategies, but those suggestions have not been implemented and many CHWs feel that no one is listening to them. A disproportionate number of community based organizations (CBOs) who have not gained access to CARES Act funding are led by and provide services and infrastructure to communities of color. A majority of CHWs are also employed by or volunteer for community-based organizations dealing a secondary wound to communities who need CHWs to be part of COVID-19 initiatives to communicate local contexts, leverage existing relationships and

lived experience, model cultural respect and support their capacity.

Recommendations:

- Develop capacity building for Community Based Organizations, such as the Community Based Workforce Alliance, through professional development and evaluate existing partnerships of CBOs and CHWs in order to connect CBOs with CHWs to expand their capacity and cultural understanding
- Invest in partnerships with CHW Networks and CBOs to build the capacity of their existing, locally sourced, COVID-19 response efforts
- Strengthen and assist COVID-19 communication and coordination between community/local and state actors to identify and fill gaps in coverage
- Acknowledge CHW networks infrastructure and information dissemination capacity and community expertise by inviting them to sit on advisory and planning boards
- Utilize COVID-19 trainings, webinars, and resources developed by and for CHWs and their Networks and disseminated by NACHW on our COVID-19 webpage and national webinars including:
    - Support CHW and Community mental health and self-care (Vision y Compromiso - California)
    - Leverage NCRN Strategic Partner existing initiatives such as the National Latino Behavioral Health Network trainings and initiatives
    - Apply CHW Network expertise in adapting services to telehealth platforms (Dia de la Mujer Latina y su Familia - Texas)
    - Adopt strategies to Advance CHW Engagement in COVID-19 (Community-Based Workforce Alliance - National)
    - Apply CHW Leader Expertise from HIV/AIDS and Refugee Trauma Initiatives (NACHW Webinar with Durrell Fox and Theanvy Kuoch)
- Invite CHW networks and training centers to add the Morehouse modules to their training curriculum to allow them to provide a more tailored training experience and disseminate more widely to this diverse workforce
- Conduct a network analysis with CHW Networks and local CBOs, to determine gaps in reaching at risk populations and improve coordination of information and strategies

NCRN Objective Three: Disseminate culturally and linguistically appropriate information **(in partnership with vulnerable communities and national, state, local, territory, tribe and government organizations)**

Most states in the NCRN initiatives are struggling with effective contact tracing and engagement with racial and ethnic minorities and non-English speakers. Contact tracers have been, in most cases, either contracted out or previous members of public health department staff, but typically not individuals hired directly from the communities that are most in need of these services. There is little evidence that contact tracers have been given cultural competency training when connecting with different communities. Lack of community trust and buy-in along with sufficient testing capability has been identified as a primary reason for failed efforts. All states that are included in the NCRN have been graded as having high readiness to test and trace (Arizona and Florida have been given medium grades).

Many CBOs and CHWs specifically have been largely left out of the conversation regarding contact tracing. There are many CBOs disseminating COVID-19 information to communities, but without coordination with

city and state officials, leaving gaps of vulnerable communities without appropriate attention and information. Most information distributed by CHWs comes from state actors with general messages in English, leaving CHWs and community organizations to translate and/or create materials which will be appropriate for each community. CHWs are largely doing this work individually without proper funding and support, once again resulting in communication and engagement gaps across communities.

In keeping with the Office of Minority Health CLAS Standards, NACHW seeks to deeply understand the cultural differences and values of all populations of focus in the Morehouse initiative in order to "advance health equity, improve quality, and help eliminate health care disparities." During the Listening Sessions and background research, we found that there were findings specific to different populations which transcended geographic areas and would be vital to developing linguistically and culturally appropriate understandings and materials.

The Navajo Nation continually has to reaffirm their sovereignty when interacting with the federal government and outside organizations. This relationship with outside entities has had a negative effect on the Nation, and their health outcomes, and contributed to the disproportionate impact of COVID-19. In addition, when working with the Navajo Nation, organizations should consider the Hopi Nation, which is a separate sovereign nation with their own struggles and needs in regard to COVID-19. Other communities such as the Pacific Islander community and recent Asian immigrants and refugees have been often overlooked and lumped into a broader category, without considering the vast diversity in their experiences and needs in order to address COVID-19, which has disproportionately affected both communities. Migrant workers and LatinX communities around the US-Mexico border have unique challenges when mitigating COVID-19 because these communities have a great diversity in citizenship status, language, and types of seasonal work. Those recently incarcerated, which is a population which has rapidly grown due to early release and reduced sentences because of COVID-19, have many additional risks which make them disproportionately vulnerable to COVID-19 and this community is in need of connections to employment and social services. Patients and patient advocates should be incorporated in the NCRN, especially when the scope of the work changes from mitigating cases to addressing ongoing health disparities caused by COVID-19.

Recommendations:

- Compensate Community Health Workers for their involvement in document and messaging translation
- Recognize CHWs unique and trusted relationships and shared experiences with communities to develop and implement culturally appropriate information regarding COVID-19
- Assess CHW workforce capacity needs based on data such as the distribution on the Mapping the New Politics of Care, which calls for hiring 1 million CHWs to properly address the COVID-19 pandemic
- Recruit and compensate CHWs with a racial equity framework to allow CHWs to be a sustainable and effective resource
- Develop pathways of administrative support and CHW self-care resources to avoid burnout
- Offer professional trainings to build on knowledge bases and expand/support CHW roles
- Develop methods of coordination/ foster relationships with CBOs, CHWs, and state actors to coordinate all COVID-19 efforts and fill gaps
- Create trainings on cultural competency on different cultural beliefs for anyone working with various focus populations
- Follow the lead of community-based organizations, health providers, tribal nations and national teams centering

the CHW workforce in COVID-19 response:

- El Sol Neighborhood Educational Center
- Siloam Health
- Penn Center for Community Health Workers ImPACT
- Pacific islander COVID-19 Response Team
- Navajo Nation Community Health Representative Program
- HOPI Tribe Community Health Representative Program

NCRN Objective Four: Link vulnerable communities to resources with technology

(connecting communities to community health workers, healthcare, and services)

CHWs have become an invaluable resource for vulnerable communities because CHWs are able to reach and communicate with communities in ways that traditional healthcare responses fail to do. CHWs traditionally work and live in the communities they serve, meaning they can meet patients in their homes and connect them to local resources. Because of their roots in a community, CHWs can also provide interpretation and translation services and provide culturally appropriate health information, which is not traditionally found in primary care or emergency medical services. CHWs also assist with communication for providers of healthcare, as CHWs integrated into care teams can explain to doctors and nurses what challenges communities face and what culturally appropriate care looks like. Despite their strengths in communication through grassroots engagement, CHWs face challenges in legitimating their role both in communities and as part of care teams, and COVID-19 has exacerbated those challenges. CHWs can no longer conduct house visits or in-person outreach in communities even as access to care becomes more difficult, and instead of engaging CHWs to reach vulnerable populations bearing the brunt of COVID-19, many institutions chose to lay them off. Now, in addition to the difficulties of outreach during the pandemic, CHWs are also lacking the resources needed to help communities most at risk of COVID-19.

In particular, CHWs and CBOs in NCRN communities lack effective communication about where resources exist for vulnerable communities. This is especially true for rural areas, which often lack resources, internet access, electricity, and the ability to organize a centralized resource center. For rural NCRN communities in Georgia, Texas, the Navajo Nation, there are the additional barriers of distance and lack of transportation to consider when accessing resources. For communities with the technological capacity and resources, the proposed NCRN app and other technologies will be a great way to organize and centralize social services, but for other rural communities without the technological infrastructure, they likely will not be able to utilize the app, causing greater disparity in access to resources. CHWs and allies also raised the persistent barrier of language access to the NCRN platform; often these technologies are not translated in a timely manner in response to urgent community needs.

CHWs and key influencers also discussed the lack of real time data on COVID-19 testing, contact tracing and social needs and mental health services (food pantries, shelters, utility benefits programs, warming centers, support groups, etc.). During the pandemic, many reported that CBOs who often coordinate these services closed their doors due to lack of revenue and to protect frontline workers. They are concerned that the NCRN platform will need to collect data and confirm these local resources through direct contact, drive-bys, phone calls and in-person visits - which will take significant time and human resources.

CHW networks offered innovative ways to use simple technologies like conference call lines to provide training and disseminate information and strategies. The

Florida CHW Coalition conducted COVID-19 training over the phone for hundreds of CHWs who could not access the internet. The Georgia CHW Coalition meets monthly with over 80 participants via conference call only to accommodate limited internet access among its members. The Navajo Nation Community Health Representative (CHR) program reports that the majority of CHRs leave work and return to homes without electricity or running water. Many CHWs lack access to the internet and mobile technologies, reinforcing their shared experience with the historically under-resourced communities where they live and serve.

Recommendations:

- Assess and respond to the current technology infrastructure (access to cell phones, laptops, internet, electricity, etc.) in NCRN communities
- Work with NCRN Strategic partners and local experts to understand and adapt NCRN platform and app to different technological literacy and comfort levels
- Mobilize CHWs and NCRN community partners expertise and compensate them to identify, confirm and enter data into the platform/app
- Prioritize NCRN platform data entry based on the most pressing needs/questions from community members
- Ensure NCRN platform addresses barriers experienced by low income, low literacy, undocumented and justice involved persons when interacting with social services
- Create/develop alternative to new technologies taking into account the resources and infrastructure of rural communities
    - Develop a help-line as an alternative to those without internet access
    - Possibly use television or radio to broadcast the most vital social services

NCRN Objective Five: Monitor and Evaluate **(identifying successes and measuring outcomes to improve the program)**

There have been very few efforts trying to track and quantify COVID-19 outreach and communication/education efforts during this time, either within or outside of the CHW workforce. The few places that have gathered data, mostly around contact tracing, have found contact tracing to be very poorly received and generally ineffective both in reaching vulnerable people and in curbing the spread of COVID-19. Many local health departments and community organizations are utilizing the CHW workforce for COVID-19 response, but their influence is not being properly measured. Without data collection at this stage, it will be difficult to make the case for more sustainable inclusion of the workforce beyond this pandemic.

In every national listening session and key informant interview we conducted, a majority of the participants indicated that NACHW's introduction of the Morehouse NCRN initiative was the first time they had heard of such an initiative and of their local community or county as being a priority community for Morehouse and the Office of Minority Health. Participants expressed the challenge of a new initiative entering their community without local endorsement or input. Many participants hesitated to confirm their willingness to "sign on" to the NCRN initiative, stating that there were so many initiatives around COVID-19 currently taking place that did not authentically engage them, invest in them or acknowledge their expertise.

Recommendations:

- Connect to CHW State associations to see if they have evaluated success/effectiveness of COVID-19 response, in order to scale capacity of successful initiatives or fill in gaps of coverage
- Develop more evaluation for the CHW workforce through NACHW and other

national partners, in order to best utilize CHWs expertise in the COVID-19 response
- Engage CHWs, CHW Networks and key influencers on the frontlines of COVID-19 response and innovation in the NCRN Strategic Advisory Partners and Community Coalition opportunities to inform all phases of design, development, implementation and evaluation /adaptation of NCRN objectives
- Recruit Advisory and Coalition organization membership who are trusted by local communities.
- Recruit CHWs from local, county and state Networks, faith-based organizations, support groups and cultural organizations, etc.
- Ensure that Advisory and Coalition members establish authentic feedback loops with local and impacted communities and provide regular insights to NCRN
- Define and track health equity measures throughout the NCRN life cycle

NCRN Objective Six: Comprehensive Dissemination

(using mainstream media, white papers, and publications to educate and train the response workforce)

The CHW workforce requires quality tools and information in order to do their jobs effectively. Evidence in this report suggests the workforce and those being trained for COVID-19 response do not have enough resources. Members of the response workforce are receiving brief, generalized training that does not effectively prepare them for the challenges vulnerable populations are facing in maintaining safety during this pandemic. Lack of clarity on CHW roles and of prior partnership with CHW Networks and CBOs has impacted successful integration of existing COVID-19 response efforts and local expertise.

Some members of the CHW workforce, particularly in rural areas, do not even have access to certain mainstream media, making it more difficult for them to connect with other CHWs, or get up-to-date COVID-19 information. NACHW was the first national organization to develop and curate a webpage with COVID-19 materials specifically related to the information, resource and self-care needs of the CHW workforce. NACHW also helped the Centers for Disease Control and Prevention develop their webpage for CHWs (launched in November 2020) and has engaged Ethnic Media Services (reaching over 80 culturally and linguistically diverse journalists) in response to the desire for communities to understand the roles of their local CHWs in COVID-19. While CHWs do have data about COVID-19, it is difficult for them to find ways to translate it and disseminate it, especially because there is no centralized dissemination source for coordinating different efforts to reach diverse populations.

Recommendations:

- Use NACHW and other CHWs Networks as a dissemination partner to connect to CHWs and other partners
- Leverage trusted local publications and distribution channels most widely utilized by the Community Workforce through workforce evaluations in order to best disseminate to CHWs
- Conduct a network analysis of NCRN National Strategic Partners and Community Coalition members to develop a COVID-19 partnership, intervention and training inventory
- Disseminate the CDC Resources for Community Health Workers, Community Health Representatives, and Promotores de la Salud
- Disseminate NCRN content through CHW Network and CHW employer newsletters and training centers, etc.
- Offer updates through national conference calls at off peak hours when CHWs are not working
- Translate NCRN updates, progress reports and all communication materials into the major languages spoken within the NCRN Priority Communities

Background

Who are CHWS?

Origins of CHW practices are as varied as the CHWs who live them and are acknowledged to be at least 300 years old in the United States. African Americans can trace their CHW origins through the history of US enslavement as plantation healers who integrated their mostly West African religious health beliefs with Indigenous Native Americans health practices and European medicine from slave masters and scientists as a form of resistance and ensure their survival.

The Community Health Representatives program was established by congress in the 1960's in response to American Indian and Alaska Native governments advocacy for the US government to provide a culturally and linguistically appropriate health care program staffed by tribal community members who were trained in the basic skills of health care provision, disease control and prevention and promotion of health services. With over 580 federally-recognized tribes in the United States - and many more not afforded that recognition - CHR practices and religious/traditional health beliefs are unique to the needs, cultural and geographic context of the people who created them.

Promotores de Salud became well known first through Latin America and then in the US as being providers for migrant and seasonal farm workers and their families. As this model flourished, promotores began implementing their model of care through programs focused on primary care utilization, immunization, diabetes, HIV/AIDS, asthma and other whole-family and community wellness programs.

It is important to note that each of these CHW origins stories, and those of Pacific Islanders, Vietnamese, Cambodian, Native Hawaiian, Haitian, Brazilian, Chinese and other communities have in common the concept of CHWs as natural helpers, persons called to service from spiritual, religious or cultural motivations, who find their fulfillment in the achievement of community wellbeing. As well, these many models of CHW work as considered in the US context always included core activities of community activation, mobilization and social justice advocacy, in addition to more traditional and mainstream services within primary care and public health models that began to leverage the trusted relationship and cultural linguistic appropriateness of their work for clinical and chronic disease prevention-based goals.

CHWs are predominantly women of color often sharing ethnicity, diagnosis, and barriers to health care and social determinants of health with marginalized communities. CHWs are also frontline public health staff, whose shared experience or unique relationships with communities facilitates trust, builds bridges, and improves clinical, behavioral and social service access, delivery, quality, and care system performance. As members of a workforce disproportionately affected by inequities, CHWs are unique stakeholders in system transformation, representing both provider and patient/community members' voices.

Despite nearly 60 years of research on CHW effectiveness, two decades of national public health recognition, landmark workforce development studies, and a national labor classification, CHWs are still building a national identity, leadership capacity building opportunities, and professional credibility and sustainable funding. When the roles and leadership capability of community health workers is actualized and their organizing infrastructure is cultivated, CHWs can join with other professions to co-create and implement programs, practices, and policies that achieve health, racial equity, and social justice.

The following definition is offered to guide the readers' understanding of the term Community Health Worker developed and endorsed by the American Public Health Association:

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Since the very beginning of the coronavirus's spread in the U.S., NACHW, our partners, and other advocates have been calling for the engagement of CHWs in COVID response. Those familiar with the CHW workforce recognize the crucial role they can play during this pandemic to combat misinformation and lack of understanding in vulnerable communities, increase access to care and support for COVID-related needs, and serve as a resource on anything from quarantine to mental health to food insecurity.

Partners and advocates have also emphasized that CHWs have been doing this work all along, and their strength in pandemic response has grown out of authentic community participation and familiarity with community-based problems. Biden's Build Back Better Plan and his Build Back Better in Rural America mention hiring large amounts of CHWs or equivalent positions to help people navigate social services and healthcare. In addition, in another future President Biden pledges to fund 150,000 CHWs. Key actors such as those writing the opinion pieces cited above realize what an effective resource CHWs can be during this time, and have called upon our country's leaders to work to engage them.

The Morehouse School of Medicine's National COVID-19 Resiliency Network (NCRN)

About the NCRN

The Morehouse School of Medicine's National COVID-19 Resiliency Network (NCRN) is an initiative to coordinate a strategic and structured national network of national, state/territorial/tribal and local public and community-based organizations that will mitigate the impact of COVID-19 on racial and ethnic minority, and rural populations. This work is supported in whole by a $40 million award from the U.S. Department of Human and Health Services Office of Minority Health as part of the National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities (NIMIC).

The initiative focuses on groups which experience high rates of COVID-19, such as African American, Hispanics, Asian Americans, Pacific Islanders, Native Indians, Alaskan Natives, migrant workers, and justice involved communities. The NCRN launches first in five priority areas as shown below, Florida & Georgia, Louisiana, Navajo Nation, California & Hawai'i, and Texas & Alaska. *(See table: National COVID-19 Resiliency Network Five Priority Communities Impacted by COVID-19 (Phase 1) on next page.)*

NACHW Role in the NCRN

NACHW is partnering with Morehouse to connect them with CHWs/promotoras de salud/CHRs in order to develop culturally appropriate strategies of disseminating information to these vulnerable communities and find out what resources are most necessary in each community to address the physical and social ramifications of the COVID-19 pandemic.

In order to better advise the Morehouse NCRN initiative and support the role of CHWs in its COVID-19 response, NACHW embarked on this Environmental Scan. Our intention was to gain a deeper comprehension of the impact of COVID-19 on NCRN Priority Communities and the experiences of the CHW workforce related to pandemic response. We sought to gather recommendations from CHWs, CHW Networks and their allies for the NCRN to foster authentic community partnership and strengthen locally sourced and effective COVID response strategies.

Our hope is that these findings and recommendations as expressed through contextual data and the voices of CHWs will support the Morehouse NCRN to build trust, increase access and ensure equity in their pandemic response. Further, we believe this document will surface barriers to national professional identity and recognition of CHWs as critical essential infrastructure workers whose trust, relationship, commitment and skill, diversity, leadership, advocacy and multi-sector integration are needed now - and should be sustained to achieve health, equity and social justice.

National COVID-19 Resiliency Network Five Priority Communities Impacted by COVID 19 (Phase 1)

State/Territory	Priority Areas	Vulnerable Communities	Reasoning (all communities touch HPSAs)
Florida Georgia	Entire states	African American Hispanic Migrant Workers	Rising COVID-19 infection rates among African Americans and Migrant Farm Workers
Louisiana	Orleans, Jefferson, East Baton Rouge Parishes	African American Incarcerated	Quick rise in cases and deaths, 2nd highest incarcerated population in US, need for culturally appropriate approach for African Americans
Navajo Nation	Reservation touches Arizona, New Mexico, Utah	Native Indian	Largest American Indian population with the highest infection rate and most deaths; Need for additional culturally relevant resources
California Hawaii	Los Angeles Hawaii, all counties	African American Asian Pacific Islanders Hispanic	CA has Highest cases in US Asian Pacific Islanders highly impacted in CA and HI
Rural consortium Texas Alaska	El Paso, Moore County Anchorage	Hispanic Migrant workers • Meat Packing • Farmers Alaskan Native	Migrant Meat Packing and Farmer industry highly impacted Alaskan Natives at higher risk for COVID-19 related morbidity and mortality

Environmental Scan

Purpose

The purpose of the environmental scan is to provide a deeper understanding of what an effective community-based response to COVID health disparities would look like in each of the Five Priority Communities. The first aspect of broadening our understanding comes from data on the structural environment: the presence of existing health disparities and health issues, where racial and ethnic inequities lie and how they manifest, and what measures states might use to address these disparities.

The second aspect is comprehending COVID-19's impact on each of our Five Priority Communities. COVID-19 has exposed the weakest points of our healthcare infrastructure. It is crucial to build an understanding of where caseloads and deaths are highest, who is disproportionately affected, and what the challenges are in mounting an effective response. Finally, looking towards a solution requires examining the current capacity of a community-based workforce and what their challenges and opportunities are in being integrated into COVID-19 response. A comprehensive scan of these factors has produced recommendations for COVID-19 response and CHW workforce engagement that are tailored to specific challenges, rooted in data, and ultimately, holistic and sustainable, and can help generate a sufficient response to our current public health crisis.

Approach/Methods

For each state included in the scan, research began with an attempt to map the landscape of community health workers in that state. Beginning with CHWs and their roles gave a foundational understanding of health infrastructure and state involvement, which informed our inquiries into COVID-19 response and health outcomes. The Association of State and Territorial Health Officials collects this data, looking at their CHW Training and Core Competencies Chart and their CHW Certifications Standards Map. These resources gave information on whether certification in a state is required, what the certification process looks like, and the scope of certification. The National Academy for State Health Policy tracks CHW presence using the State Community Health Worker Models Map. The map was used to track state legislation on CHWs, intended roles for CHWs, and CHW organizations. Organizations and workgroups for CHWs were also found through the Meharry-Vanderbuilt Alliance's National Scan of Community Health Worker Statewide Associations. From there, more general web searches were undertaken to find other CHW organizations, working groups, or publications that initial sources may have missed. General searches were also used to hone in on county-specific organizations, if they existed, for the specific counties in question.

COVID Response Strategy

The next area of research was the current COVID-19 response being organized in each state. In some cases, previous research into CHW organizations led to information on current COVID-19 related work. If that was not the case, each state's Department of Health website was visited for COVID-19 information. The Department of Health websites generally had plans for contact tracing and other response methods, but a web search was also used for more information on contact tracing. Some states have also released their vaccine roll-out plan now that the CDC has required it, so information on vaccines was gathered from a combination of those plans and a general web search. States with populations participating in vaccine trials were found through web searches. All COVID-19 case numbers and death counts came from the New York Times COVID-19 Tracker, and case numbers and death counts organized by racial and ethnic demographic came from The COVID Tracking Project.

Other Data Tools

In order to gather a complete picture of health and its social determinants in each state/locality, more national data was collected namely from three sources: the CDC's Social Vulnerability Index, County Health Rankings, and the Mapping the New Politics of Care Project. The Social Vulnerability Index (Figure NUMBER) and County Health Rankings (Figure NUMBER) contribute to the purpose of the scan by capturing where health inequities and social challenges lie which would be further exacerbated by a crisis like COVID-19. The allocation from Mapping the New Politics of Care (Figure 3) provided information for the third objective of this scan by displaying current gaps in the CHW workforce and how allocation of workers should connect to COVID-19 caseloads. The data for states and counties was collected from these sources and analyzed to contribute to our findings at the national level, and particularly the allocations from Mapping the New Politics of Care was used when drafting state-specific recommendations.

Findings Summary

Diversity of Workforce Roles and Employers, and Lack of National and State-Level Professional Identity

Discrepancies Seen in Reporting CHW Numbers

Primary findings describe how difficult it was to find accurate summary information about CHWs and their roles, employers, and funding because of the diversity of the workforce. As revealed below, every state has a slightly different approach to engaging CHWs, and even within states there is a lot of variability in CHW roles. Not only are CHWs housed at an abundance of differing organizations, but they are also known by many titles and classifications. This variety is one reason certification can be difficult to achieve, because unifying such a diverse workforce around common goals that every employer agrees on is not a simple task. The problem of a lack of identity is also reflected in discrepancies (or simply a dearth) in accurate numbers of CHWs in a state or county. Even statewide organizations, likely the most grassroots and community-connected resource for CHWs, might not have an accurate count or be representative in their membership base because of the diversity of CHW classifications. Struggles around COVID engagement tie directly to the problem of diversity, as stakeholders in COVID-19 response may want to connect with CHWs, but do not understand how to engage them properly due to lack of clarification on roles and qualifications.

Establishing Professional Identity: Workforce Assessments

The findings below confirm the struggle for the development of a comprehensive professional identity for CHWs. A national report conducted in 2018 found that two thirds of CHW networks were established in the last 10 years, half of networks said they have no paid staff and operating budgets of less than $50,000, and half stated that their primary source of revenue was grants and membership dues. The study also confirmed that many of these groups lack the capacity or leadership to take on workforce policy issues, even on a smaller scale. These findings reflect the struggle to determine a professional identity, as lack of recognition is both a product of and a reason for the lack of capacity and resources CHW networks face. Without a unified identity of CHWs, networks, and their allies and partners, barriers to national CHW policy, scaling of best practice, and sustainability like those mentioned in the 2018 study will remain.

Perhaps because of the struggle for clarity in CHW workforce roles, several states who did not already have intimate connections with CHWs have in recent years organized forums or working groups to get to know the workforce better and learn to properly engage them. Feedback from those

states, however, proves that even states who have had recommendations produced from working groups, forums, and reports are not seeing those recommendations through. Even in a state like Texas, who has a very deep connection between state health officials and CHWs, CHW and promotora organizations have struggled during this time to become involved in COVID response. Clarity on the roles of the CHW workforce are likely to come out of recommendations many of these states already have, but effort has not yet been put into generating support for provided recommendations.

Patterns in COVID Ethnic and Racial Demographic Data

Lack of Data for Minorities, Particularly Native Hawai'ians/Pacific Islanders and American Indians/Alaskan Natives

Since the beginning of the pandemic, public health officials have strained to understand how the virus is affecting different segments of the population. These efforts are made that much more difficult, however, when certain states do not report effectively on COVID-19 cases and deaths for racial and ethnic groups. Four out of seven states of focus in this report (excluding the Navajo Nation) do not report full data on every racial and ethnic group in their states: Florida only reports cases for Whites, African Americans, and Hispanics/LatinX; Hawai'i does not report on their numbers for Hispanic/LatinX or American Indian/Alaskan Native populations; Louisiana does not report the number of Hispanics/LatinX COVID cases; and Texas only reports number for Whites, Asian Americans, African Americans, and Hispanics/LatinX. All these failures in accurate reporting are concerning, especially for those trying to assist minority communities in preventing COVID-19 cases. However, the lack of accurate reporting of case numbers and deaths for Native Hawaiians and Pacific Islanders is particularly concerning because they were the most likely to both contract COVID-19 and die from it when adjusting to population numbers in a majority of states scanned. American Indians and Alaskan Natives are also threatened by inaccurate case and death counts because they are likely to be in a low-resourced area where access to healthcare may already be difficult; Alaska and California also have American Indians and Alaskan Natives in the top three racial and ethnic demographics most burdened by cases and deaths when adjusting for population.

Challenge of Engaging Migrant/Factory Workers

COVID-19 case data and reports also suggest migrant and factory workers are facing a challenging combination of high case counts and low visibility/access to resources. Migrant workers and LatinX front-line workers are addressed in Section on Key Stakeholder Interviews.

Ubiquitous Disproportionate Burden of COVID Cases and Deaths on Racial and Ethnic Minorities

Despite differences in COVID-19 burden per racial and ethnic groups, one thing remains clear across all states (excluding the Navajo Nation) in the environmental scan: the COVID-19 case counts and deaths for White populations are far below their share of state populations. In three of the seven states in the scan, Whites rank last in COVID cases per 100,000 individuals, and in three other states, they are second to last. These numbers indicate, as has become evident across the United States, that racial and ethnic minority groups are bearing an unequal burden of COVID cases and deaths in this country.

Similarities in County Health Rankings

Above Average in Uninsured and Unemployed Populations

When zooming in on the specific counties in the environmental scan, county health rankings reveal that there are certain health issues a majority of counties struggle

with. Two health factors in particular stand out during this pandemic: unemployed and uninsured populations. A majority of counties in our scan had above average numbers of unemployed and uninsured populations for their respective states, challenges which existed pre-COVID, and since the county health ranking data was gathered, the pandemic has made levels of unemployment and lack of health insurance increase rapidly.

Low Birth Weight as a Poor Health Indicator

A health outcome measured in county health rankings that many of our scanned counties struggled with was low birth weight: 9 of 11 counties in the scan had average or above average percentages of infants born with low birth weight for their respective states. As a health outcome, low birth weight serves as an indicator for other health issues the county is facing, as many health factors can affect a pregnant mother and cause her child to be born at a low weight. The high prevalence of low birth weight suggest the scanned counties are experiencing larger systemic health issues. It is well documented that pregnant women who are of a racial or ethnic minority in the United States are more likely to experience low birth weight of their infants, indicating many of the scanned counties face health inequities according to race.

Narrative

National Perspective
Data Tools: County Health Rankings, Social Vulnerability Index, and Mapping the New Politics of Care

Table: County Health Rankings

Anchorage (AN)

☐ Show areas to explore ☐ Show areas of strength

County Demographics +

	Anchorage County	Trend	Error Margin	Top U.S. Performers	Alaska	Rank (of 25)
Health Outcomes						10
Length of Life						8
Premature death	7,700		7,300-8,000	5,500	8,000	
Quality of Life						15
Poor or fair health	15%		15-15%	12%	18%	
Poor physical health days	3.5		3.4-3.6	3.1	4.0	
Poor mental health days	3.2		3.1-3.3	3.4	3.9	
Low birthweight	6%		6-7%	6%	6%	
Additional Health Outcomes (not included in overall ranking) +						
Health Factors						5
Health Behaviors						4

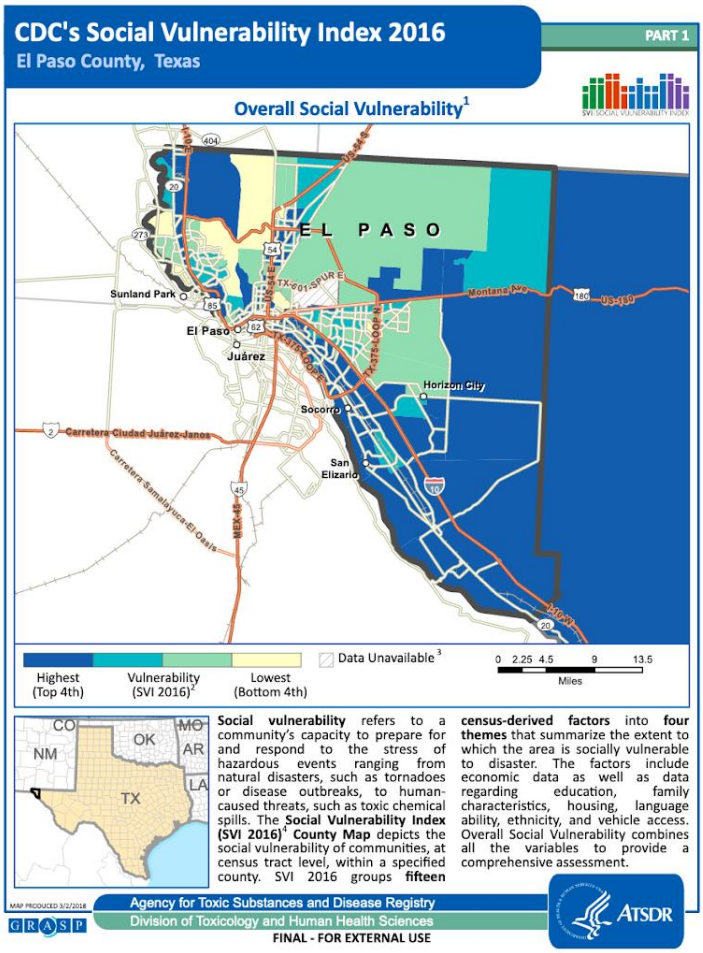
This scan utilized County Health Rankings as a method of examining and comparing health-related trends per county to measure the specific health needs of each county in our focus. County Health Rankings is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, who use databases mostly at the national level to collect information from state and county public health officials to coalesce and then rank data by county. The data is split into two general categories: health factors and health outcomes. Health factors "represent those things we can modify to improve the length and quality of life for residents," and health outcomes "reflect the physical and mental well-being of residents within a community through measures representing not only the length of life but quality of life as well." Health factors is further divided into the categories of health behaviors, clinical care, social and environmental factors, and physical environment. County Health Rankings then uses all of the data from those indicators to rank each county in a state according to health factors and health outcomes. *(See Table: County Health Rankings by County for Health Outcomes and Health Factors)*

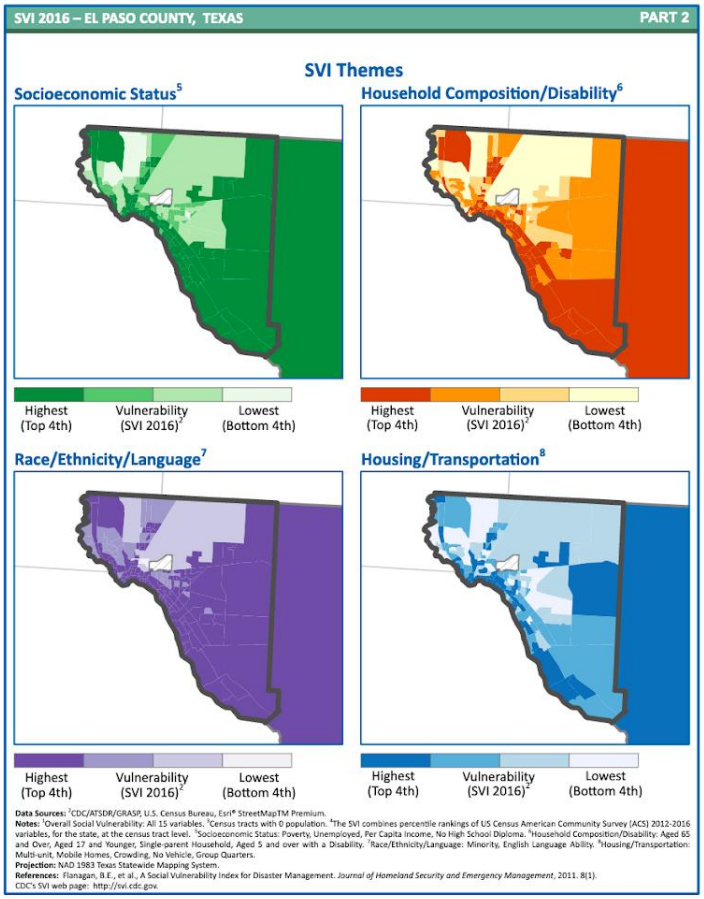
As the table below indicates, most of the specific counties scanned ranked somewhere toward the middle of counties in their respective states for health outcomes and health factors. The counties in the scan most frequently were at or above the average for their respective states in percentage of premature deaths, excessive drinking, sexually transmitted infections, teen births, unemployment, uninsured populations, children in poverty, income inequality, and violent crime. Nine of eleven counties in the scan had above average percentages for their states of children in single-parent households, and for infants born with low birth weight. It is evident from these percentages that the counties scanned contain communities struggling with damaging health factors that ultimately lead to poor health outcomes such as low birth weight.

County Health Rankings by County for Health Outcomes and Health Factors

County	Health Outcome Ranking	Health Factor Ranking
Anchorage Municipality, AK	10 of 25	5 of 25
Los Angeles County, CA	21 of 58	32 of 58
Hawai'i County, HI	4 of 4	4 of 4
Honolulu County, HI	2 of 4	1 of 4
Kauai, HI	3 of 4	2 of 4
Maui, HI	1 of 4	3 of 4
East Baton Rouge Parish, LA	29 of 64	7 of 64
Jefferson Parish, LA	11 of 64	9 of 64
Orleans Parish, LA	32 of 64	29 of 64
El Paso County, TX	56 of 244	125 of 244
Moore County, TX	79 of 244	64 of 244

Social Vulnerability Index



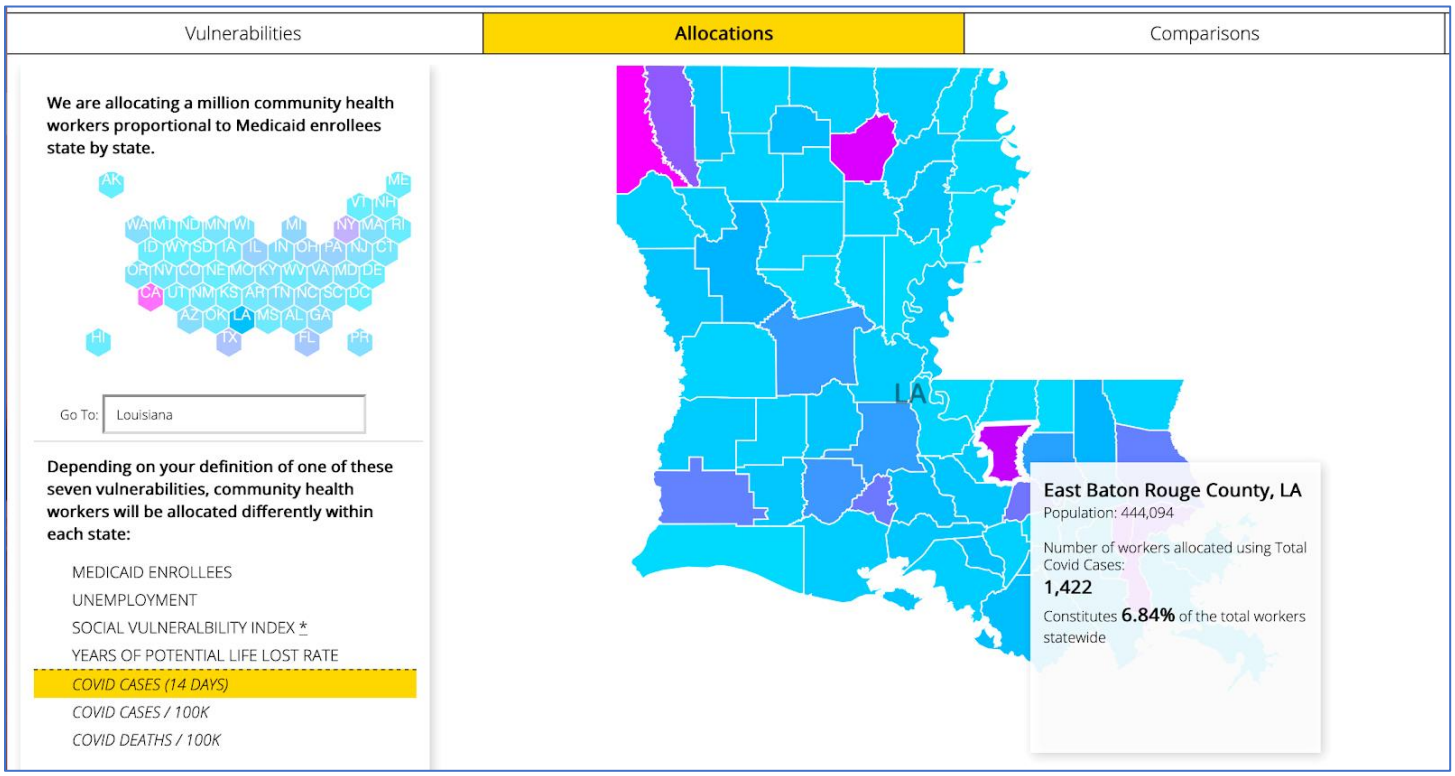


The Center for Disease Control and Prevention has generated a map of social vulnerability as a way to display which communities across the U.S. are more likely to face challenges in responding to hazardous events. The Social Vulnerability Index uses U.S. Census data to make determinations of social vulnerability using 15 social factors including poverty, crowded housing, lack of vehicle access, etc. and groups the factors into four themes: socioeconomic status, household composition, race/ethnicity/language, and housing/transportation. Overall vulnerability and vulnerability in the four general categories are rated on a scale of 0 to 1, 0 being the least vulnerable and 1 being the most vulnerable. (See table: Social Vulnerability Scores by County)

An average of over 0.5 suggests all the counties in this scan experience medium to high social vulnerability. The scanned counties across the board had the greatest vulnerability in race/ethnicity/language and in housing/transportation related factors. These numbers indicate that an event just like COVID-19 would pose a serious challenge to a large majority of the counties in focus, and particularly to counties that have diversity in race, ethnicity, and languages spoken.

Social Vulnerability Scores by County					
County	Overall Social Vulnerability	Socioeconomic	Household Composition /Disability	Race/Ethnicity /Language	Housing /Transportation
Anchorage Municipality, AK	0.4005	0.0755	0.2697	0.8558	0.7857
Los Angeles County, CA	0.7883	0.6517	0.1388	0.993	0.894
Hawai'i County, HI	0.5594	0.4585	0.3085	0.9198	0.4798
Honolulu County, HI	0.461	0.1226	0.0449	0.9758	0.9589
Kauai, HI	0.2923	0.1353	0.0961	0.9484	0.3973
Maui, HI	0.3836	0.1566	0.1289	0.9421	0.6371
East Baton Rouge Parish, LA	0.6024	0.4218	0.3483	0.8453	0.7391
Jefferson Parish, LA	0.5527	0.453	0.347	0.9284	0.4218
Orleans Parish, LA	0.7599	0.6823	0.1971	0.9058	0.8344
El Paso County, TX	0.9567	0.8797	0.7256	0.9965	0.8812
Moore County, TX	0.8055	0.6886	0.5702	0.9895	0.5842
Average	0.5966	0.4296	0.2886	0.9364	0.6921

Mapping the New Politics of Care



The Mapping the New Politics of Care project is a collaboration between the Yale Global Health Partnership and the Columbia Center for Spatial Research that tracks various vulnerabilities within counties in the United States, including Medicaid enrollees, unemployment numbers, the social vulnerability index, and years of potential life lost. The project also tracks COVID data by county, including the number of cases in the last 14 days, the number of cases per 100,000 individuals, and the number of deaths per 100,000 individuals. The project then uses those various measures of vulnerabilities, taken from national databases, and combines it with the proposal of a Community Health Corps consisting of 1 million community health workers to create an allocations map. The allocations map displays the number of community health workers that would be allocated to a specific county, and the percentage of total workers statewide a county would receive, based on any of the aforementioned vulnerabilities. The intention of the project is to show how a Community Health Corps, discussed as a public health measure by several legislators in Congress, would be allocated differently to areas of the country based on different measures of social vulnerabilities. *(See Table: Numbers and Percentages of CHWs Allocated by County According to the New Politics of Care Project)*

For the sake of our scan, we only looked at allocation of CHWs according to one factor: the total number of COVID cases per 100,000 individuals. As one can see from the table, there is a vast range in what percentage of state workers each scanned county would receive according to COVID cases per 100,000: anywhere from 0.09% to 82.85% of statewide workers. However, six of the fourteen would be receiving at least one thousand new workers. Allocation of CHWs on this scale (Los Angeles County alone would be receiving 48,047 CHWs) displays what a dire need there is for support personnel for those contracting COVID-19, and the need to imagine how incorporation of these workers should proceed.

Numbers and Percentages of CHWs Allocated by County According to the New Politics of Care Project		
County	Number of CHWs Allocated	Percentage of State Allocation
Anchorage Municipality, AK	1,757	57.35
Los Angeles County, CA	48,047	30.92
Hawai'i County, HI	513	11.11
Honolulu County, HI	3,826	82.85
Kauai, HI	79	1.71
Maui, HI	187	4.05
East Baton Rouge Parish, LA	1,469	7.07
Jefferson Parish, LA	1,316	6.33
Orleans Parish, LA	948	4.56
El Paso County, TX	7,786	13.33
Moore County, TX	54	0.09

CHW Infrastructure and Associations

CHW Networks in Phase 1 Areas, Member Numbers, and Expertise			
State/Tribal Nation	CHW Network	# of Members	Expertise
Alaska	Community Health Aide Program (CHAP)	550	Certification and uplifting voices of Alaskan Natives
California	The California Association of CHW (CACHW)	N/A	Develop CHWs at the state-level and nationally
	Visión y compromiso	4,000+	Training, policy, networking
Florida	Florida CHW Coalition	1,030	Developing best practices for CHWs
Georgia	CHW Advisory Board and an Advocacy Coalition	70+*	Policy and Advocacy for CHWs
Hawai'i**	N/A	N/A	N/A
Louisiana	Louisiana Community Health Outreach Network (LACHON)	N/A	Core competency training, CHW development
Navajo Nation	Community Health Representative program (CHR)	99	Direct home care and community outreach
Texas	Dia de la Mujer Latina	4,213	Expand and support work on CHWs
	DFW CHW Association	87	Advocacy, education opportunities, professional development workshops, connecting to community and employment resources, and providing opportunities for networking.
	Health Promotores Network Paso del Norte Region/Red de Promotores de Salud Región Paso del Norte	180	Monthly meeting group
	The Health Worker Network	500	Events dealing with health literacy within the community
	San Antonio Community Health Workers Association	200	Facilitate continuing education and promote collaboration across disciplines
	Texas Association of Promotores and Community Health Workers	92	Advocate for CHWs at the state and local level through education, empowerment, and policy
	Texas Gulf Coast CHW/Promotores Association	300	Improving communication, providing access to resources, and improving job opportunities.
	West Texas Community Health Worker/Promotores Association	100-200	Information, exchange, peer-support, professional development and continuing education

** This number represents the number of CHWs and/or allies in the Coalition*

***Hawai'i does not have a CHW Network or Association*

When looking into the CHW workforce in each state, there was a clear presence of CHWs in each locale. The distinctions between states in their CHW landscape tended to be in methods of funding and how much state health departments and legislatures are involved with the CHW workforce. As seen in Table [NUMBER] very state in the scan except for one, Hawai'i, has a state CHW association or coalition that joins CHWs together for decision-making purposes. In some states, like California, Georgia, and Louisiana, CHWs formed their own associations in order to organize trainings and events. In Alaska, Florida, the Navajo Nation, and Texas, CHWs in addition to forming their own coalitions/associations participate in some kind of board or association that was formed by the state and serves as its advisor on CHW matters, typically on issues around certification. *(See Table: Comparing the Number of CHWs as Reported by the Department of Labor, CHW State Workforce Study/State Training Center, Trained CHWs by State as Determined by State/Association Training, and the Number of CHWs Needed to Respond to COVID-19 Based Off of Politics of Care by State)*

Comparing the Number of CHWs as Reported by the Department of Labor, CHW State Workforce Study/State Training Center, Trained CHWs by State as Determined by State/Association Training, and the Number of CHWs Needed to Respond to COVID-19 Based Off of Politics of Care by State

State/Tribal Nation	# of CHWs from DOL	# of CHWs from State Workforce Study/State Training Center	# of CHWs Need to Respond to COVID-19 Based off of Politics of Care Map by State
Alaska	550	550	3,063
California	5,720	6,000+	155,407
Florida	3,120	1,030	50,916
Georgia	1,200	70+	25,159
Hawai'i	480	480	4,618
Louisiana	600	n/a	20,782
Navajo Nation	~80*	99	~1,560**
Texas	2,900	4,122	58,407

**The DOL does not report directly for the Navajo Nation, but does for the general region of Northeast Arizona, which this number represents.*

*** The Mapping the New Politics of Care does not separate out the area of the Navajo Nation, this number is based off of the estimates for all counties which the Navajo Nation occupies.*

CHW State Legislation and Involvement

This extension to an advisory role for the state mentioned above may reflect greater state participation in CHW roles, as Alaska and Texas are the only two states in this scan to have produced legislation on CHWs. Some states or CHW organizations may be using workforce studies to generate greater state involvement and support: California, Georgia, Hawai'i, and Louisiana have all undertaken a kind of study or forum in recent years to examine CHW roles, competencies, and potential for certification. Texas has also completed a workforce study, but not since 2011. State legislation is complicated for the Navajo Nation as it spans the three states of Arizona, New Mexico, and Utah. Of those three states, New Mexico has the most elaborate and state-supported program, and COPE has recently devoted efforts to getting CHRs certified as CHWs in New Mexico.

CHW Certification

Almost all states in our scan include some kind of centralized training or certification process, but there is variance in the requirements of that certification and how robustly it covers all CHWs in a given state. Alaska, the Navajo Nation, and Texas all have training and certification programs which are mandatory for at least some part of the workforce, whether that be certified first responder training for Navajo Nation CHRs, or whether training is required to seek reimbursement for services as is true in Alaska and Texas. California, Florida, Georgia, Hawai'i, and Louisiana, on the other hand, have no statewide training or certification requirement, and many of them have training organized by public colleges or non-profits. California and Georgia are currently working towards a statewide certification system, whereas Louisiana after their recent workforce assessment is not recommending moving to statewide certification at this time.

CHW Funding and Employment

Funding sources for CHWs typically depend on legislation from the state, particularly around Medicaid, as Medicaid expansion can be used to reimburse CHWs. Alaska, a Medicaid expansion state, already reimburses their CHWs through Medicaid, and California is working on obtaining funding through Medi-Cal, the state's Medicaid blueprint. Florida (not an expansion state) and Louisiana (an expansion state) at least partially fund their CHWs through Medicaid Managed Care Organizations. Texas, also not an expansion state, uses a section 1115 waiver and the Health and Human Services Commission (a Medicaid agency) to obtain reimbursement for CHWs. All other states hire CHWs through community-based organizations and federally qualified health centers, who tend to hire using grant funding. The Alaskan CHAP program and the Navajo Nation also receive funding from Indian Health Services due to their work with Indigenous populations. The Navajo Nation receives all of its funding from the IHS or grants, and CHRs are employed by the Navajo Nation Department of Health, reflecting the centralization of CHRs.

COVID-19 Health Impact within Morehouse Five Priority Communities

Health Impact on Race/Ethnicity Demographics

Health disparities in the states scanned are particularly palpable in their COVID-19 demographic numbers. For every state that reported on racial and ethnic data for COVID-19, the percentage of white people in the state was greater than the percentage of white people in reported COVID-19 cases. In other words, racial and ethnic minorities in each state had disproportionately high numbers of COVID cases and deaths. Additionally, for every state reporting specific race and ethnicity data (Florida and Texas

only report numbers for Black, Hispanic/LatinX, White, and Asian), Native Hawaiians/Pacific Islanders had at least the second highest number of per capita COVID cases and deaths, and in four out of five states, they had the highest.

Community Health Workers in COVID Response

These disparities in case and death numbers by race/ethnicity display the hard truth that the states scanned are struggling to reach minority and marginalized populations. To do so, some states have incorporated CHWs into their COVID response plans: cities and counties in California, Florida, and Texas have recruited CHWs to connect with communities of color or non-English speaking communities who are struggling during COVID to access resources and stay at home. Louisiana and Hawai'i have directly hired CHWs to their state-organized contact tracing and COVID response, and Alaska will be using their CHAP workers to assist in vaccine rollout in the coming months. The Navajo Nation have also been using their Representatives to connect with difficult-to-reach and rural populations to conduct home visits and provide access to care.

COVID-19 Response Leaders

In every state in our scan, the Department of Health or main state-run health body is the leader in statewide COVID response, and typically serves as the hub for COVID information. In recent times, those entities have also been asked to produce plans for COVID vaccine rollout in their state. On both of those fronts, universities or private corporations are assisting state health apparatuses. In Alaska, California, Hawai'i, and Texas, health departments are collaborating with public universities to conduct trainings for contact tracers and other community response workers. Florida, Georgia, Louisiana, and Texas have contracted private companies to assist in contact tracing efforts. For approaching COVID vaccination, populations in California, Hawai'i, Louisiana, and the Navajo Nation are participating in vaccine trials, and California and Florida have been selected as two of four states running a pilot program of vaccine distribution to prepare for country-wide rollout.

State Specific Descriptions

Alaska

COVID-19 Data and Response Strategy

Alaska Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020 by State and Anchorage County		
State/ County	**Total COVID-19 Cases**	**Cases Per Day in the Week Prior to November 17th**
Alaska	24,268 cases	583 cases (79.7 cases per 100,000)
Anchorage County	12,713 cases (4,414 per 100,000)	331.6 cases (115.1 per 100,000)

The target population for Anchorage County, Alaska is Alaskan Natives who according to the Census, comprise 9.1% of the population. Since the beginning of the pandemic, there have been 24,268 COVID-19 cases and 92 deaths in Alaska as of November 17. As seen in the table above, over half of Alaska's cases are located in Anchorage County.

COVID-19 Data and Response Strategy by Race

Alaska COVID-19 Cases by Race		
Race	**% of Total Population**	**% of Total Cases**
White	65%	40%
African Americans	3%	4%
Asian Americans	6%	5%
Hispanics/LatinX	7%	11%
American Indians/Alaskan Natives	14%	30%
Native Hawaiians/Pacific Islanders	1%	4%

When looking at racial and ethnic demographic data, Native Hawaiians and Pacific Islanders have been the most likely to contract COVID and to die of it in Alaska when looking at cases and deaths per 100,000 individuals.

In response to these numbers, the Alaskan Department of Health and Social Services has taken the lead on COVID response efforts, with its Section of Epidemiology organizing contact tracing and town halls with communities, and connecting with other response actors when a positive case is reported. For contact tracing, the University of Anchorage is hosting trainings. Plans for COVID vaccine rollout are also being put together by the DHSS and the Alaskan Native Tribal Health Consortium. The state now holds a weekly call known as Vaccine ECHO for emergency managers, immunization coordinators, and community partners to prepare for a vaccine.

Community Health Worker Workforce Overview

The Alaskan CHW workforce is built around the Community Health Aide Program (CHAP), which was established by a bill from the state legislature in 1993. Since then, CHAP has grown into a network including over 170 rural Alaskan villages. The program currently has an Association which organizes meetings and education opportunities, and a Certification Board which oversees all training and certification efforts. Certification is required for Medicaid reimbursement, and trainings are organized into four regional hubs. The main aim of CHAP is to engage with rural and Native Alaskan communities, which is why they also receive support from the Alaskan Native Health Consortium. This intention means most of the funding for CHAP comes from Indian Health Services, but aides can also be reimbursed for services to Medicaid beneficiaries.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reports that as of May 2019, Alaska had 550 CHWs currently employed. This number seems to be pulled directly from the data provided for the Community Health Aide Program, which in 2017 stated it had approximately 550 health aides. As evident in this estimation, CHAP is a very robust program within the state, and is deeply connected at various levels to the state government and public health infrastructure. The program also makes sure to include and uplift the voices of Alaskan Natives through the Health Consortium, which is crucial to the success of the program, particularly as we look at the burden of COVID cases Native Alaskans represent. However, this estimate from the Bureau of Labor Statistics does leave the possibility that there are other CHWs in Alaska who may not be considered health aides but who still serve in the same capacity and are left out of discussions of the workforce.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, Alaska would receive 3,063 workers, or 0.31% of total workers being allocated nationwide.

When looking at allocations of workers according to the number of COVID cases per 100,000 individuals, Anchorage Municipality would receive 255 workers, or 8.32% of workers statewide.

Recommendations

As evident in COVID caseloads, American Indians and Alaskan Natives are bearing a disproportionate burden of COVID in Alaska. This disproportionate burden exists despite CHAP working for decades to improve healthcare access to Indigenous Alaskan communities. It is very encouraging that the state health apparatus intentionally includes CHAP in decision-making and, more recently, in COVID vaccine planning, but it is also clear that the program requires greater support if they are trying to address health inequities for Indigenous populations that have been exposed by COVID-19. The state should also consider, if it will be receiving a number of CHWs approaching the recommendation from Mapping the New Politics of Care, whether they will be automatically absorbed into CHAP or whether they may be classified outside of the Aide program. The state should recognize how health inequities caused by COVID will last and potentially expand after a vaccine is rolled out.

California

COVID-19 Data and Response Strategy

California Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/20 by State and Los Angeles County		
State/ County	Total COVID-19 Cases	Cases Per Day in the Week Prior to November 17th
California	1,047,081 cases	8,783 cases (22.2 per 100,000)
Los Angeles County	342,425 cases (3,411 per 100,000)	2,675.1 cases (26.6 per 100,000)

The focus populations for Los Angeles County, California are African Americans, Asian Pacific Islanders, and Hispanics. Since the beginning of the pandemic, there have been at least 1,047,081 COVID-19 cases and 18,304 deaths in California as of November 17.

COVID-19 Data and Response Strategy by Race

California COVID-19 Cases by Race		
Race	**% of Total Population**	**% of Total Cases**
White	38%	18%
African Americans	6%	4%
Asian Americans	14%	6%
Hispanics/LatinX	39%	60%
American Indians/Alaskan Natives	<1%	<1%
Native Hawaiians/Pacific Islanders	<1%	<1%

When looking at racial and ethnic demographic data, Hispanics/LatinX have been most likely to contract COVID, and African American and Native Hawaiian/Pacific Islanders have been most likely to die of it in California when looking at cases and deaths per 100,000 individuals.

California in response to these caseloads has organized the California Connected program, which is a collaboration of the Department of Health, local health

departments, the University of California San Francisco, and the University of California Los Angeles. UCSF and UCLA host contact tracing training, which is funded by the DPH and includes many of their employees. UCLA's School of Medicine is a CEAL grant recipient, focusing on COVID-19 awareness and education in minority communities and ensuring their consensual participation in therapeutics and vaccine trials. UCLA's School of Medicine is also the leader of HELP STOP COVID LA, an initiative of five medical centers across California using locally informed approaches to stopping and treating COVID. In preparation for a vaccine, California was one of four states chosen by the CDC to conduct a pilot for vaccine distribution. The Department of Health is currently putting together a Vaccine Task Force for eventual distribution. The northern part of the state is also participating in a COVID vaccine trial run by the Kaiser Permanente Vaccine Study Center.

Community Health Worker Workforce Overview

California's workforce is primarily organized by associations and community-based organizations. The California Association of CHWs is the overarching CHW entity, who support the development of CHWs both in the state and nationally. A prominent CBO in the state is Visión y Compromiso, an organization founded by promotoras that provides capacity building, advocacy, and leadership development for CHWs. For development of the workforce, the University of California San Francisco has a Healthforce Center which has produced publications with recommendations for CHWs in care coordination models, healthcare teams, and whole person care. The city of Los Angeles has recently hired CHWs through the Department of Health Services to serve in their Whole Person Care Program. The state does not require certification, but several universities and colleges offer CHW training programs. While the state legislature has not been very involved with the CHW workforce, it is now working to include reimbursement in its state Medicaid blueprint.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reports that as of May 2019, California had 5,720 currently employed CHWs in the state. It is not immediately evident where that number came from, but given the scope of CHWs in California, it is likely that each CBO, hospital, healthcare center, or MCO reported their own numbers. This reflects the current state of the workforce in California: CHWs and promotoras are a large and diverse workforce that are frequently utilized in the state, but despite various statewide organizations there is very little support from the state itself. The lack of state involvement around certification and Medicaid reimbursement is particularly concerning for the sustainability of the workforce.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, California would receive 155,407 workers, or 15.54% of total workers being allocated nationwide. When looking at allocations of workers according to the number of COVID cases per 100,000 individuals, Los Angeles County would receive 2,815 workers, or 1.81% of workers statewide.

Recommendations

Whether or not the number of CHWs from Mapping the New Politics of Care are honored, California is clearly well understaffed for workers supporting those with COVID-19 or related needs. In particular, the state needs assistance reaching Hispanic and LatinX communities, who are facing dual challenges of being essential workers and having difficulty isolating while also often having trouble with contact tracing due to a language barrier and distrust in the government. Thankfully, organizations like

Visión y Compromiso who hire promotoras and work closely with Hispanics/LatinX have already done a lot of advocacy around reaching Spanish-speaking populations and could be engaged more thoroughly by the state to provide guidance. There are also several examples of cities and organizations in California who are already working to reduce the burden of COVID-19 on Hispanic and LatinX communities by hiring CHWs and Spanish-speaking employees, including LatinX Health Access in Orange County and the CHW Outreach Initiative in Los Angeles County. The state should look to these organizations for guidance on engaging Spanish speaking and immigrant communities and should also finalize their efforts to include CHW reimbursement into Medi-Cal in order for CHWs to be properly financially supported during this time.

Hawai'i

COVID-19 Data and Response Strategy

Hawai'i Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020 by State and County		
State/ County	**Total COVID-19 Cases**	**Cases Per Day in the Week Prior to November 17th**
Hawai'i	16,711 cases	83.9 cases (5.9 per 100,000)
Hawai'i County	1,489 cases (739 per 100,000)	9.9 cases (4.9 per 100,000)
Honolulu County	14,429 cases (1,481 per 100,000)	68.7 cases (7.1 per 100,000)
Kauai County	83 cases (115 per 100,000)	1.8 cases (2.5 per 100,000)
Maui County	710 cases (424 per 100,000)	4 cases (2.4 per 100,000)

Since the beginning of the pandemic, there have been at least 16,711 COVID-19 cases and 221 deaths in Hawai'i as of November 17. Over the past week, the state has seen an average of 83.9 cases per day, or 5.9 cases per 100,000 individuals.

Hawai'i COVID-19 Cases by Race		
Race	**% of Total Population**	**% of Total Cases**
White	25%	14%
African Americans	2%	2%
Asian Americans	38%	34%
Hispanics/ LatinX*	n/a	n/a
American Indians/ Alaskan Natives**	n/a	n/a
Native Hawaiians/ Pacific Islanders	10%	45%

When looking at racial and ethnic demographic data, Native Hawaiians and Pacific Islanders have been the most likely to contract COVID and to have died of it in Hawai'i when looking at cases and deaths per 100,000 individuals.

During COVID, Hawai'i's Department of Health has been in charge of the state's response, organizing contact tracing and leading the state up and down a continuum of reopening based on case loads. The DoH is working with the University of Hawai'i to train personnel and CHWs to conduct contact tracing. Hawai'i is also the home of two trial sites for the Pfizer COVID vaccine, one at the University of Hawai'i at Manoa, and one at the East-West Medical Research Institute. The DoH also recently received new CARES Act funds to begin working on a vaccine preparedness plan.

Community Health Worker Workforce Overview

Despite several recent publications about the state of the CHW workforce in Hawai'i, there still does not exist a statewide organizing entity for CHWs. The Hawai'i Public Health Institute, an organizational hub for all state public health matters, and the Hawai'i Primary Care Association have both supported CHW work, and the Primary Care Association has an Outreach and CHW arm, but neither of them were organized specifically for CHWs. The Department of Health has put together CHW conferences in recent years, which along with the publications may result in a statewide association. There are certification programs, despite there being no state requirement, which are run by community colleges.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reported that Hawai'i had 480 CHWs as of May 2019. It is difficult to verify that number, given the lack of a statewide association for CHWs and the lack of a centralized certification process. A recent report on the state of the Hawai'ian CHW workforce noted that those in the healthcare field mention CHWs being able to assist with implementing individual and community assessments, but that few CHWs are being engaged in such a way currently. CHWs also identified a training need in policy and advocacy. Despite these challenges to defining roles for CHWs, participation in recent reports and forums proves that there is energy around forming a statewide association, and the reports have already provided suggestions for how these efforts could be organized. A crucial element could be support from the state, which may be more likely considering the DoH's contract with the University of Hawai'i to train CHWs for their contact tracing program.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, Hawai'i would receive 4,618 workers, or 0.46% of total workers being allocated nationwide. When looking at allocations of workers according to the number of COVID cases per 100,000 individuals, Hawai'i County would receive 1,755 workers, or 38% of workers statewide. Honolulu County would receive 1,889 workers, or 40.9% of workers statewide, Kauai County would receive 356 workers, or 7.71% of workers statewide, and Maui County would receive 605 workers, or 13.1% of workers statewide.

Recommendations

The most important step for the future of Hawai'i is CHW workforce is to establish a statewide association or coalition. Considering previous assistance and encouragement from the state it may come out of that, or it may come out of independent meetings, but if Hawai'i is going to properly support CHWs during this time and beyond, it needs the infrastructure of a statewide association. The same is true for potentially thousands of new workers who will be sent to the state, who will need guidance on training and cultural context. Through listening sessions and other means of communication with workers and officials, it is evident that two phenomena are still occurring in Hawai'i: firstly that CHWs are not being meaningfully engaged during this time, and second that the two most populated islands are receiving the vast majority of government support, while the other two islands are severely lacking in resources. In particular, the program intended to train CHWs at the University of Hawai'i for contact tracing has not been hiring those CHWs after training and has pushed them to the side of the response. For an effective response that reaches all people of Hawai'i, and especially Native Hawai'ians who are bearing the undue burden of COVID, the state should guarantee CHWs a place in

contact tracing if it is a mutual decision, and provide resources to CHW organizations across the state to continue their work engaging rural and marginalized populations.

Florida

COVID-19 Data and Response Strategy

Florida Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020		
State/County	**Total COVID-19 Cases**	**Cases Per Day in the Week Prior to November 17th**
Florida	889,856 cases	6,006 cases (28 per 100,000)

The Morehouse's NCRN initiative for the areas of Florida and Georgia are focusing on African Americans, Hispanics, and Migrant Workers. Since the beginning of the pandemic, there have been at least 889,856 COVID-19 cases and 17,558 deaths in Florida as of November 17. Over the past week, the state has seen an average of 6,006 cases per day, or 28 cases per 100,000 individuals.

COVID-19 Cases by Race		
Race	**% of Total Population**	**% of Total Cases**
White	75%**	37%
African Americans	16%	17%
Asian Americans*	n/a	n/a
Hispanics/ LatinX	25%	40%
American Indians/ Alaskan Natives*	n/a	n/a
Native Hawaiians/ Pacific Islanders*	n/a	n/a

** Florida includes all other racial and ethnic groups in an "other" category, which means they cannot be compared to state population percentages.*
*** This number likely includes Hispanics/LatinX*

When looking at racial and ethnic demographic data, Hispanics/LatinX have been the most likely to contract COVID, and African Americans have been most likely to die of it in Florida when looking at cases and deaths per 100,000 individuals.

Florida's Department of Health and Department of Emergency Management have been tasked with the response to COVID cases in the state. The DoH is in charge of contact tracing, and also houses a public call center for COVID-related questions. The private company MAXIMUS was hired by the state to hire 400 more contact tracers, but it appears county health departments have also been setting up their own contact tracing efforts. The Department of Emergency Management is handling testing capacity, and has thus far been in charge of securing and organizing supplies. In addition to California, Florida has been tapped by the CDC to conduct a pilot of vaccine distribution.

Community Health Worker Workforce Overview

In Florida, the CHW workforce is organized by the Florida CHW Coalition, which serves as a partnership of CHWs across the state and was a result of a grant from the Department of Health examining best practices for CHWs. CHWs are typically hired by CBOs, Medicaid MCOs, and FQHCs, some of whom conduct their own training. Training is also offered from the AHEC network of schools, who are supported by the Florida AHEC Network, which oversees all AHEC training centers. The Florida Certification Board provides oversight for their approved education providers who conduct trainings for certain CHWs, but there are other organizations in the state who have their

own accreditations. Certification for CHWs in Florida is not mandatory.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reported that there were 3,120 CHWs in the state of Florida as of May 2019. According to the Florida CHW Coalition, they currently have 1,030 members, which may suggest the Coalition is not reaching a majority of CHWs in Florida. This could also be a reflection, however, of differing roles or considerations for CHWs, because they are housed at mostly separate, independent organizations. A report from 2015 that examined the CHW statewide census found that there was a lot of eagerness from CHWs to become certified and join the Coalition.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, Florida would receive 50,916 workers, or 5.09% of total workers being allocated nationwide.

Recommendations

Particularly over the summer, Florida saw an explosion of COVID cases that clearly disproportionately impacted racial and ethnic minorities in the state. The state already has a fairly deeply-connected coalition for CHWs, but especially if the state will be receiving thousands more, it requires a deeper connection with the state. It appears the coalition was formed with funding from the Department of Health, but engagement has been lacking since then. The workforce is evidently scattered across various CBOs and FQHCs, but is needed now at a more centralized organization to respond to COVID needs. Palm Beach County has noted they have hired CHWs to be present at testing sites to do education and referrals, but beyond that there are no concrete examples of CHWs being implemented during this crucial time. Especially if Florida is a pilot state for vaccine distribution, they will need organization around messaging that CHWs can provide, and that messaging needs to be more centralized from a joint CHW organization.

Georgia

COVID-19 Data and Response Strategy

Georgia Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020		
State/County	**Total COVID-19 Cases**	**Cases Per Day in the Week Prior to November 17th**
Georgia	410,518 cases	2,619 cases (24.7 per 100,000)

The focus populations for the state of Georgia are African Americans, Hispanics, and Migrant Workers. Georgia has the highest amount of workers on H2-A guest worker visas, with 12% of their workforce being on visas for over 200,000 seasonal migrant workers in 2018.Since the beginning of the pandemic, there have been at least 410,518 COVID-19 cases and 8,740 deaths in Georgia as of November 17. Over the past week, the state has seen an average of 2,619 cases per day, or 24.7 cases per 100,000 individuals.

Georgia COVID-19 Cases by Race		
Race	**% of Total Population**	**% of Total Cases**
White	53%	45%
African Americans	31%	34%
Asian Americans	4%	2%

Hispanics/LatinX	9%	16%
American Indians/Alaskan Natives	<1%	<1%
Native Hawaiians/Pacific Islanders	<1%	<1%

When looking at racial and ethnic demographic data, Native Hawaiians and Pacific Islanders have been most likely to contract COVID and die from it in Georgia when looking at cases and deaths per 100,000.

In response to these numbers, the Georgia Department of Public Health has been put in charge of contact tracing, using both new hires and their previous staff. The DPH's Emergency Preparedness and Response arm is holding weekly calls with healthcare providers and public health entities to organize a united response. For contact tracing, private company MTX developed an online monitoring platform for the DPH. For a COVID vaccine, the Governor is currently putting together a task force to organize a distribution program and awareness campaign, led by Insurance Commissioner John King.

Community Health Worker Workforce Overview

The state of Georgia currently has no state legislation or certification standards for their CHW workforce, but in recent years has gotten more involved in CHW workforce-related efforts. In 2017, the Department of Health, in partnership with the Morehouse School of Medicine and Kaiser Pemanente, co-sponsored a CHW Forum, which produced a CHW Advisory Board and an Advocacy Coalition. Georgia Watch, the state's primary organizing and advocacy arm for CHWs, serves on the board and in the coalition. Georgia Watch gathers training and certification recommendations, and recently recommended statewide certification for CHWs. The Morehouse School of Medicine, in addition to being on the Advisory Board, also provides trainings for CHWs.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reported that as of May 2019, Georgia had 1,200 CHWs currently employed in the state. Considering that the forum from 2016 on CHWs organized by the DPH, the first one held in the state, was attended by 130 stakeholders, that is a large number of current CHWs. The DPH along with the Advisory Board and Advocacy Coalition has continued to organize forums in the last 4 years, and the forums are evidence that partners from across the state are dedicated to forwarding the work of CHWs. The Advisory Board and Advocacy Coalition have previously put out, and continue to produce recommendations for the workforce, but those recommendations have not yet been translated into practice.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, Georgia would receive 25,159 workers, or 2.52% of total workers being allocated nationwide.

Recommendations

Thanks to the work of Georgia Watch and other CHW organizations, state officials are now well-versed in the needs and strengths of the Georgia CHW workforce. The collaboration between the Advisory Board and the state was cut short this year, but the Advisory Board and Advocacy Coalition have provided ample material for the state to consider that would expand the abilities of the workforce. It is important that the state adopt these recommendations now, so that the workforce can begin to tackle the disproportionate burdens of COVID on racial and ethnic minorities, and prepare for the expansion of the workforce by the thousands

who as of now would not have centralized roles or training.

Louisiana

COVID-19 Data and Response Strategy

Louisiana Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020 by State and Focus Parishes		
State/ Parish	**Total COVID-19 Cases**	**Daily Average for the Week Preceding November 17th, 2020**
Louisiana (total state)	205,059 cases	1,670 cases (35.9 per 100,000)
East Baton Rouge Parish	17,952 COVID cases (4,079 per 100,000)	174.9 cases (39.7 per 100,000)
Jefferson Parish	20,193 COVID cases (4,669 per 100,000)	139 cases (32.1 per 100,000)
Orleans Parish	14,593 COVID cases (3,740 per 100,000)	107 cases (27.4 per 100,000)

Since the beginning of the pandemic, there have been at least 205,059 COVID-19 cases and 6,139 deaths in Louisiana as of November 17. Over the past week, the state has seen an average of 1,670 cases per day, or 35.9 cases per 100,000 individuals.

Louisiana COVID-19 Cases by Race		
Race	**Total % of the population**	**% of COVID-19 Cases***
White	62%	45%
Black or African American	32%	39%
Asian American	2%	6%
Hispanic/ LatinX	n/a	n/a**
American Indians/ Alaskan Natives	<1%	<1%
Native Hawaiians/ Pacific Islanders	<1%	<1%

**% of COVID-19 cases based off of deaths per 100,000 individuals*
*** Louisiana does not report COVID-19 case numbers for Hispanics/LatinX*

When looking at racial and ethnic demographic data, Native Hawaiians and Pacific Islanders are the most likely to have contracted COVID and to have died of it in Louisiana when examining cases and deaths per 100,000 individuals. African Americans and Asian Americans have disproportionate cases of COVID-19.

Louisiana's main COVID response actor, the Department of Health, has hired out to five companies to conduct recruitment of contact tracers. Oversight of the contact tracing training and management has been given to Louisiana State University's Stephenson Disaster Management Institute. The DoH is also considering using its Immunization Program to create guidelines for COVID vaccine providers. Louisiana is also hosting three vaccine trial sites, one for the Pfizer vaccine at the Ochsner Health System, and two for the Moderna vaccine at Meridian

Clinical Research in Baton Rouge and Benchmark in Jefferson Parish.

Community Health Worker Workforce Overview

The CHW workforce in Louisiana is supported by two main organizations: the Louisiana CHW Institute and the Louisiana Community Health Outreach Network (LACHON). LACHON is the main organizing arm for CHWs across the state, is run primarily by CHWs, and frequently convenes CHWs for development. The Institute works with LACHON and employers of CHWs to provide technical assistance for CHW programs and trainings. In 2019, members of both organizations were involved in a workforce study put on by the Louisiana legislature to learn more about best practices for CHWs. The Workforce Study Committee, who produced a report in 2020, will likely be transformed into a working group that will continue to provide guidance to the state on the CHW workforce. The study did not support statewide certification at the time it was published, but the Institute provides core competency trainings for all CHW programs.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reported the state of Louisiana had 600 employed CHWs as of May 2019. Similar to other states in this report, CHWs in Louisiana are housed in a variety of different occupational settings, and the Workforce Study report from 2019 shows CHWs have many different roles and responsibilities within the state. The existence of the study and the presence of the Institute and LACHON give evidence that the workforce has a crucial role within the state that state officials would like to examine further. However, like Georgia, it is crucial as well that the state follows through on the recommendations from the study and steps in where the Institute and LACHON may not be able to.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, Louisiana would receive 20,782 workers, or 2.08% of total workers being allocated nationwide. When looking at allocations of workers according to the number of COVID cases per 100,000 individuals, East Baton Rouge Parish would receive 193 workers, or 0.93% of workers statewide. Jefferson Parish would receive 200 workers, or 0.96% of workers statewide, and Orleans Parish would receive 192 workers, or 0.92% of workers statewide.

Recommendations

Similar to Georgia, Louisiana state officials have very recently received guidance and recommendations from CHW organizations, but have yet to implement those changes. CHWs in Louisiana still work for a wide array of separate organizations, and the state has not yet fully taken advantage of reimbursements from Medicaid expansion. Parts of the state are very high on the social vulnerability index, and those numbers were gathered prior to our current public health crisis. The state should adopt recommendations from LACHON and the Institute as quickly as possible, and then work on incorporating the workforce into COVID relief for racial and ethnic minorities in the state. The state at one point over the summer hired 12 CHWs to assist with contact tracing, but that is a small number that workforce organizations had to push for. If thousands more workers are to be effectively engaged, they will require greater input and support from the state.

Navajo Nation

COVID-19 Data and Response Strategy

Navajo Nation Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020		
Nation	**Total COVID-19 Cases**	**Cases Per Day in the Week Prior to November 17th**
Navajo Nation (total)	13,596 cases	121.5 cases (69.5 per 100,000)

Since the beginning of the pandemic, there have been at least 13,596 COVID-19 cases and 603 deaths in Alaska as of November 17. Over the past week, the state has seen an average of 121.5 cases per day, or 69.5 cases per 100,000 individuals.

The Department of Health and IHS have been leaders in COVID response for the Navajo Nation. The DoH's Health Command Operations Center is the lead on contact tracing and community response, and IHS facilities have been where community members have actually been treated for the virus. Community Health Representatives have been engaged in the effort as well, spanning rural geographic areas to ensure coverage and serving on case investigation teams. For a potential vaccine, Pfizer also has a trial site for its vaccine in the Navajo Nation.

Community Health Worker Workforce Overview

As mentioned previously in this report, the Navajo Nation has had an established Community Health Representative program since 1968, created to provide direct home care, community outreach, and health education to Navajo Nation members who are typically disconnected from the healthcare system. All CHRs are certified nurses and first responders, and there are specific programs for addressing STIs, oral health, tuberculosis, and maternal and child care. The Department of Health currently runs the CHR program, with funding from the Indian Health Services (IHS). Certification outside of the CHR program is difficult because the Navajo Nation spans the three states of New Mexico, Arizona, and Utah, and each state has their own system for CHWs. New Mexico has the most robust system: after putting a committee together (which included members of the Navajo Nation) to decide on certification in 2014, they have offered voluntary certification as of 2019. COPE, a joint initiative of the CHR program, IHS, Brigham and Women's Hospital, and PIH, have been working with CHRs to get them certified in New Mexico. COPE is involved with aspects of training and advocacy for the CHR program.

Workforce Challenges and Opportunities

With such a well-established program already in place, and with CHRs already being incorporated into COVID response, the Navajo Nation is ahead of many states in terms of effective community-based response to COVID and strong workforce infrastructure. However, the CHR program faces challenges that all rural health programs face in terms of servicing disparate communities who face many barriers to access to care, and these challenges are exacerbated by the extreme lack of resources available to many communities within the Navajo Nation. Support from COPE has helped to lessen the burden of these disparities in resources and access to care, but as can be seen from COVID spikes within the Navajo Nation, grave disparities remain. Even with a workforce that is experienced, well-trained, culturally competent, and grassroots, it is clear their response cannot be robust without proper support from the federal government via IHS funding. In recent years, the Navajo Nation has written grant proposals to generate funding outside of IHS, which they have to refile for each year. It is crucial that such an important community-based workforce like the CHR program be sustainably funded.

Mapping the New Politics of Care and Other Data

It should be noted that the Social Vulnerability Index, County Health Rankings, and Mapping the New Politics of Care Project do not organize data by Indigenous tribes, so while it is possible to collect data on the counties which make up the Navajo Nation, there is no data currently representing the health challenges and opportunities specifically present in the Navajo Nation. This lack of specified data leaves members of the Navajo Nation marginalized in county and state-wide responses such as that proposed by the Mapping the New Politics of Care project, and is inappropriate considering the Navajo Nation and many other Indigenous tribes organize public health responses through their own systems, typically supported by Indian Health Services at the federal level. In order for programs like the CHR program to mount an effective response to issues like social vulnerabilities, they should be recognized as independent entities in data collection like that done by the CDC's SVI. Instead, they are left out of data collection on this kind of scale, and must collect representative data on their own. This approach is particularly problematic for Mapping the New Politics of Care numbers, because according to the current paradigm, either the CHR program would receive CHWs as part of the allocation and would have to work through incorporating them into the well-established and culturally significant CHR program likely without much support, or the CHR program would be left out of consideration entirely and CHWs would be allocated to states, where their certification would not match the requirements of the CHR program. In either case, considerations and allocations of this scale without appropriate consideration of Indigenous nations as sovereign states means their specific needs and requirements will not be met.

Recommendations

Because of its well-established role, the CHR program has been a hugely important resource for the Department of Health to lean on during the pandemic, as case numbers have exploded at certain points in the Navajo Nation. However, CHRs have documented a huge lack of resources that is impacting people's ability to isolate or support themselves. Despite their long seated relationship to public health infrastructure, the CHR program still requires greater support to continue their work completing house visits and reaching rural populations. The IHS must also not forget the Hopi tribe, who live within the Navajo Nation and are even more burdened by COVID and struggling with a lack of resources. The Hopi tribe also have utilized CHRs to do house visits and have also conducted interviews for mass education campaigns, but they require much more support if they are to effectively contain the virus. Additionally, as mentioned above, data collection at a county and state level must recognize the Navajo Nation as sovereign, collect data specific to the nation, and involve tribes in conversations around data such as SVI and Mapping the New Politics of Care to ensure the Navajo Nation are able to reap the benefits of this kind of data and are not marginalized in these processes.

Texas

COVID-19 Data and Response Strategy

Texas Total COVID-19 Cases and Daily Averages for the Week Preceding 11/17/2020 by State and Focus Counties		
State/ County	**Total COVID-19 Cases**	**Cases Per Day in the Week Prior to November 17th**
Texas	1,101,719 cases	10,749 cases (37.1 per 100,000)
El Paso County	76,075 cases (9,065 per 100,000)	4.7 cases (22.5 per 100,000)
Moore County	1,545 cases (184.1 per 100,000)	4.7 cases (22.5 per 100,000)

Since the beginning of the pandemic, there have been at least 1,101,719 COVID-19 cases and 20,157 deaths in Texas as of November 17.

For racial and demographic data, Texas has only reported that data for 5% of cases in the state. Based on current data and on more robust data for deaths, African Americans are most likely to have contracted COVID, and Hispanics/LatinX are most likely to have died from it in Texas based on the number of cases and deaths per 100,000 individuals.

Similarly to other states, Texas' main state health apparatus, the Department of State Health Services, is in charge of COVID response. Earlier in the pandemic, contact tracing as a response was left to local health departments to organize, but the DSHS now runs Texas Health Trace, an online database created by the tech start-up MTX, which local health departments can opt into. The University of North Texas is another CEAL recipient, and is currently conducting outreach and engagement efforts with racial and ethnic minority communities. Texas will also involve a private company, the McKesson Corporation, into the logistics planning for a vaccine. The plan from the DSHS is for healthcare providers to register with the DSHS' Immunization Program, and providers must agree to distribute a vaccine regardless of a patient's ability to pay.

Community Health Worker Workforce Overview

Similar to Alaska, Texas' state legislature has had a large impact on the CHW workforce. The legislature passed a bill in 1999 establishing the Promotor(a) Program Development Committee, and then passed another bill in 2001 calling on the Department of State Health Services to establish a CHW training program and a Promotora and CHW Training and Certification Advisory Committee to advise the DSHS. The Advisory Committee assists the Texas HHS Commissioner in organizing the state-run certification program, which is offered at various community colleges, AHEC schools, and CBOs. The latest workforce study was conducted in 2011, but the DSHS produces a report every year on the current state of the CHW workforce. Outside of state-connected groups, there is also the Texas Association of Promotoras and CHWs, which aims to expand and support work of CHWs and organizes annual conferences and membership.

Workforce Challenges and Opportunities

The U.S. Bureau of Labor Statistics reported the state of Texas had 2900 employed CHWs as of May 2019. Texas' Statewide Health Coordination Council also reported on CHW demographics in 2019, and reported the state had 4,122 licensed CHWs. This discrepancy may indicate that the state internally has a better count of CHWs than the numbers state officials generate for national reporting. The discrepancy may also be a result of the fact that while the DSHS reports on the CHW/Promotora workforce each year, there has not been a workforce study since 2011, which could result in an inaccurate account of licensing for CHWs. The support and organization from state health officials around CHWs in Texas is very robust, but CHW/Promotora organizations still struggle to convey to health officials what their purpose is and how they can be best engaged, especially during the current pandemic.

Mapping the New Politics of Care Data

According to the data coalesced into the Mapping the New Politics of Care project, Texas would receive 58,407 workers, or 5.84% of total workers being allocated nationwide. When looking at allocations of workers according to the number of COVID cases per 100,000 individuals, El Paso County would receive 1,434 workers, or 2.46% of workers statewide. Moore County would receive 335 workers, or 0.57% of workers statewide.

Recommendations

Despite the long history of state engagement with the CHW workforce in Texas, it is clear from CHWs and promotoras working in the state that state officials still do not understand the strengths or proper roles of CHWs. Community based organizations are struggling to make their case for greater resources as they become overworked with the amount of cases particularly affecting Spanish-speaking and migrant populations. The cities of Austin and Houston have put together programs that would incorporate CHWs into contact tracing and community response, and the entire state should consider support and engagement of that nature for such a robust workforce already present in the state.

Listening Sessions

Purpose

NACHW engaged our members, partners, and selected associates of the NCRN project to understand the current role of CHWs in COVID-19 response in the Five Priority Communities, to understand the capacity of the partners, to identify potential barriers or challenges and opportunities for partnership. Our Listening Sessions, and the following section on Key Informant Interviews, were conducted in alignment with the Office of Minority Health CLAS Standards, which prioritizes building trust through engaging communities, ensuring transparency, increasing equity, monitoring trends in disparity, and preparing to respond "to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

Methods

The scope of this scan required a methodological approach that addressed the need for the findings to be relevant to NCRN funders, leadership and partners across the country generalizable, yet focused on geographic, cultural and CHW workforce contextual factors defined by the NCRN Phase One target communities and applicable to the scope of NACHW.

NACHW is well positioned to conduct Listening Sessions in the NCRN Five Priority Communities due to our diverse membership which spans all of Morehouse's initial Five Priority Communities and target populations. In addition, NACHW has Board Members and NACHW member ambassadors in six of the eight states which the initiative targets. This allowed us to assemble highly diverse groups of CHWs, CHW Network representatives, and other public health partners with identities and expertise which aligned with many of Morehouse's focus populations.

NACHW Members, Board Members and Ambassadors in NCRN Priority Communities (Phase 1)

State/ Tribal Nation	NACHW Members	NACHW Board Members and Ambassadors
Alaska	2	n/a
California	20	Lily Lee (Board Member) Maria Lemus (Board Member)
Florida	8	n/a
Georgia	24	Durrell Fox (Board Member) Lisa Renee Holderby-Fox (Board Member) Adrianne Serrano Proeller (Ambassador)
Hawai'i	20	Nicole Moore (Ambassador)
Louisiana	13	Catherine Haywood (Board Member) Ashley Wennerstrom (Board Member)

Navajo Nation	3	Mae-Gilene Begay (Board Member)
Texas	96	Carl Rush (Board Member) Ricardo Garay (Board Member) Dolontria Bryant-Williams (Ambassador)

filtering membership and partnership data, we received inquiries from partners across the country about the Morehouse NCRN initiative and invited them to attend. During the

Listening Sessions, we administered a semi-structured listening session question guide and conducted one hour and/or 90-minute sessions with participants in the following Five Priority Communities; Louisiana, California, Texas, Alaska, Hawai'i, Georgia and Florida. One to two note takers were present in each listening session, listening session notes were reviewed by focus area for themes and learnings, note takers compiled a matrix aggregating themes and learning across all Five Priority Communities for deeper analysis and then the narrative was developed. Responses were de-identified at the individual level. When appropriate organization types (national, regional, member association, etc.) were used as identifiers to provide additional context. Quotes and/or summary analysis were identified by state or region.

Listening Sessions				
Location	**Date**	**Organizations Present**	**# of Participants**	**Amount of Time**
Louisiana	10/9/20	LACHON	29	60 minutes
California	10/16/20	Vision y Compromiso El Sol Neighborhood Educational Center	4	90 minutes
Texas	10/28/20	Texas Tech University Science Center Texas Association of Community Health Workers (TACHW) University of Texas Austin	5	90 minutes
Alaska	10/29/20	Alaskan Office of Rural Health	1	60 minutes
Florida & Georgia	10/30/20	Florida CHW Coalition Roster Health John Snow, Inc (JSI) Healthy Start Coalition of Jefferson, Madison, and Taylor Counties	5	90 minutes
Georgia*	12/1/20	Georgia CHW Coalition Georgia Watch	83	60 minutes
Hawai'i	11/19/20	KCC Community Health Program Kauai District Health Office CHW Dual Special Needs United Health Care D-SNP community Lanai Community Health Center HMONO Ka'u Rural Health Community Association	48	90 minutes

**NACHW with NCRN partners presented at the December Georgia CHW Coalition Call*

Questions asked at the Listening Sessions:

1. What questions come up for you right away about this Morehouse NCRN initiative?
2. Are there other local, parish, county or state COVID-19 initiatives that are being implemented now that this Morehouse NCRN initiative should partner with or should be aware of?
3. In what ways might this initiative be beneficial to CHWs, your organization or to your communities and partners?
4. In what ways might this initiative be harmful to CHWs, your organization or to your communities and partners?
5. Describe some specific resources, strategies or approaches you would like to see in the Morehouse NCRN provides for you, your organization or your community.
6. How can NACHW support you and/or your organization to be informed and engaged in this NCRN initiative?
7. What other questions should we be asking of CHWs, Networks and partners in NCRN target communities?

Question 1- Initial Throughs on the NCRN

The first question posed to attendants was "What questions come up for you right away about this Morehouse NCRN initiative?" This question was designed for an initial brainstorm to get participants' reactions after a brief overview of the Morehouse NCRN had been provided. Participants across listening sessions in various locations asked how the initiative will be administered, fundamental questions about the objectives, and the approach the initiative will encompass. Participants elevated questions about leveraging existing assets, collaboration at the local level, and wanted to know more about why Morehouse was driven to do this work.

In Louisiana, there was focused concern about the COVID-19 vaccines and specific questions were asked about how this initiative will support the rollout of the vaccine and why certain vulnerable communities are being identified as the subjects for clinical trials. One respondent asked, "Aren't our lives valued more than "test dummies"?" (Louisiana).

Recommendations resulting from this question focused on the positive opportunity for Morehouse to incorporate local branding to make the initiative more recognizable by the local community and build trust (California). The following topics were generated out of this question:

- Could the NCRN fund initiatives which are already successful? (Alaska, California, Florida & Georgia)
- What is the NCRN role in vaccine distribution and developing information? (Louisiana)
- How are the surveys being administered? (Louisiana)

Question 2- Local COVID-19 Initiatives in Focus Area

The participants were next asked "Are there other local, parish, county or state COVID-19 initiatives that are being implemented now that this Morehouse NCRN initiative should partner with or should be aware of?" This question was designed to gage the actors and organizations already doing work surrounding COVID-19 in a given focus area. Participants elevated various government efforts, community networks, CHW associations, and other medical schools, which have been effective in their COVID-19 outreach efforts (Alaska, Louisiana, California, Texas). The list of current organizations which participated named are the following:

- Community Health Aide Program (CHAP) (Alaska)
- ECHO (Alaska)
- FQHCs (Alaska).

- New Orleans Dept of Health, Resilience Corps (Louisiana)
- City of New Orleans Office of Emergency Prep. (Louisiana)
- GOLDEN CHANGE, INC. (Louisiana)
- Visión y Compromiso - LA (California)
- Migrant Clinicians Network (Texas)
- Foster Medical School - El Paso (Texas)
- Paso del Norte Foundation (Texas)
- Texas Rural Health Association (Texas)
- Texas Tech University Health Sciences Center TTUHSC (Texas)

Question 3- Possible Benefits of the NCRN

Attendees were then asked, "In what ways might this initiative be beneficial to CHWs, your organization or to your communities and partners?" The purpose of this question was to encourage participants to think of possible ways their organization or community could partner or benefit from the NCRN initiative. Participants responded positively to the prospect of the proposed app with local/regional resources and suggested it would be beneficial if the NCRN could fund or partnering with local COVID-19 initiatives.

Many organizations from various states all commented that their CHWs did not have any centralized method of culminating social services and community resources, they named the app of services as potentially one of the biggest benefits of the initiative (Texas, Florida & Georgia, Louisiana).

"Being able to provide real referrals and solutions to the public is necessary - it is not enough to collect data and capture needs" (Texas).

One participant from Alaska felt that their government and specifically the governor's office already had a strong centralized messaging system, which was being supported by their CHW and rural health programs, but felt that the NCRN could be beneficial if it had the flexibility to provide additional supplies for the successful programs (Alaska). Other states also thought it would be beneficial if the initiative could partner or fund existing programs which already gained the trust of the community (Florida/Georgia, Texas).

- Funding or partnering with other local initiatives which are under resourced
- An app which could provide centralized resource and community

Question 4- Possible Harms of the NCRN

The fourth question posed to our participants was "In what ways might this initiative be harmful to CHWs, your organization or to your communities and partners?" The purpose of this question was to understand the possible harms the initiative could have on existing COVID-19 programs or initiatives and reveal any hesitations attendees had about the proposed program. The listening sessions revealed that participants were concerned about possible conflicting messages in the community, taking focus away from local successful COVID-19 programs, distrust of medical/academic institution from vulnerable populations, overburdening CHW with keeping up with the NCRN initiative, that this could be a "helicopter" solution without addressing the long-term, underlying disparities within the community, and concern about lack of clarity from Morehouse (Texas, Alaska, Georgia/Florida).

Most representatives from different areas cited concern about over-burdening or over relying on CHW to implement the initiative. Multiple attendees also expressed concern that this initiative would be a "helicopter solution" which drops into an area to help, without addressing existing inequalities while conflicting or over-shadowing local initiatives who have done previous work to gain trust of the focus communities (Texas, Florida/Georgia, Alaska).

"Lots of people don't identify as CHWs even though they are. This can then over burden people and overwhelm them. Especially when CHWs have their families and COVID to worry about in addition to the communities that they are trying to support" (Georgia/Florida).

Attendees from Louisiana elevated concerns from the community regarding COVID-19 vaccinations and these fears are aggravated by mistrust of medical/academic institutions by the vulnerable focus communities. Some Louisiana participants felt that there should not be an over-reliance on vaccinations, and instead a greater focus on mitigating COVID-19 through other methods (Louisiana). Most participants were concerned over the lack of concrete details about goals and methods from Morehouse, and felt like that uncertainty would be a barrier for communities/organizations to volunteer to be involved (Texas, California, Florida/Georgia, Alaska).

- Possible Conflicting Messaging
- Mistrust of medical/academic institutions
- Overburdening CHWs
- Concern over the lack of detail from Morehouse

Question 5- Suggested Strategies for the NCRN

The next question posed to attendees was "Describe some specific resources, strategies or approaches you would like to see in the Morehouse NCRN provides for you, your organization or your community." This question was designed to engage participants in what strategies or resources the attendee would find useful or beneficial from the NCRN initiative. Common themes which emerged were the necessity of a grounded approach, taking into account the needs and experiences of those living and working within the target communities (all), partnering/funding local programs addressing COVID-19 (Texas, Florida/Georgia), and flexibility with the use of technology (Alaska, Hawai'i).

Some participants were concerned about Morehouse's focus on technology and felt like this might alienate some rural communities who do not have access to certain technologies, especially broadband internet, and therefore if the initiative wants to work in those remote areas, they would need to be flexible with their reliance of technology as a dissemination tool (Alaska, Texas, Hawai'i). There were several other more specific methods suggested, such as utilizing faith based leaders and providing detailed breakdowns of vaccine information and developments (Louisiana, Hawai'i).

All participants who attended a listening session specified the need for the NCRN to be heavily influenced by the needs of the given community. Many other stakeholders also mentioned that it would be useful for Morehouse to partner or fund local initiatives, in order to avoid conflicting messaging and to capitalize off of the groundwork set by local CHW and public health organizations (Alaska, Georgia, Florida, California).

"(The initiative needs to be) in the advice and experiences of the most underserved individuals to effectively identify areas of need" (Texas).

- Grounded approach, following the lead of community members
- Partnering/funding local COVID-19 programs
- Flexibility in the use of technology
- Partnering with faith-based leaders
- Providing vaccine information

Question 6- Engagement with the NCRN

Participants were then asked "How can NACHW support you and/or your

organization to be informed and engaged in this NCRN initiative?" This question was designed to understand the way our members and partners wanted to be involved with NACHW and the NCRN. Participants preferred to get updates on the NCRN initiatives from NACHW, they wanted NACHW to obtain more information about the NCRN and its goals, and for NACHW to continue reaching out and prioritizing the voices of CHWs in the focus communities (Alaska, Texas, Louisiana, Georgia/Florida).

Most of our attendees stated that they preferred to get updates on the NCRN from NACHW, through emails or occasional meetings, because they have a previous relationship and trust built (Louisiana, Texas, Georgia/Florida). Many of our participants felt that there was not enough specific information about the methods and goals of the NCRN for them to sign up directly with Morehouse, and therefore they preferred to receive information from NACHW (Texas, Alaska, Georgia/Florida).

"Keep taking the time to listen to CHWs and people like us so that we are in the loop" (Georgia/Florida).

- Connecting CHWs through NACHW because has earned trust through local CHWs
- Find out more about the Morehouse initiative
- Listening/prioritizing people living/working in those communities

Question 7- Other Questions about the NCRN

The last question posed to our attendees was "What other questions should we be asking of CHWs, Networks and partners in NCRN target communities?" This question was meant to inform what questions NACHW should elevate with our contacts at NCRN. Participants asked a variety of questions without many emerging themes.

- Do those communities have access to technology? Or even just access to broadband internet? (Alaska)
- Will CHWs be required to receive the vaccine in order to continue doing the work? (Louisiana)
- What's the incentive for the CHWs, Networks and partners in the initiative? What's in it for the target communities? (Louisiana)
- Will this be sustainable? (Texas)

Summary Findings from Listening Sessions

Through our listening sessions, we have found that CHWs feel they were largely left out of the COVID-19 response, especially in regard to contact tracing. CHWs are often overburdened, underpaid, lack administrative and professional development, and these challenges are magnified due to the COVID-19 pandemic. Across regions, communities have developed successful local/community initiatives for COVID-19, but due to a lack of funding and coordination there are gaps in coverage and resources. Many CHWs and other stakeholders emphasized the importance of a grounded approach, centering and following the guidance of the community. There were concerns from CHWs and allies about the NCRN being a "helicopter solution," which inserts programs/money to address the symptoms of issues (in this case COVID-19), without working towards alleviating the underlying systemic problems which cause the disproportionate health outcomes in disadvantaged communities. Many regions had positive feedback about the possibility of an app with a centralized list of thorough and detailed social services. But other, more rural regions, had concerns about the reliance on technology for communities who lack the infrastructure and/or the technological literacy.

Key Informant Perspectives on Challenges and Strategies to Partner & Engage Populations of Focus

Purpose:

In the last ten years, the US has increasingly become more diverse due to lowering birth rates for Whites and immigration being at its highest rate since 1910. While this diversity brings strength and cultural multiplicities, systematic racism has caused large health disparities for many groups in the US. These health disparities coupled with the COVID-19 pandemic have caused many different communities to be disproportionately impacted.

The Priority Communities for the Morehouse NCRN are highly diverse, it will be a challenge to create one initiative for all the needs of these diverse communities. During our key informant interviews with national partners, unique aspects of the experiences of the preference and challenges were highlighted, this section is emphasizing equity and inclusion, centering community voices, deep understanding of cultural and health beliefs, in keeping with Office of Minority Health CLAS Standards. This section discusses the Navajo Nation, the Hopi Nation, Alaskan Natives, Pacific Islanders, Asian American immigrants and refugees, LatinX frontline and migrant workers, those recently released from prisons and jails, and patients and Patient Advocates.

Methods:

In order to create a deep understanding of cultural and health beliefs of various populations NACHW embarked on a series of semi-structured Key Informant Interviews with various partner organizations, in addition to supporting research from webinars, policy, academic research, and other data sources.

Key Informant Interview Information by Focus Population and Partner Organization			
Focus Population	**Partner/Organization**	**Date**	**Length of Session**
Navajo Nation	Community Health Representative Program	10/20/20	60 minutes
Hopi Nation	n/a*		
Alaskan Natives	Alaskan Office of Rural Health	10/29/20	60 minutes
	Community Health Aide Program (CHAP)	11/25/20	60 minutes
Pacific Islanders	National Pacific Islander COVID-19 Response Group	11/10/20	60 minutes
Asian American Immigrants and Refugees	n/a*		
Latino Frontline Workers	University of Texas, El Paso (UTEP) The National Latino Behavioral Health Association (NLBHA)	11/6/20	90 minutes
Re-entry Community	n/a*		
Patients/Patient Advocates	National Patient Advocate Foundation (NPAF)	11/23/20	60 minutes

**For these groups, instead of a Key Stakeholder Interview, research was done on the group.*

Navajo Nation

The Navajo Nation is one of over 570 Indigenous tribal nations in the US. Across the country, tribal nations have faced unique connectivity, information, resource challenges in the pandemic. In preparation for our listening sessions, we reached out to a contact in the Navajo Nation who is a prominent Community Health Representative. Our contact was concerned that Morehouse had not formally reached out to the Navajo Nation's government when they were selected as a focal population.

As part of our research, we attended a webinar entitled "COVID-19 and Native American Health: How Tribal Leaders Are Beating Back the Virus" hosted by the U.S. News & World Report with panelists from the IHS, the Chippewa tribe, and President Jonathan Nez of the Navajo Nation. In this webinar, President Nez emphasized the necessity of sovereignty and self-determination in regard to mitigating COVID-19, due to the Navajo Nation's specific risk factors, resource concerns, and cultural differences. President Nez elevated the fact that Navajo Nation residents are disproportionately vulnerable to COVID-19 due to health disparities including, high rates of alcoholism, diabetes, obesity, cancer, chronic liver disease, and HIV/AIDS. He also cited the fact that between the 1940's and the 1980's the US mined uranium within the bounds of the Navajo Nation, this has led to continued kidney failure and cancer. Recent studies suggest traces of uranium are still common in newborn babies and is likely the cause of many ongoing health disparities in the Navajo Nation.

President Nez also highlighted the challenges people of the Navajo Nation face in regards to COVID-19 prevention due to lack of access to clean running water and electricity. The Foundation for Economic Education reports that "On the Navajo reservation, 32 percent of homes lack electricity, 31 percent lack plumbing, 38 percent lack running water, and 60 percent lack telephone services." At the current rate of electric installation, it would take 35 years to connect the entire Navajo reservation to electricity. According to Indian Country Today, 43% of the Navajo Nation live below the poverty line.

As described in the Navajo Nation section of the Environmental Scan, the Navajo Nation has a CHW program called Community Health Representatives (CHR). CHRs can be found in many tribal nations, and each program is closely tied to the specific tribe and their cultural beliefs and understandings. The representatives are likely to come from the tribal nation they are serving. The Community Health Aide Program (CHAP), described in the section on Alaska, has begun to be introduced in the lower 48 for various tribal nations and reservations. The CHR and the CHAP programs are both funded through Indian Health Services (IHS). The two programs differ because CHAP usually requires more medical training than the CHR program. In addition, the CHAP program is national and may place aides with communities they do not come from.

- The NCRN should reach out to the government of the Navajo Nation and elders for approval, in order to respect sovereignty
- The Navajo Nation prioritizes sovereignty and self-determination, especially when dealing with COVID-19
- The Navajo Nation have high rates of pre-existing conditions making them disproportionately vulnerable to COVID-19
- The Nation lacks infrastructure which would be make COVID-19 prevention easier (running water, electricity, ect)
- Any CHW initiative undertaken in the Navajo Nation should be partnering with and default to the expertise of the CHR program, and take into account the presence of CHAP

Hopi Nation

Two articles (I, II) from the CDC profile the Hopi Nation, COVID-19 impact on their nation, and their response. The Hopi Nation is a sovereign nation located in the middle of the Navajo Nation occupying 1.5 million acres. It has approximately 7,500 people spread across 12 villages. During April to June 2020, the Hopi Health Care Center (HHCC, an Indian Health Services facility) reported 136 COVID-19 cases in the Hopi nation with 27 requiring hospitalization. In order to mitigate the spread of the virus, the Hopi Nation in partnership with the CDC deployed Community Health Representatives (CHRs) and volunteers to two villages to provide information and testing.

- This nation has its unique challenges apart from the Navajo Nation, Morehouse will need to respect the sovereignty and unique attributes of every tribal nation

Alaskan Natives

Alaskan Natives and their needs vary greatly from Indegenous peoples on reservations in the continental US. On most reservations in the US, medical care comes mostly through Indian Health Services (IHS) or residents have to leave the reservation to access other medical care. In Alaska, while Alaskan Natives do control some land, there are not that same "reservation" structures that, for example, the Navajo Nation has. This means for medical care, Alaskan Natives are more likely to be utilizing both IHS and the regular Alaskan healthcare system. In addition, due to the rural nature of Alaska's general population and Native population, non-native individuals also can use services from IHS. This means when working towards mitigating COVID-19 rates in Alaskan Native communities, special attention must be made towards the unique healthcare system and positionality of Alaskan Natives.

As described in the Alaska portion of the Environmental Scan, Alaskan Natives rely heavily on the Community Health Aide Program (CHAP), run through IHS, this program has its own training and evaluation system. Any CHW initiatives in Alaska should work closely with CHAP to identify their needs and respect their expertise.

- Identifying and taking into account the difference in healthcare systems between Alaskan Natives and Indegenous groups in the lower 48

Pacific Islanders

Through the process of this environmental scan it became apparent that Pacific Islanders were being disproportionately impacted by COVID-19, despite often being a small segment of the population in Morehouse's Five Priority Communities. When this trend emerged, NACHW reached out to a Pacific Islander Community Health Worker to discuss the reasoning for the disproportionate COVID-19 impact on Pacific Islander Communities. Themes which emerged were that Hawaiians and Other Pacific Islanders work together, but Hawaiians do not represent the priorities or needs of other Pacific Islanders. Many PI's come to the US through worker programs and bring over other family members, but these communities are generally uninsured and do not have knowledge of the social services available to them. CHW is a new job title in Pacific Islander communities, but many Pacific Islander cultures have similar "community navigators" often known as an "auntie" or "uncle."

- Hawaiians and Other Pacific Islanders work together, but Hawaiians do not represent the prioritizes/needs of other Pacific Islanders
- Many PI's come to the US through worker programs and bring over other family members, but are generally uninsured and don't have knowledge of social services available
- CHW is a new job title in PI communities, but many PI communities have similar "community navigators"

Vietnamese and Cambodian Refugees

A three part article series (I, II, III) by the LA Times explores the unique barriers Cambodian and Vietnamese immigrants and refugees face in accessing medical care compared to other Asian Americans and immigrants from other places. The articles credit this to the lack of access to education and health care resources, intergenerational trauma in these communities, the lack of knowledge about interpreters by the communities and providers, and providers lack of cultural competency.

Cambodian and Vietnamese refugees have been found to be "less likely to have health insurance, have lower per capita incomes and lower rates of higher education compared to the overall U.S. population." Over time this lack of access to resources leads to a lack of providers from those communities, which leads to issues with cultural competency by medical providers. The articles give many examples about various issues with interpreters, while the law requires providers to use certified medical interpreters, lack of availability, lack of cultural understanding, and lack of patients knowing their rights to interpreters, leads to many instances of uncertified interpreters, or even children, incorrectly translating and leading to poor health outcomes in these communities. Medical providers need cultural competency training in order to understand the particular health issues of each community and correctly frame health issues, in particular mental health issues. Many people in these communities experience intergenerational trauma and suffer PTSD. Many community organizations have made significant strides in addressing these issues.

- Patients and providers need to know about their rights to certified medical interpreters
- Providers need mandatory cultural competency training
- Support and knowledge sharing should be done with community organizations, such as:
  - Southeast Asia Resource Action Center
  - Asian Americans Advancing Justice-Los Angeles
  - Asian Americans Advancing Justice-Orange County
  - Viet-CARE
  - Orange County Asian and Pacific Islander Community Alliance
  - Orange County Health Care Agency
  - The Cambodian Family
  - APAIT
  - Southland Integrated Services
  - County of Orange Social Services Agency
  - Fountain Valley Regional Hospital and Medical Center
  - Viet Rainbow of Orange County
  - California Reducing Disparities Project
  - Cambodian Advocacy Collaborative
  - Cambodian Assn. of America
  - United Cambodian Community
  - Khmer Parent Assn
  - Khmer Girls in Action

LatinX Front Line Workers

NACHW hosted a meeting with a few of the NCRN Strategic Partners to discuss the initiative and each organization's role in the project, particularly about the focus on Hispanics and migrant workers. We discussed the concern about helicopter interventions, sharing resources, possible challenges regarding technology, and addressing particular issues within Hispanic and migrant workers.

All parties present at the meeting were apprehensive about the NCRN being a "helicopter solution" or only addressing COVID-19, without taking into consideration the underlying issues making certain communities more vulnerable, one participant described it as "if we don't know how it's broken, you can't fix it."

During the meeting, we also discussed various CHW resources each program had and how we could share these resources among ourselves. Then, we moved on to discussing Morehouse's focus on technology and the proposed app. One participant did remark that LatinX do have high rates of using apps but emphasized the importance of the accuracy of those resources because, "We're not going to telehealth ourselves out of a pandemic," therefore the creators of the app need to be aware of certain concerns Hispanics and migrant workers will have with accessing resources such as:

- Zip codes are not the way to organize resources, people don't know their zip code (especially where they live vs. where they work)
- Will this include information on whether the resources demand documentation?
- What language does the resource offer?
- What hours are they open?
- Do they have to drive hours to get to the resource?

In the same vein, there are other limitations and aspects to consider when working with migrant worker communities, one participant called them "Tri-state binational communities" and spoke of the importance of considering what is happening in Mexico with COVID-19. As one attendee put it there are "No borders on health."

- Addressing underlying disparities for effective COVID-19 mitigation and avoiding helicopter solutions
- Make sure to ask the right questions and make sure of accurate resource information for the app
- Keep in mind the realities of "no border on health" for migrant workers

Incarcerated Population/Re-Entry Community

The Prison Policy Initiative Louisiana Incarceration by Race		
Entire State/ Race	**Incarceration per 100,000 people**	**Times larger than the rates for Whites**
Louisiana	1,052	1.5x the rate for Whites
Black residents	2,749	4x the rate for Whites
Hispanic residents	1,114	1.7x the rate for Whites
White residents	675	n/a

Louisiana is one of the Five Priority Communities for the NCRN, with a focus on African Americans and Incarcerated populations, in the parishes of East Baton Rouge, Jefferson, and Orleans. The Prison Policy Initiative reports that over 50,000 people are incarcerated in Louisiana at a rate of 1,052 prisoners for every 100,000 residents in Louisiana. There are 41 ICE detention centers in Louisiana with 21,000 cases pending. As previously established African Americans are disproportionately impacted by COVID-19 and disproportionately involved in the criminal justice system. Therefore, the intersection of these two communities should be given special consideration in concern to African Americans who were recently incarcerated.

Many researchers, advocates, and reporters have published about the dangers of COVID-19 for those currently incarcerated. CHWs are not typically involved with those currently incarcerated, but many CHWs work closely with the "re-entry" community assisting with key issues such as accessing jobs, healthcare, housing, food, behavioral health, and transitional programs. Those previously incarcerated face additional barriers to accessing job opportunities and

essential resources under normal circumstances. During this moment of the COVID-19 pandemic, it can be assumed, they face insurmountable barriers to accessing essential services, particularly services to address substance issues and mental health programs, which are often key programs to prevent re-incarceration.

Studies suggest that the two weeks after release, the previously incarcerated person has a risk of dying 12.7 times higher than the general public, it can be assumed that this risk will be heightened during this time due to COVID-19, especially due to the high unemployment and economic downturn. In addition, heightened risk of COVID-19 in prisons and jail has led to an increase in early releases and reduced intake which has expanded the number of people being released and created a large number of people in this stage of re-entry with few resources and little support. Little research has been produced about the ways in which CHWs are involved with the re-entry community during COVID-19.

"Decarceration and community re-entry in the COVID-19 era" from The Lancet Infectious Disease Journal outlines a set of recommendations in regards to those who were previously incarcerated during the COVID-19 pandemic. Many of their recommendations surround connecting individuals to resources and accessing healthcare/health insurance which can be achieved through utilizing CHW expertise in these areas.

- The re-entry community has rapidly grown due to increased early release and reduce sentences
- CHWs expertise should be utilized to address many of the gaps in accessing healthcare and social services which disproportionately affect those previously incarcerated
- Special attention should be give to the intersection of African Americans, the disproportionate effect of COVID-19 and disproportionate effects of the criminal industrial complex

Patients & Patient Advocates

During the course of this research, we felt like patients and patient advocates were missing from the NCRN. As COVID-19 rates skyrocket across the US, millions of people affected by the virus have been thrust into dealing with the convoluted US healthcare and insurance systems. Looking forward to the entirety of the three year initiative, after rates hopefully fall, millions will be left to deal with ongoing health issues caused by the virus and will need assistance and advocacy when dealing with healthcare and insurance. Many CHWs and their peers work in care coordination and patient advocacy, which millions of people will be in need of assistance with due to the impact of the virus. While researching for this report, NACHW representatives met with partners from the National Patient Advocacy Foundation (NPAF) to discuss the NCRN. The representatives from the NPAF were excited at the possibilities of the NCRN, but felt that the initiative would reach its capacity quickly without investing in infrastructure to help COVID-19 affected populations navigate the healthcare and insurance system.

- Think about future impacts of COVID-19 on patients and plan to address their needs of advocates
- Utilize CHWs and other who work in patient advocacy and care coordination
- Partner with the National Patient Advocate Foundation (NPAF) to utilize their knowledge and expertise in dealing with healthcare systems

Findings:

- The Navajo Nation continually has to reaffirm their sovereignty when interacting with the federal government and outside organizations. This relationship with outside entities has had a negative effect on the Nation, and their health outcomes, and caused the disproportionate impact of COVID-19.

- The Hopi Nation is a separate sovereign nation with their own struggles and needs in regards to COVID-19.
- The Pacific Islander community and recent Asian immigrants and refugees have vast diversity in their experiences and needs in order to address COVID-19.
- Migrant workers and Hispanic communities around the US-Mexico border have unique challenges when mitigating COVID-19 because the communities have a great diversity in citizenship status, language, and types of seasonal work.
- The amount of people recently released from incarceration has rapidly grown due to early release and reduced sentences because of COVID-19. This community has many additional risks which make them disproportionately vulnerable to COVID-19 and are in need of connections to employment and social services.
- Patients and patient advocates are an important group which should be incorporated in the NCRN, especially when the scope of the work changes from mitigating cases to addressing ongoing health disparities caused by COVID-19.

Appendix - Summary Slides

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN ALASKA

***Covid case per 100k population*: 1,339 | Deaths per 100k: 8**

CHW Funding

All levels of CHAs can be reimbursed for services to Medicaid beneficiaries per a state plan amendment

Most funding still comes from Indian Health Services

CHW Certification

Does not have state-run certification program, but The Community Health Aide Program Certification Board oversees all training and education, and certification is mandatory for Medicaid reimbursement

Core competencies are described here

4 regional training centers (Anchorage, Bethel, Nome, and Fairbanks) and some training available online

State CHW Legislation

Passed a bill to allow operation of Community Health Aide Program that provides grants to third-parties to train Community Health Practitioners -- trainees must complete examination at end of training

CHW ORGS and workgroups

Alaska Community Health Aide Program -- Network of Community Health Aides/Practitioners in over 170 rural Alaskan villages, the Program organizes education opportunities and meetings of committees

Have a CHA Association that organizes monthly meetings for all Aides

Alaskan Native Tribal Health Consortium -- non profit tribal health org, supports the CHA Training Program; located in Anchorage

CHW roles in state

Health workers function as Community Health Aides and Practitioners, Dental Health Aides, and Behavioral Health Aides, each of whom is subject to specific standards of practice defined by Certification Board and in the CHAP manual

Intended to reach rural Alaskans and Indigenous populations

Key influencers (people or groups) on CHW strategy

Certification Board members:

Miranda Petruska
CHP CHAP Director/Specialist, RASU
Southcentral Foundation
907-729-4245
mpetruska@SouthcentralFoundation.com

Heidi Hedberg
Director of Public Health
Dept. of Health & Social Services
Division of Public Health
907-269-2042
heidi.hedberg@alaska.gov

COVID Presence in Alaska

154 average cases per day this week

- increase of 80% from 2 weeks prior

Anchorage Municipality

83 average daily cases, or 29 per 100k

COVID Response in Alaska

State COVID Response Actors

DHSS is lead -- the Section of Epidemiology is holding town halls with communities, and is leading contact tracing

- University of Alaska Anchorage is hosting trainings

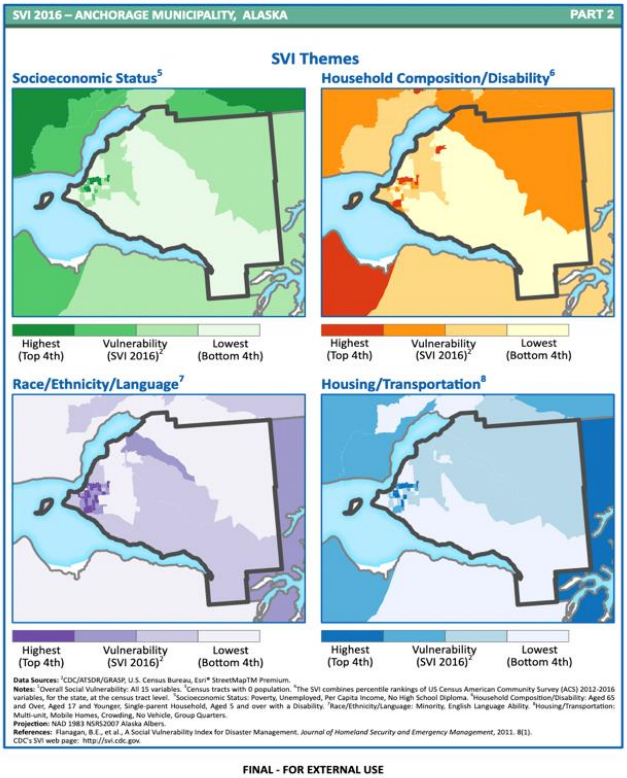
Once Section of Epidemiology is alerted of a positive case, it reaches out to various partners in CRS response

Vaccine Readiness Actors

COVID-19 Vaccine ECHO -- weekly call for emergency managers, immunization coordinators and community partners to prepare for vaccine rollout

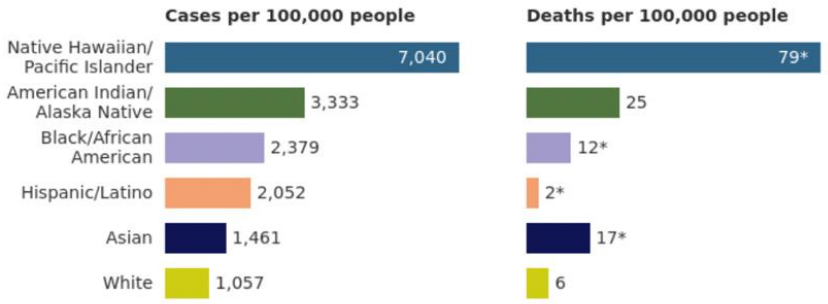
DHSS and Alaska Native Tribal Health Consortium are working on joint plan

- Part of plan would have healthcare workers enroll in Vaccine Program administered through Alaska Immunization Program



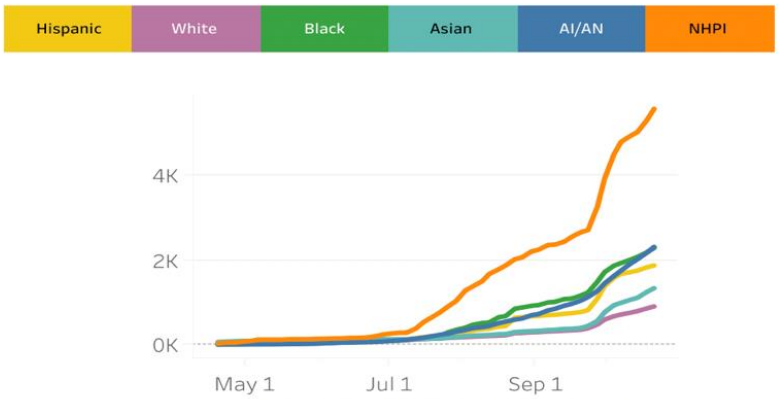
County Health Rankings	Health Outcomes	Health Factors
Anchorage	10 of 25	5 of 25

In **Alaska**, through November 2, Native Hawaiians/Pacific Islanders were most likely to have contracted COVID-19 and were also most likely to have died.



Source: https://covidtracking.com/race/dashboard

Case Rate per 100,000 by Race and Ethnicity



Source: https://pi-copce.org/covid19response/

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN CALIFORNIA

***Covid case per 100k population*: 2,149 | Deaths per 100k: 41**

CHW Funding

Done through employers such as health plans and CBOs

- Grant funding potentially available through organizations like the California Endowment and the Sierra Health Foundation

Are currently working on obtaining funding through Medi-Cal (CA's Medicaid blueprint)

CHW Certification

Not required by the state

Number of colleges that offer programs, including CCSF and Berkeley City College

State CHW Legislation

Nothing beyond a definition of CHWs

CHW ORGS and workgroups

California Association of CHWs – support the development of the CHW workforce in California and nationally

Visión y Compromiso -- org founded by Promotores that provides leadership development, capacity building, advocacy building, and support to CA CHWs

- House a National Network of CHWs and Promotores
- Provide several specific trainings

Building a Sustainable CHW/P Workforce Webinar – completed national scan on CHW/P workforce and how it can influence California's workforce

Healthforce Center at UCSF has an entire research arm dedicated to researching CHWs in California, and has publications on CHWs in care coordination models, health care teams, and whole person care

CHW roles in state

Hired to reach specific populations -- Hispanic/Latinx, immigrant, low-income

Involved in many care management teams such as with health plans and health homes

Los Angeles DHS hires CHWs directly in part for their Whole Person Care Program

Key influencers (people or groups) on CHW strategy

Maria Lemus
Executive Director of Visión y Compromiso
maria@visionycompromiso.org

Susan Chapman
lead faculty for Healthforce Center at UCSF
Susan.chapman@ucsf.edu

COVID Presence in California

3297 average cases per day this week

- decrease of 7% from 2 weeks prior

Los Angeles County

1042 average daily cases, or 10 per 100k

COVID Response in California

State COVID Response Actors

UCLA School of Medicine is CEAL recipient and leader of STOP COVID LA, an initiative of 5 medical centers in CA using locally informed approaches

California Connected program: collaboration of DPH, LHDs, UCSF and UCLA

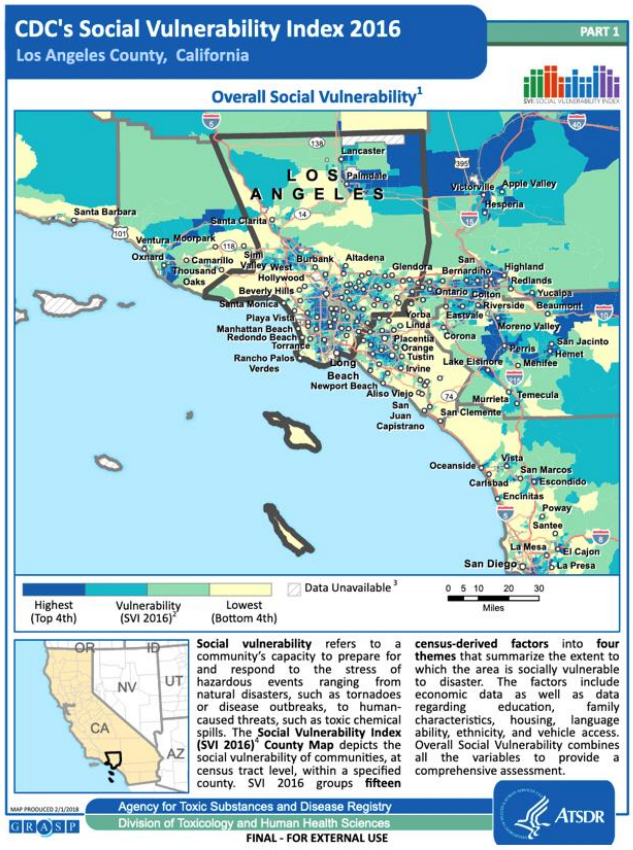
- UCSF and UCLA host CT training which is funded by the DPH and include many of their previous employees

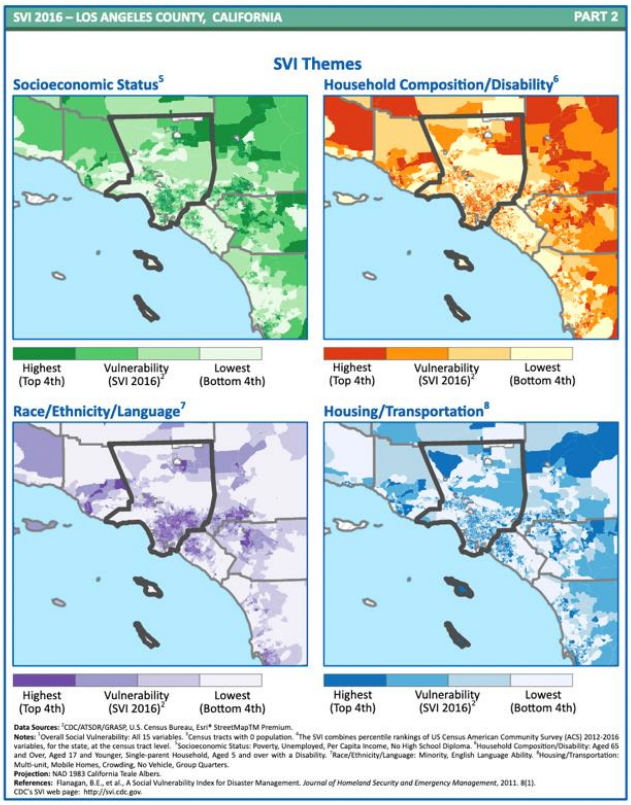
Vaccine Readiness Actors

One of 4 states that will be used as a pilot for vaccine distribution by CDC

Currently putting together a Vaccine Task Force run out of the DoH

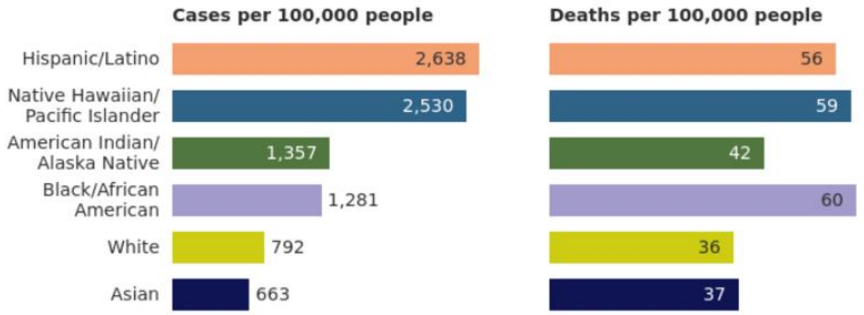
Kaiser Permanente Vaccine Study Center is conducting a COVID vaccine trial in northern California





County Health Rankings	Health Outcomes	Health Factors
Los Angeles	21 of 58	32 of 58

In **California**, through November 2, Hispanic/Latino people were most likely to have contracted COVID-19. Black/African American people were most likely to have died.



Source: https://covidtracking.com/race/dashboard

Case Rate per 100,000 by Race and Ethnicity

Source: https://pi-copce.org/covid19response/

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN FLORIDA

***Covid case per 100k population*: 3,413 | Deaths per 100k: 72**

CHW Funding

Provided by employers of CHWs -- CBOs, Medicaid MCOs, universities and FQHCs

CHW Certification

Have established the Florida Certification Board, but certification is not mandatory

The Certification Implementation Team has developed 28 tasks in 5 performance domains (communication and education, resources, advocacy, foundations of health, and professional responsibility)

Florida AHEC network of schools provides training

- Many nonprofits have their own training

State CHW Legislation

None

CHW ORGS and workgroups

Florida Community Health Worker Coalition -- statewide partnership to support and promote the profession of CHWs, began in 2011 from a grant from the Florida DoH to look into best practices for CHWs

Statewide Partnership for Training Florida's CHWs in Patient-Centered Research -- project intended to build on structured training to develop PCOR elective module that could be used to create state certification

- Part of larger national effort

CHW roles in state

CHWs conduct home visits to address conditions such as asthma or medication therapy management, as well as through the DOH Healthy Start program

Key influencers (people or groups) on CHW strategy

Tonya Bell
Certified CHW with Healthy Start Coalition of Jefferson, Madison, and Taylor Counties
Stated contact for FCHWC
tbell@healthystartjmt.org

COVID Presence in Florida

2410 average cases per day this week

- decrease of 9% from 2 weeks prior

Jefferson County

2 average daily cases, or 14 per 100k

Taylor County

4.6 average daily cases, or 21 per 100k

COVID Response in Florida

State COVID Response Actors

DoH is in charge of contact tracing and currently runs a public call center for COVID-related questions

- Appears County Health Departments are in charge of organizing their own contact tracing
- Private company MAXIMUS contracted by state to hire 400 more tracers

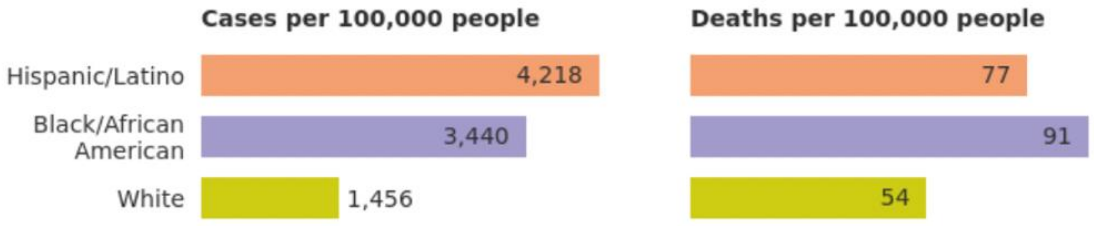
Department of Emergency Management sponsors testing sites and is in charge of expanding testing capacity

Vaccine Readiness Actors

One of 4 states that will be used as a pilot for vaccine distribution by CDC

Florida Division of Emergency Management has been in charge of securing supplies thus far

In **Florida**, through November 2, Hispanic/Latino people were most likely to have contracted COVID-19. Black/African American people were most likely to have died.



Source: https://covidtracking.com/race/dashboard

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN GEORGIA

***Covid case per 100k population*: 3,159 | Deaths per 100k: 70**

CHW Funding

Grants and private funds

CHW Certification

No current certification, but Georgia CHW Advocacy Coalition and Georgia CHW Advisory Board are advocating for statewide certification

Recommendations include renewal of certificate every 2 years and 20 hours of continuing education every 2 years

State CHW Legislation

None

CHW ORGS and workgroups

Georgia Watch advocates for statewide certification, legislation and integration of CHWs, along with standardized curriculum and continuing education

Morehouse School of Medicine trains CHWs through various programs

- Also provides a high school CHW training program

In 2017, there was a Community Health Worker Forum sponsored by Georgia DPH, Kaiser Permamente of Georgia and Morehouse School of Medicine to begin to outline a CHW model and plan

- They created a CHW Advisory Board (part of DPH) and an Advocacy Coalition

CHW roles in state

CHWs conduct home visits to address conditions such as asthma or medication therapy management, as well as through the DOH Healthy Start program

Key influencers (people or groups) on CHW strategy

Jake Sneed
CHES CHW Initiative Program Manager @ DPH
Jake.Sneed@dph.ga.gov

Arletha Williams-Livingston
Morehouse School of Medicine Director of Innovation
awlivingston@msm.edu

COVID Presence in Georgia

1218 average cases per day this week

- decrease of 16% from 2 weeks prior

Dougherty County

4.1 average daily cases, or 4.7 per 100k

COVID Response in Georgia

State COVID Response Actors

DPH is in charge of contact tracing, using their previous staff and new hires

- MTX developed online monitoring platform for them, Healthy Georgia Collaborative
- Emergency Preparedness and Response arm is holding weekly calls with healthcare providers and public health entities

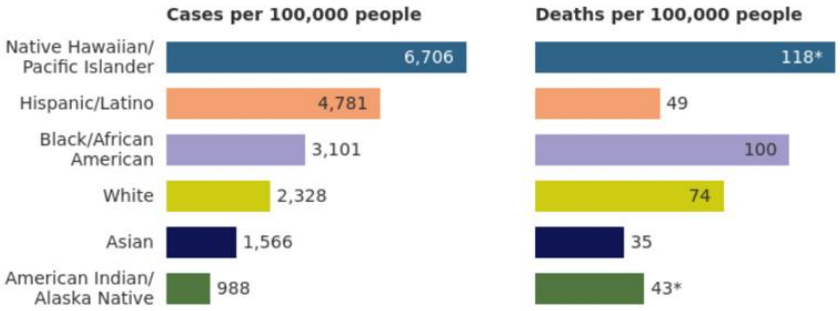
Vaccine Readiness Actors

State government is currently putting together a task force that will plan a distribution program and awareness campaign

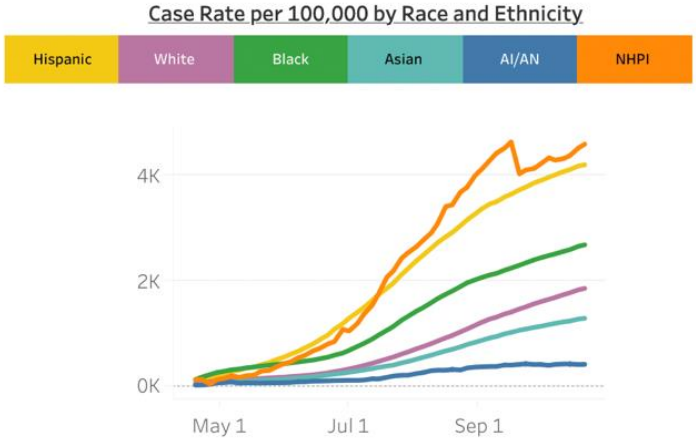
- Led by Insurance Commissioner John King

The DoPH has an Immunization Section and a Registry

In **Georgia**, through November 2, Native Hawaiians/Pacific Islanders were most likely to have contracted COVID-19 and were also most likely to have died.



Source: https://covidtracking.com/race/dashboard



Source: https://pi-copce.org/covid19response/

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN HAWAI'I

***Covid case per 100k population*: 963 | Deaths per 100k: 11**

CHW Funding

FQHCs and CBOs hire them through grants

CHW Certification

No state required certification

The Department of Labor TAACCCT Grant funds CHW certification programs at community colleges

- One at Kapiolani Community College

State CHW Legislation

None

CHW ORGS and workgroups

Two conferences, one in 2017 and one in 2019, funded by the DoH

Hawai'i Primary Care Association -- represent HCCs across Hawaii and inform decision makers and advocates, have supported CHW work

Hawaii Public Health Institute -- non profit that serves as a hub for all public health efforts in Hawaii, have supported many of the CHW efforts in recent years

Review of CHWs in Hawai'i -- analyzed usage and roles of CHWs

- Suggested providing more accessible training and certification, getting CHWs more involved in policy development, and building capacity

Editorial: Moving Towards a CHW Association -- efforts since 2017 to bring together CHW organizations to lay groundwork for a statewide association

- Still no statewide organization

CHW roles in state

Cover a range of specific interventions, including chronic diseases, cardiovascular health, diabetes, cancer, and asthma

Focus on specific populations – Native Hawaiians, Pacific Islanders, and Filipinos

Build community-clinic linkages

Key influencers (people or groups) on CHW strategy

Nicole Moore
CHW on Hawai'i Island and contributor to editorial

Napualani Spock
HPCA's Outreach and Community Health Worker Director
nspock@hawaiipca.net

COVID Presence in Hawai'i

91 average cases per day this week

- decrease of 9% from 2 weeks prior

Hawai'i County

19 average daily cases, or 9.4 per 100k

Honolulu County

71 average daily cases, or 7.3 per 100k

Maui County

2.4 average daily cases, or 1.4 per 100k

COVID Response in Hawai'i

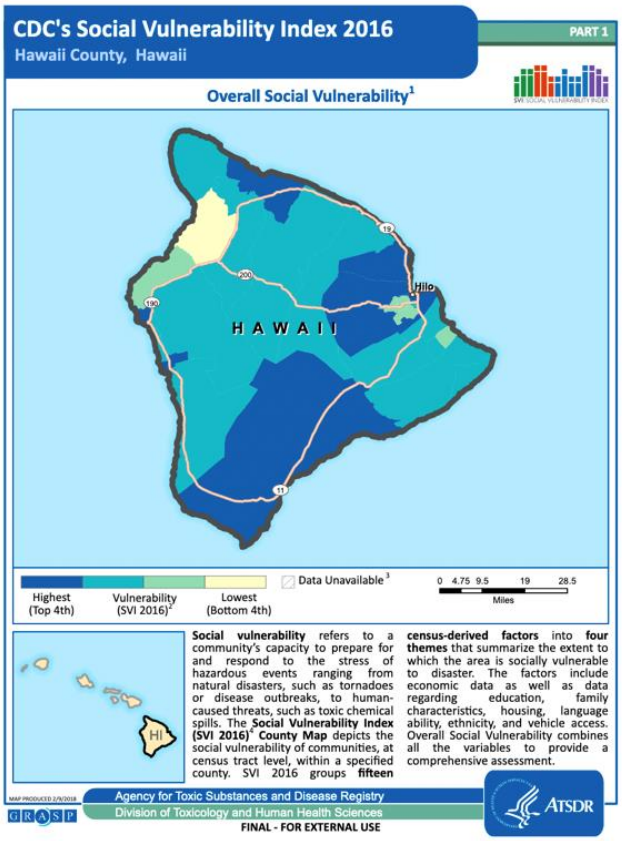
State COVID Response Actors

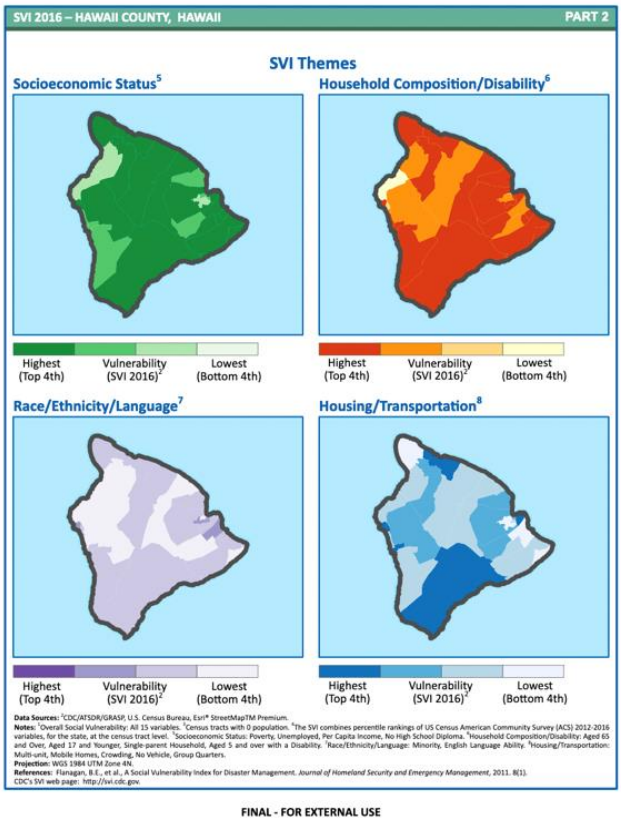
DoH is the center for response strategy and contact tracing, has put together a continuum for reopening and closing as needed
University of Hawai'i is training personnel and CHWs to do contact tracing

Vaccine Readiness Actors

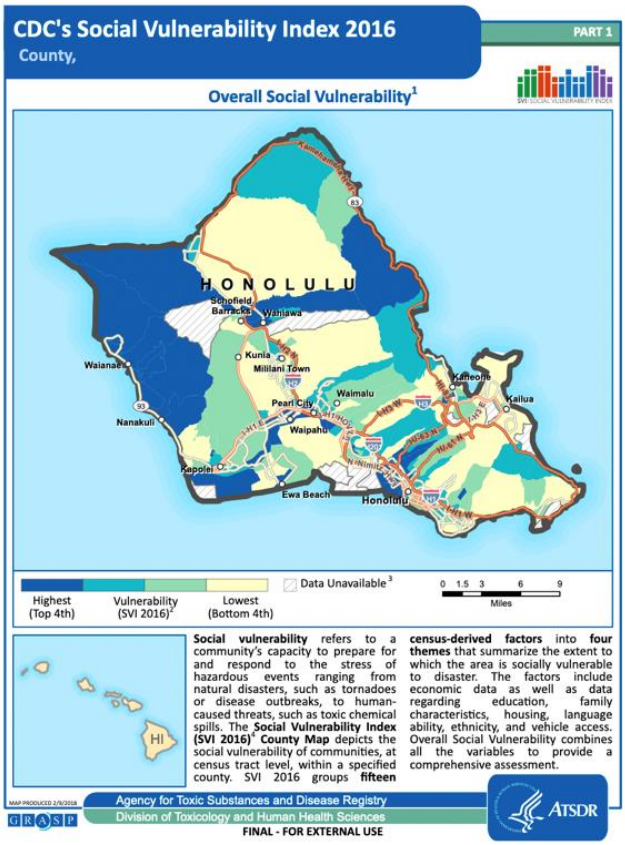
University of Hawaii at Manoa was selected as one of trial sites of Pfizer vaccine, as was East-West Medical Research Institute

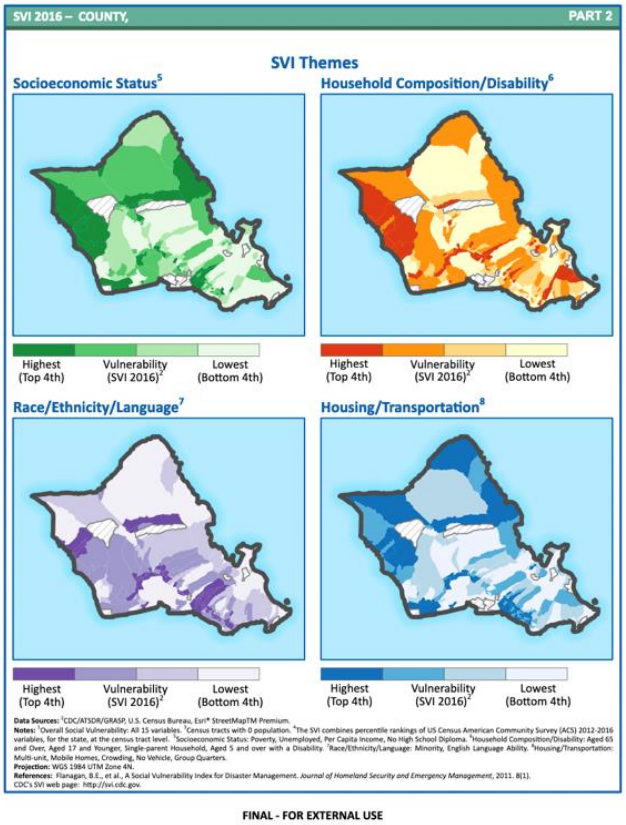
Recently received new CARES Act funds to DoH to develop a vaccine preparedness plan



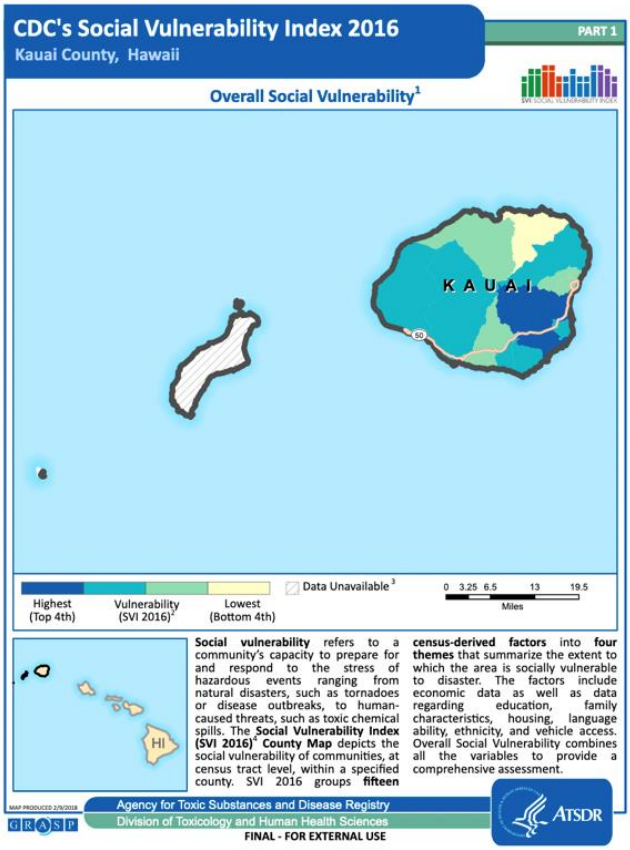


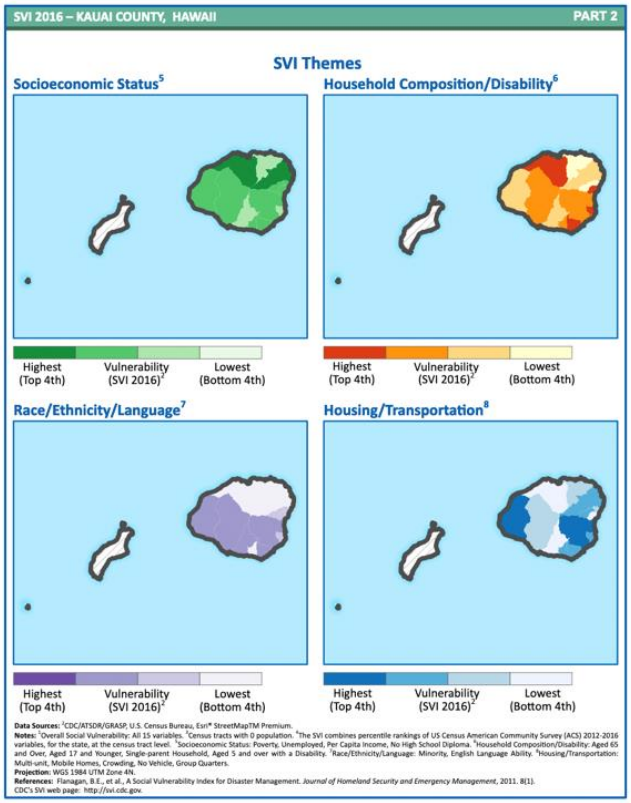
County Health Rankings	Health Outcomes	Health Factors
Hawaii	4 of 4	4 of 4



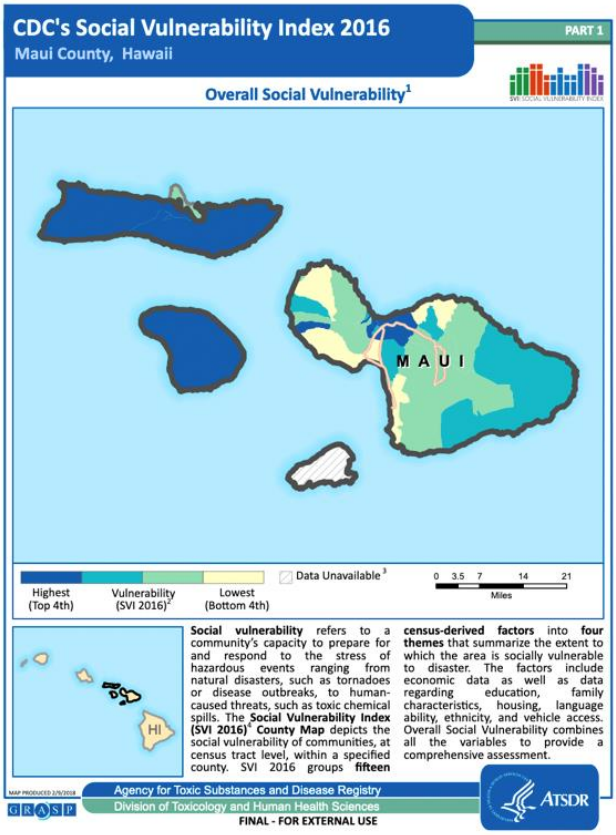


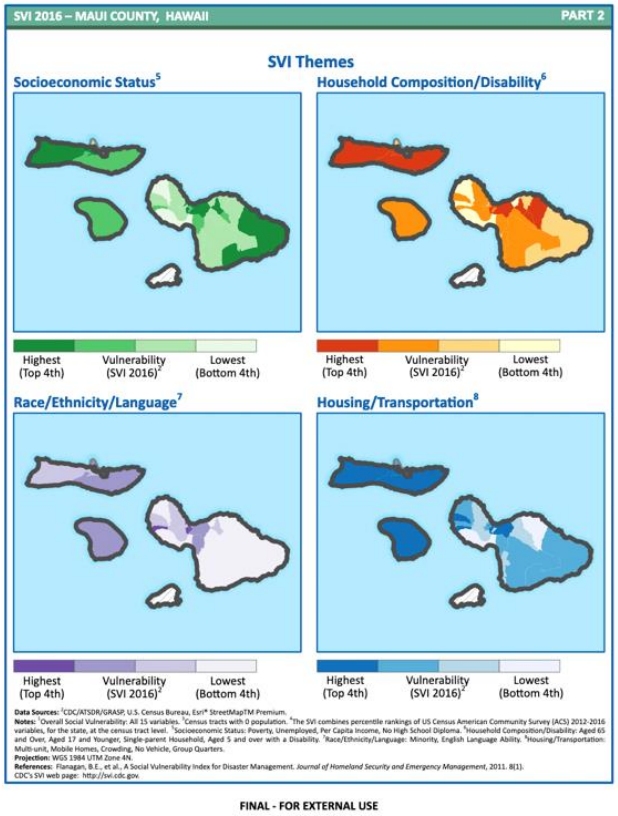
County Health Rankings	Health Outcomes	Health Factors
Honolulu	2 of 4	1 of 4





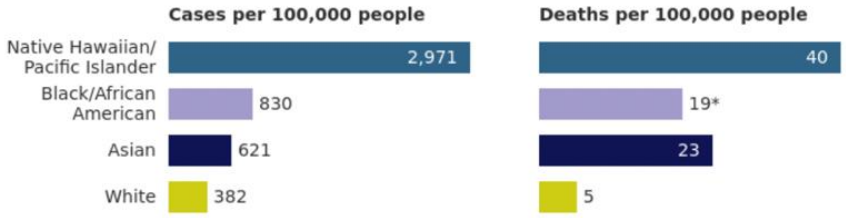
County Health Rankings	Health Outcomes	Health Factors
Kauai	3 of 4	2 of 4



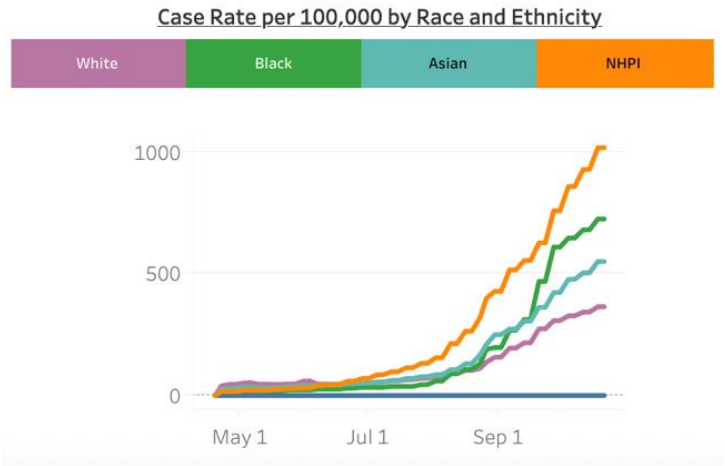


County Health Rankings	Health Outcomes	Health Factors
Maui	1 of 4	3 of 4

In **Hawaii**, through November 2, Native Hawaiians/Pacific Islanders were most likely to have contracted COVID-19 and were also most likely to have died.



Source: https://covidtracking.com/race/dashboard



Source: https://pi-copce.org/covid19response/

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN LOUISIANA

***Covid case per 100k population*: 3,748 | Deaths per 100k: 121**

CHW Funding

Managed Care Organization funding and grants

CHW Certification

The Louisiana Community Health Worker Institute offers a core competency training program that is not state approved

According to the Workforce Study Committee, statewide certification is not recommended at this time

State CHW Legislation

None

CHW ORGS and workgroups

The Louisiana Community Health Worker Institute is currently based out of LSU Health Sciences Center - New Orleans, and provides technical assistance to CHW programs as well as core competency trainings

Louisiana Community Health Outreach Network (LACHON) is a support organization for CHWs that holds monthly meetings to bring together CHWs and discuss recognition and development

In 2019, the Louisiana Legislature created the Louisiana Community Health Worker Workforce Study Committee to examine how CHWs were functioning in Louisiana and to offer expertise for designing a better system in the future; they published a study in 2020 outlining improvements to their CHW program

CHW roles in state

All MCOs employ CHWs – they focus on outreach and education, care coordination, etc.

Key influencers (people or groups) on CHW strategy

Ashley Wennerstrom
Director of the Louisiana Community Health Worker Institute
Founding member of LACHON
awenne@lsuhsc.edu

COVID Presence in Louisiana

734 average cases per day this week

- increase of 25% from 2 weeks prior

East Baton Rouge Parish

29 average daily cases, or 6.6 per 100k

Jefferson Parish

39 average daily cases, or 9.1 per 100k

Orleans Parish

29 average daily cases, or 7.4 per 100k

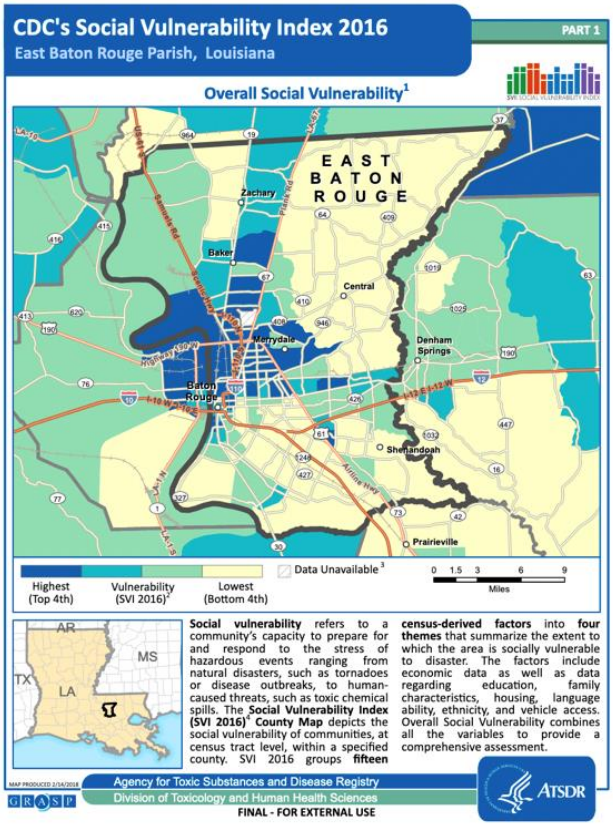
COVID Response in Louisiana

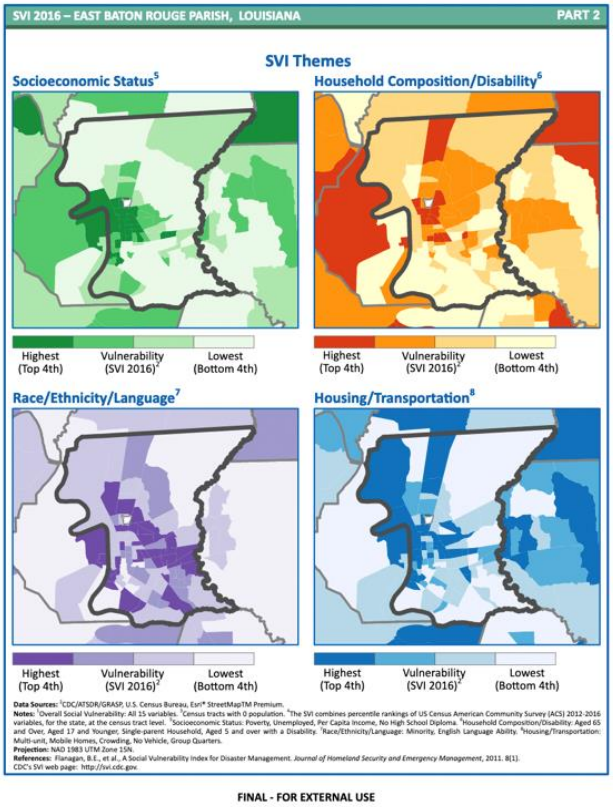
State COVID Response Actors

The DoH has hired out CT training to 5 major companies: HUB Enterprises, Calls Plus, Coast Professional, Hammerman & Gainer International, Inc., and Volunteers of America
Oversight of CT training and management has been given to LSU's Stephenson Disaster Management Institute

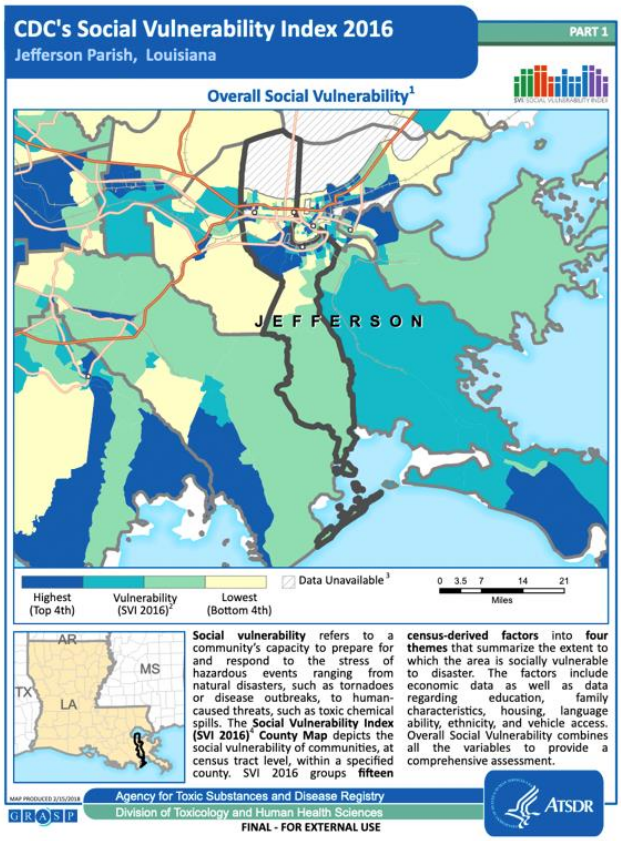
Vaccine Readiness Actors

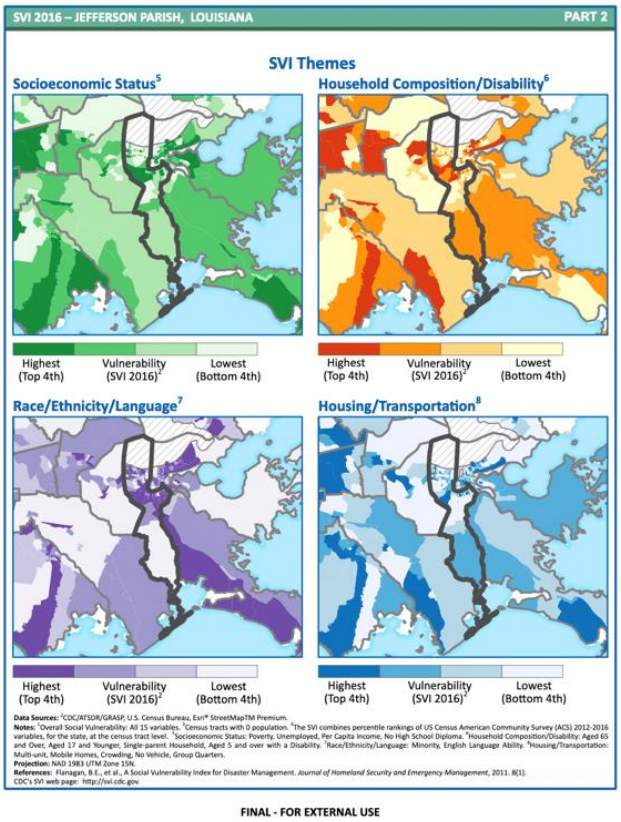
DoH has an Immunization Program which is already discussing guidelines for COVID vaccine providers
Pfizer clinical trial is being undertaken by Ochsner Health System, and Meridian Clinical Research in Baton Rouge and Benchmark in Jefferson Parish are conducting vaccine research for Moderna



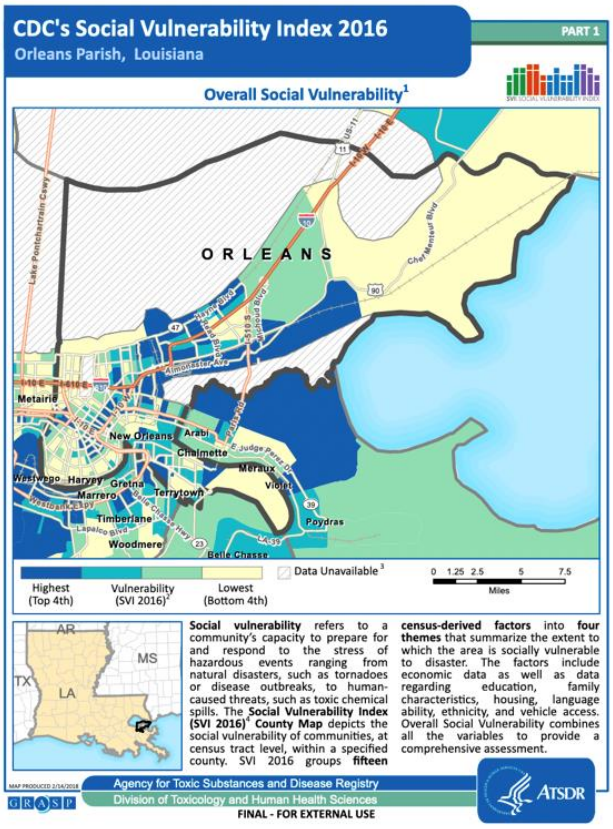


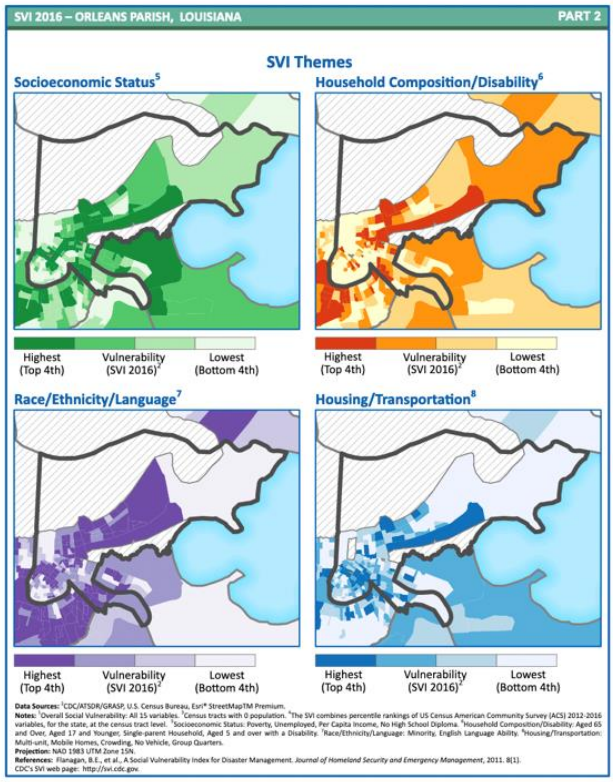
Parish Health Rankings	Health Outcomes	Health Factors
East Baton Rouge	29 of 64	7 of 64





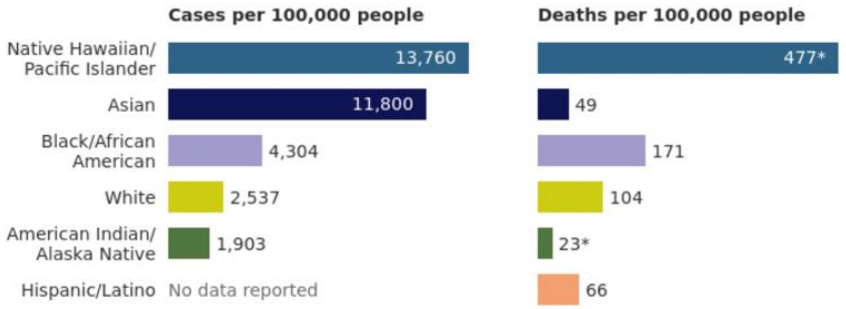
Parish Health Rankings	Health Outcomes	Health Factors
Jefferson	11 of 64	9 of 64



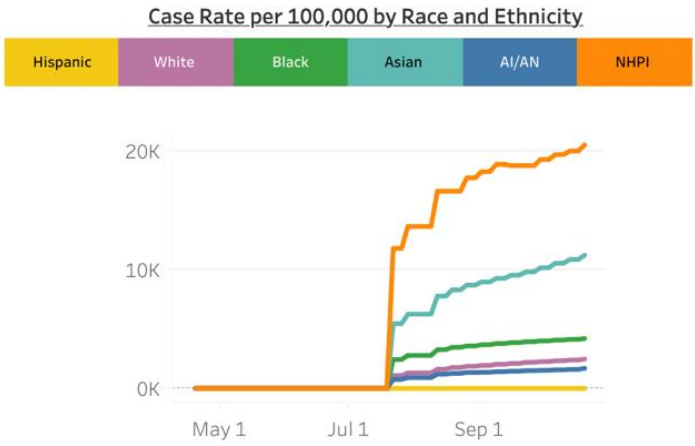


Parish Health Rankings	Health Outcomes	Health Factors
Orleans	32 of 64	29 of 64

In **Louisiana**, through November 2, Native Hawaiians/Pacific Islanders were most likely to have contracted COVID-19 and were also most likely to have died.



Source: https://covidtracking.com/race/dashboard



Source: https://pi-copce.org/covid19response/

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN NAVAJO NATION

***Covid case per 100k population*: 6,182 | Deaths per 100k: 329**

CHR Funding

Indian Health Services provides funding but budget must be submitted each year

Navajo Nation also receives grant funding for 14 preventative health programs

CHR Certification

All CHRs are certified nurse practitioners and first responders, but CHW-specific certification depends on the state

COPE leads training for Navajo Nation CHRs in NM, classes were available at community colleges but also available in communities

IHS provides basic core training for CHRs across all Indian territories

State CHW Legislation

New Mexico -- were considering legislation for certification in 2014, put together an advisory group with CHW/R organizations, passed voluntary certification in 2019

Arizona -- also has voluntary certification

Utah -- no legislation

COVID Presence in Navajo Nation

26.44 average cases per day this week

- increase from 2 weeks prior

CHR ORGS and workgroups

CHR program established in 1968 -- currently run by the Department of Health

- Intended to support work of IHS and is contracted under NAIHS

COPE – partnership between CHR program, IHS, Brigham and Women's Hospital and PIH, Native-led, aims to support and advocate for better health programs for AI/AN communities, are working to get CHRs certified as New Mexico CHWs

CHR roles in state

Cover direct home health care, community health care, and health education

Specifically address STIs, oral health, MCH, and TB in Navajo communities

Key influencers (people or groups) on CHR strategy

Hannah Sehn
COPE Program
Hannah@copeprogram.org

Mae Gilene-Begay
Director of CHR/Outreach Program
maegilene.begay@nndoh.org

COVID Response in Navajo Nation

State COVID Response Actors

Department of Health's Health Command Operations Center is the CRS center -- they are in charge of contact tracing

IHS facilities are where people are actually being treated for COVID

CHRs have been covering certain geographic areas to ensure coverage, are also serving on case investigation teams

Vaccine Readiness Actors

Have been recruited for Pfizer vaccine trials

COMMUNITY HEALTH WORKERS AND CONTACT TRACING IN TEXAS

***Covid case per 100k population*: 2,770 | Deaths per 100k: 57**

CHW Funding

The Health and Human Services Commission (Medicaid agency) contracts with MCOs and allows CHWs to receive reimbursement

CHWs are also incorporated under a section 1115 waiver

CHW Certification

Texas has a state-established and run certification program through the DSHS, who oversees all certification and training

- Training Competencies: communication skills; interpersonal skills; service coordination skills; capacity-building skills; advocacy skills; teaching skills; organizational skills; and a knowledge base on specific health issues

Community colleges and other educational institutions, AHECs, and CBOs all offer training

State CHW Legislation

Bill establishing the Promotor(a) Program Development Committee

Bill requiring the Department of State Health Services to establish a CHW training program (mandatory for those being compensated), and a Promotora and CHW Training and Certification Advisory Committee to advise the DSHS

CHW ORGS and workgroups

The Promotor(a)/CHW Training and Certification Advisory Committee -- advises the Texas HHS commissioner on implementing standards for training programs and certification of CHWs

Texas Association of Promotores and CHWs -- aim to support and expand opportunities for CHWs, currently organizing an annual conference and memberships

Texas CHW Study -- published in 2011 at the request of the DSHS, indicated CHWs/promotoras are greatly sought out in the state, but lack of stable funding is a barrier to sustainability

DSHS also produces an annual report on CHWs

CHW roles in state

CHWs help patients navigate the healthcare system, access community resources, help manage chronic conditions, and engage in outreach and health education and promotion activities in people's homes, schools, churches and neighborhoods

Certified promotoras in South Texas counties provide education related to reduction of asthma triggers in the home

Key influencers (people or groups) on CHW strategy

Ashley Rodriguez
Vice President, DFW-CHW Association
Board member of TAPCHW
Ashley.rodriguez2@bswhealth.org

COVID Presence in Texas

4649 average cases per day this week

- increase of 9% from 2 weeks prior

Moore County
3.7 average daily cases, or 18 per 100k

COVID Response in New York

State COVID Response Actors

University of North Texas Health Sciences Center received CEAL grant funds to lead COVID outreach and engagement efforts with racial and ethnic minority communities

Texas DSHS runs Texas Health Trace, an online database used for contact tracing created by the tech start-up MTX

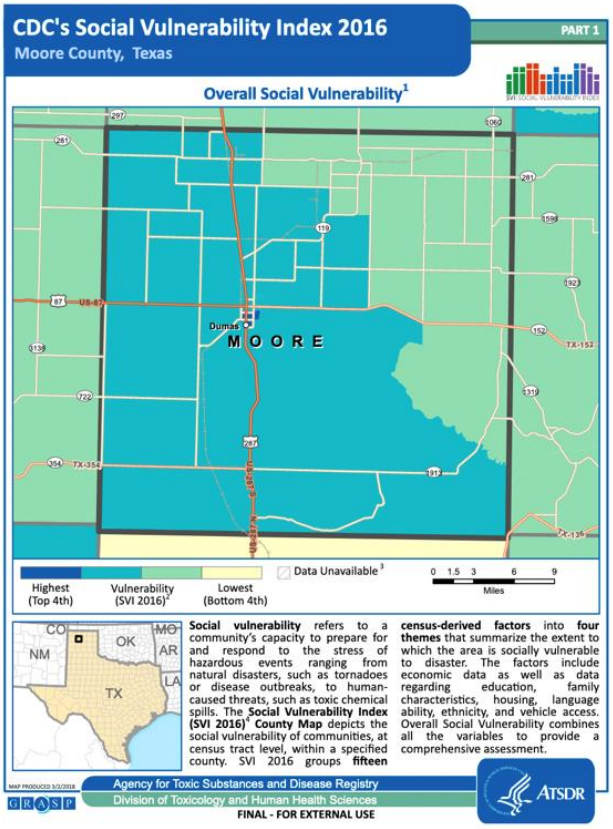
- CT approach was at first up to LHDs, and now LHDs can opt into Texas Health Trace

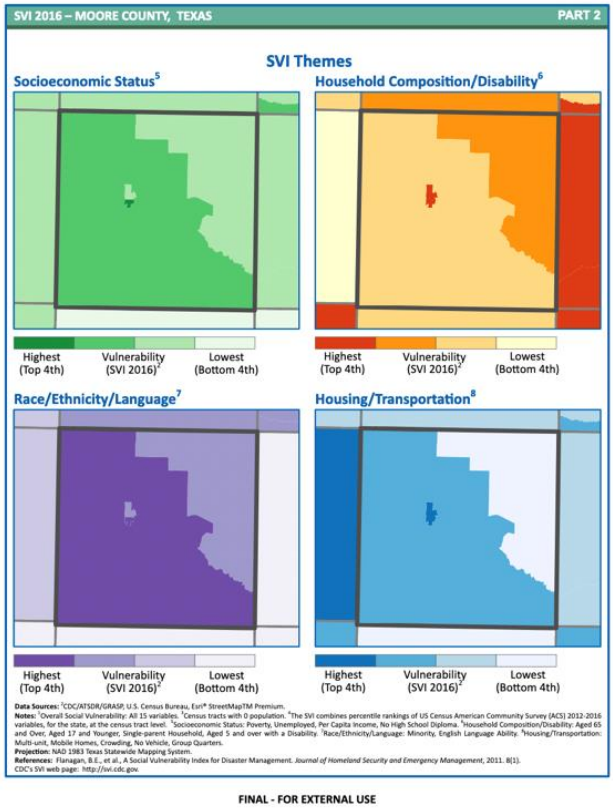
Vaccine Readiness Actors

Healthcare providers who distribute vaccine will have to register with the DSHS' Immunization Program

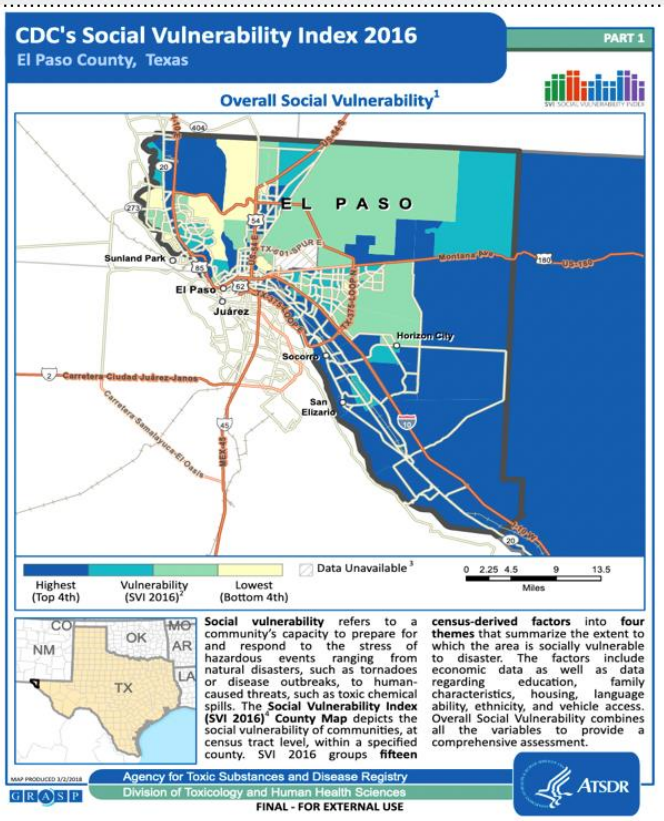
- Providers must agree to vaccinate regardless of people's ability to pay

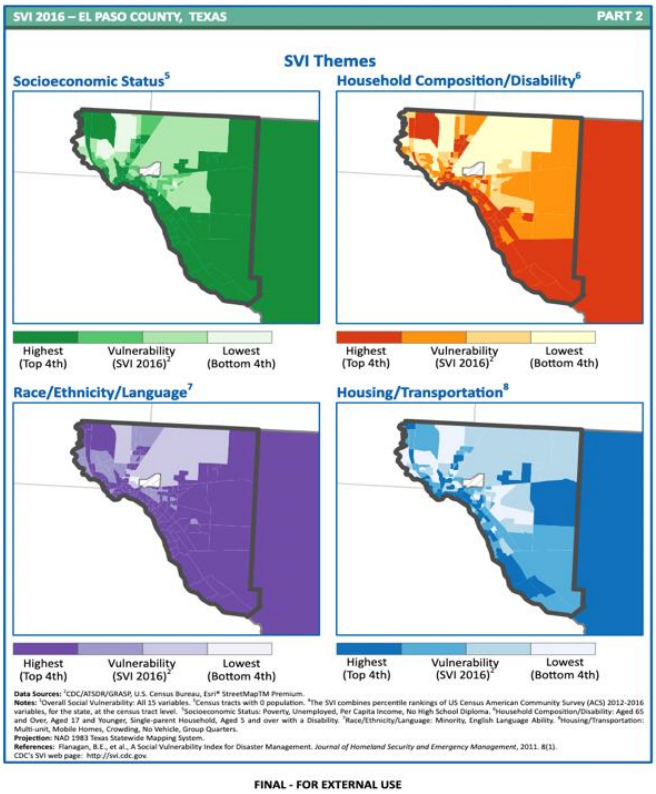
McKesson Corporation will be handling logistics of vaccine distribution





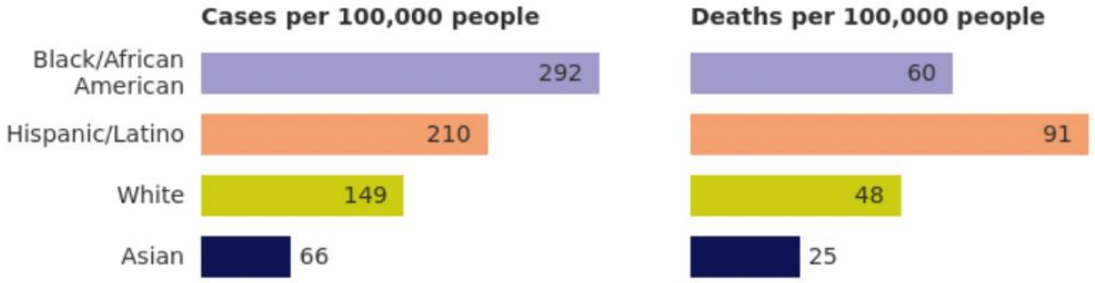
County Health Rankings	Health Outcomes	Health Factors
Moore	79 of 244	64 of 244





County Health Rankings	Health Outcomes	Health Factors
El Paso	56 of 244	125 of 244

In **Texas**, through November 2, Black/African American people were most likely to have contracted COVID-19. Hispanic/Latino people were most likely to have died.



Source: https://covidtracking.com/race/dashboard