Project Narrative

A. Background

Doña Ana County (County)—the catchment area—is located in southwestern New Mexico and spans 65 miles of the U.S.-Mexico border. The County has been disproportionately affected by the COVID-19 pandemic compared to the rest of New Mexico. A total of 11.4% of County residents have tested positive for COVID-19 as of May 23, 2021, compared to 9.6% of New Mexico residents.[1] Mortality is also slightly higher, with COVID-19 having led to the deaths of .21% of the County population versus .19% of the New Mexico population. As of May 13, 2021 Doña Ana County remained one of the top 12 counties in New Mexico based on the number of new cases for the previous three weeks.

County residents have also been disproportionately impacted by the secondary impacts of necessary public health orders such as stay-at-home orders, business closures, and school closures. High poverty levels, a large Hispanic population, low literacy levels, high levels of chronic disease, low levels of access to health care, and other social and economic factors render residents vulnerable to housing and job loss, substance use, domestic violence and other crimes, and mental health challenges.

Disparities in disease incidence and mortality are accentuated by the County's location in the economically and socially integrated U.S.-Mexico border region. Differences in public health orders between New Mexico and its neighboring states of Texas and Chihuahua, Mexico, create conflicts in enforcement and pose additional risks to County residents. In addition, the country's interdependent economies continue to facilitate necessary movement of people and goods throughout the region. According to data from the U.S. Census, as of March 21, 2021, Mexico was listed as the top trading partner of the United States.[2] While such mobility is necessary for the economic functioning of both countries, this movement nonetheless presents an increased risk of COVID-19 infection for border populations.

Many families—some of them original settlers of the region—are transnational, with family members living on both sides of the political border line between the two countries. In addition, a significant percentage of County residents live in families of mixed documentation status. The SARS-CoV2 virus does not check for papers and passes readily through border checkpoints.

Documentation status creates a high level of distrust in government and local authorities, posing challenges to delivering services and providing reliable information. Further, many communities are located in extremely rural areas and residents are often suspicious of unfamiliar visitors, organized health systems, health-care providers, and social services. Recent "public charge" rules increased the level of distrust among community members, making it less likely that residents will seek COVID-19 testing, treatment, or care. Recent community workshops regarding this grant application confirmed these barriers. Workshop participants in the northern rural areas of the

[1] New Mexico Department of Health. (2021). *NMDOH COVID-19 public dashboard.* https://cvprovider.nmhealth.org/public-dashboard.html

[2] United States Census Bureau. (2021). Top Trading Partners—March 2021. https://www.census.gov/foreign-trade/statistics/highlights/top/top2103yr.html&sa=D&source=editors&ust=1621717659913000&usg=AOvVaw15ESydsyrYLWPWwcd7-CNp

County, specifically Hatch, indicated that residents originally from Zacatecas and other parts of southern Mexico feared traveling to the County's urban core (Las Cruces) for medical care because of U.S. Customs and Border Patrol checkpoints. Even after years of living in Hatch and the surrounding towns and villages, many families are of mixed documentation status and would prefer to remain at home when a family member is sick rather than face deportation (Incite Network, personal communication, May 22, 2021).

In this context, community health workers (CHWs), as defined by the American Public Health Association, are often the only bridge to information and necessary health and social services for County residents. They are essential partners in stemming the spread of COVID-19, educating community residents, interpreting and adhering to health and public health recommendations, and helping residents navigate economic and social challenges associated with this public health emergency.

B. Approach

B.i. Purpose. Based on the premise that CHWs are agents of change in their communities, HHS will enhance and expand the County's CHW workforce to wholistically address COVID-19, including its clinical and socioeconomic impacts in this hard-hit U.S.-Mexico border county; increasing capacity to manage CHWs as a sustainable component of the County workforce by educating area clinical and nonclinical organizations about CHW roles and skills and promoting their integration into care teams and other settings, and developing policy recommendations for sustainable financing of CHW programs. CHWs will be involved in the design, delivery and evaluation of all training and outreach materials.

B.ii. Outcomes. The intended project, *Agentes de Cambio: Building COVID-19 Resilience in Doña Ana County with Promotores de Salud, p*roposes the following outcomes for Category A: Capacity Building. All outcomes indicate the intended direction of change, i.e., increase, decrease, maintain.

Train Strategy CB1 proposed outcomes are to *increase* CHW skills/capacity/roles to provide services and support for the County COVID-19 public health response efforts among priority populations within communities. In collaboration with state-led CHW training efforts, the County **will have increased its workforce by 50 CHWs** who have completed local HHS-led COVID-19 response training efforts to mitigate the effects of the pandemic on its priority populations by the end of the performance period.

Deploy Strategy CB3 proposed outcome is to *increase the capacity* of County CHW workforce delivering services to manage the spread of COVID-19. **10 non-traditional and 20 traditional CHW employers/organizations** will have increased their workforce with CHWs to support COVID-19 for their clientele by the end of the performance period.

Engage Strategy CB5 proposed outcome is to *increase* the utilization of community resources and clinical services for those at highest risk for poor health outcomes among priority populations within communities. Measures include **50 individuals/organizations within communities and/or clinical settings reached through outreach and education**, including those at highest risk for poor health outcomes, including those resulting from COVID-19, among priority populations within communities. This will also be completed by project term.

Strategy CB6 (Year One and Year Two) supports CB5's proposed outcome and will yield a project measure of **300 referrals** for individual, specific, named health and social conditions, and social conditions that increase the risk of COVID-19 for people at highest risk of poor health outcomes, within clinical and/or community settings by the term of the project period.

The final optional Strategy CB7, also under Engage, will increase engagement of health insurance providers, including the state's MCOs and the state Medicaid program to discuss ways to reimburse employers for CHW services. Project measures will show **20 partnerships established** with clinical and non-clinical partners who will receive education about the roles and value of CHW services and how to integrate CHWs into their staffing patterns.

B.iii. Strategies and Activities. HHS will enhance and expand its CHW workforce through its existing community coalition and CHW infrastructure by 1) developing, delivering, and monitoring an interactive, instructor-moderated training program, website, and peer-mentoring program for CHWs county-wide to wholistically address COVID-19, including clinical and socioeconomic impacts and interventions. Training will be delivered online, hybrid, and/or face-to-face depending on CHWs' needs and public health orders; 2) deploying COVID-19-trained CHWs to support community members in this hard-hit U.S.-Mexico border County; 3) creating a Doña Ana County (DAC) COVID-19 Community Corps that will share timely, accurate information with family, friends, and neighbors about the pandemic and its mitigation; 4) increasing internal capacity to manage CHWs as a sustainable component of the County workforce; 4) educating area clinical and nonclinical organizations about the roles and skills of CHWs and promoting their integration into care teams and other settings; and 5) developing a white paper that includes policy recommendations for sustainable financing of CHW programs. Experienced CHWs will be involved in the design and delivery of all training and outreach materials and evaluation activities.

This project complements the New Mexico Department of Health (NMDOH) three-year CDC-funded project to employ an increased number of CHWs throughout the state under the *National Initiative to Address COVID-19 Health Disparities Among Populations at High Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities.* NMDOH intends to work in five counties. Eleven CHWs will be placed in Doña Ana County and will participate in HHS program activities. Given that the County has been one of the areas hardest hit by COVID-19, HHS and NMDOH will blend resources, avoid duplication, and strengthen the capacity of the CHW workforce to address COVID-19 and other public health emergencies. Please see the attached required letter of collaboration from NMDOH.

Curricula will be updated and expanded as necessary to reflect emerging knowledge and rapid changes in the COVID-19 situation. Topics will include COVID-19 prevention (e.g., culturally appropriate vaccine outreach), secondary impacts of COVID-19 (e.g., identifying and supporting COVID-19 "long-haulers" and their families; parent education to support children's social emotional learning in the context of COVID-19) and border-specific issues (e.g., supporting transnational and mixed-documentation families in the context of COVID-19). Subject-matter experts will be engaged to provide guidance and review of materials. Curricula will be developed in English and translated to Spanish. Each module will include assessment tools, interactive content, and resource lists. CHWs will learn how to use their skills to assist clinical and non-

clinical employers and local governments with mitigation of the pandemic and build community resilience.

HHS will leverage the Doña Ana Wellness Institute/Health Council to act as the required community coalition for this application. The mission of the Wellness Institute is to foster a community-centered, integrated health system to improve the health of County residents. The community coalition will support CHW and employer recruitment in this initiative to achieve the respective application outcomes. Below is a detailed description of strategies and activities employed under the CDC's three-pronged approach—train, deploy, and engage.

TRAIN—Required Strategy CB1 activities include—

1. Annually develop up to six online, interactive COVID-19 modules, each two to three hours in length.
2. Develop a three-hour total COVID-19 course for community members to create the Doña Ana County COVID-19 Community Corps (Community Corps).
3. Develop a facilitation guide and train CHWs to deliver the Community Corps training
4. Hire two CHWs, a Program Coordinator, and Data Coordinator to oversee training efforts, data management, and organizational engagement strategies.
5. Deploy the modules through a learning management system (LMS), housed initially through a link to the County website.
6. Train 50 CHWs over the project period, disseminating reliable, up-to-date information about COVID-19 treatment, testing, vaccinations, and other key public health response factors through a County-run webpage.
7. Administer stipends to enhance and incentivize CHWs to complete the curriculum, inform activities, and participate in peer mentoring to support potential placement in organizations addressing COVID-19 disparities.

Each module will include multiple self-contained units of interactive content, assessments, resources, and discussion opportunities. Each unit will require approximately 15-20 minutes to complete, for a total of 2-3 hours per module. The coursework will be taught by two HHS-employed CHWs (titled Community Health Worker-Promotora in attached HHS position description). A curriculum development and outreach consultant/firm will design the modules and train the HHS CHWs to facilitate the courses. These self-paced and live instruction, instructor-moderated courses will be offered for free, be used for continuing education credits, and complement current CHW training and certification efforts in the catchment area.

In addition, CHWs will be trained to facilitate the Community Corps training, which will complement and expand the federal COVID-19 Community Corps' project beyond vaccination to address prevention, resources, and other COVID-19 impacts. HHS will deploy the Community Corps training by month six of the project term at partnering locations to include local federally qualified health centers, public libraries, County community resource centers, and jurisdictions within the County (e.g. Village of Hatch, City of Anthony). Both CHW and Community Corps trainings will be available in English and Spanish and incorporate best practices in health literacy, adult education, and online pedagogies.

Participating CHWs will be automatically enrolled in the *Agentes de Cambio* listserv and will receive reliable, timely information on COVID-19 and other emerging public health issues in the catchment area. The listserv will be open to all CHWs.

DEPLOY—Required Strategy CB3: The three-year outreach campaign goal is to approach organizations at the appropriate time with the appropriate message to affect their decision-making process on whether to engage or employ CHWs in COVID-19 prevention, treatment, and/or education. The outreach campaign will also emphasize the benefits of the CHW model to deliver patient-centered care, including improved access to health-care and safety-net services, more efficient care teams, increased patient engagement, and reduced unnecessary care.

Activities include—

1. Deploy a targeted outreach campaign to educate organizations and care teams on the critical role CHWs play in delivering services and managing the spread of COVID-19 among high-risk populations.
2. Educate organizations about CHWs and their essential role in addressing COVID-19 disparities.
3. Conduct focus groups with three targeted audiences to design the outreach campaign.
4. Support the community coalition in creating a list of organizations/employers from their respective networks to interview and/or invite to a focus group.
5. Survey targeted employers' to gauge their understanding and value of CHWs, scope of work, and importance to combating COVID-19 disparities.
6. Create profiles of organizations most likely to employ CHWs.
7. Complete a list of organizations that typically hire CHWs for the "Engage" phase.

Targeted organizations include (1) health-care providers; (2) community-based organizations and local government entities; and (3) non-traditional CHW employers. Non-traditional employers are defined as libraries, community action agencies, workforce boards, schools, credit unions, health information exchanges, pharmacies, and other entities that directly or indirectly address the pandemic. Priority organizations include entities that serve rural areas of the County and central and southern Las Cruces, where disparities are greatest. The focus groups and survey, and direct input from CHWs will inform collateral materials, which will be designed and deployed by month 6 of the initiative.

The outreach campaign will ensure that the organizations understand the 10 core roles of CHWs as identified by Rosenthal, Menking, and St. John (2018): 1) cultural mediation among individuals, communities, and health and social service systems; 2) culturally appropriate health education and information; 3) care coordination, case management, and system navigation; 4) Coaching and social support; 5) advocating for individuals and communities; 6) building individual and community capacity; 7) providing direct service; 8) implementing individual and community assessments: 9) conducting outreach; and 10) participating in evaluation and research.

ENGAGE—Required Strategy CB5 (Required)

Activities include—

1. Create a peer-to-peer mentoring system, administered by the two CHWs hired for this grant and under the supervision of the HHS Program Coordinator.

2. Work with the curriculum design and outreach consultant to create an onboarding toolkit to be distributed to organizations that will be engaging CHWs during the project term.

HHS CHWs will work to provide an environment, both online and in person, where seasoned and experienced CHWs will mentor one another as they go through placement in a new position or engage a new organization in their work to mitigate COVID-19. The environment will empower both parties to shape their learning context. The peer mentoring program will leverage best practices and findings from the Community Health Worker Core Consensus Project from Texas Tech University Health Sciences Center El Paso, the C3 project[3], to inform CHW roles, skills, and qualities to expand cohesion in the CHW field and contribute to a better understanding of the full model's potential. Prior to the start of mentoring, the HHS CHWs will be trained by the curriculum development and outreach consultant.

The toolkit will include a position description, ways to best integrate a CHW into the operational staffing plan, and work performance evaluation measures. Moreover, the CHWs and Program Coordinator will provide onboarding consultation hours to speak with care teams or other organizational staff that will be overseeing the CHW(s). Together, they will discuss best practices and answer organizational questions on how to best integrate a CHW into the work environment.

With CHWs more widely integrated into different communities and sectors county-wide, HHS will be able to increase use of community resources as more residents begin to receive clinical care or social services. To quantify the outcome, an estimated 300 people will be reached through outreach and education, including the targeted population in central and southern Las Cruces and the rural areas. This metric will be calculated through the collective CHW outreach efforts being reported to the Program Coordinator on a monthly basis.

Strategy CB6 (Year One and Year Two) activities for both years one and two will include—

1. Create a vehicle for documenting how CHWs are integrated into direct care, support, or follow-up.
2. Contact each participating organization on a quarterly basis, asking a series of key questions regarding the use of the new CHW position(s).
3. Deploy a larger survey every six months, to gather data from the base of participating organizations.
4. Host focus groups with CHWs who are employed with clinical and nonclinical organizations and supporting coordination of care and social services for people at highest risk for poor health outcomes including those resulting from COVID-19.
5. Analyze and use focus group results to inform the ongoing development and refinement of modules for both CHW and DAC COVID-19 Community Corps curricula (see the earlier described TRAIN strategy.

[3]St. John, J., Byrd-Williams C., Rosenthal E. L., Menking, P., Redondo, F., Ewing, M., Herrington, E., Sieswerda, S., Kwentua, V., Dixon, M., & Simpson, J. (2021). The Final Report of the Community Health Worker COVID-19 Impact Survey: Texas Results & Methodology. The University of Texas at Houston Health School of Public Health; Texas Tech Health Science Center El Paso Paul L. Foster School of Medicine; & Texas Tech Health Science Center School of Biomedical Sciences.

Elected—Strategy CB7: activities include engagement with—

1. The state's Managed Care Organizations (MCOs) and the State Medicaid Office (New Mexico Human Services Department, Medical Assistance Division) to explore reimbursement options for CHW services, in collaboration with other employers of CHWs in New Mexico and the NMDOH.
2. The New Mexico Primary Care Association, the New Mexico Hospital Association, and other health professional organizations and state coalitions such as the New Mexico Alliance of Community Health Councils to solicit input regarding reimbursement of CHW services and advocate for adequate salaries to sustain their positions.
3. County employers to promote the services of CHWs and the value this position brings to organizations, clients, and constituencies.
4. Completion of a white paper and policy recommendations to explore payment models for reimbursement of CHW services by private payors and New Mexico Medicaid.

1. Collaborations

In preparation for submission of this application, HHS held planning calls with the required CDC-funded partners who effect change in the catchment area. These partners include the NMDOH and Presbyterian Healthcare Services. Both agreed to receive regular communication and written updates regarding the award should this grant be funded. HHS routinely corresponds with NMDOH, given that HHS facilitates on-the-ground service coordination for those impacted by COVID-19 in Dona Ana county, while NMDOH processes vaccination distribution, scheduling, and CDC reporting.

We expect additional collaborators to join the project network as it evolves, including the Southern New Mexico Promotora Committee (SNMPC), an organization of CHWs that provides a network for them to share ideas about how to better serve their communities. We will solicit their suggestions for training topics, available resources, and fair working conditions for CHWs.

Given that the catchment area is in the U.S.-Mexico border region, other partners include the University of Texas at El Paso, a strategic partner to the National COVID-19 Resiliency Network. They have formalized partnerships with CHWs in key areas of southern Doña Ana County, as well as the incorporated city of Anthony, New Mexico. We will exchange best practices and create awareness among their base of participating CHWs about the training and engagement opportunities developed through *Agentes de Cambio*. Others include the Texas A&M Colonias project with a satellite program in the neighboring community of El Paso Texas; New Mexico State University, federally qualified health centers, the New Mexico Primary Care Association, Southern New Mexico Family Medicine Residency Program, and surrounding medical schools.

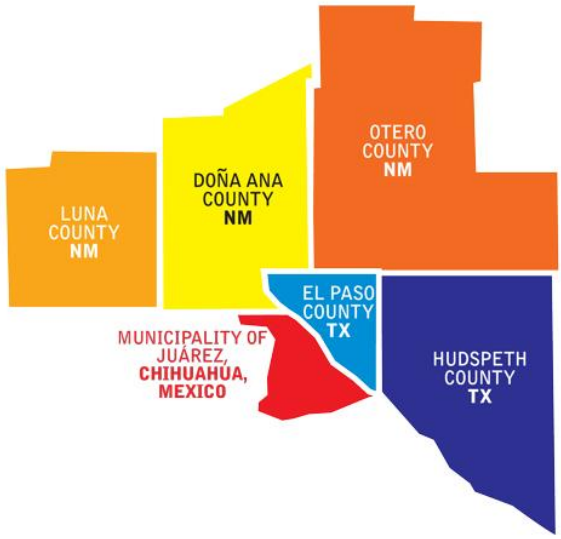
The Dona Ana Wellness Institute will act as the community coalition and champion for *Agentes de Cambio*. The Institute, which also serves as the County Health Council, includes more than 25 diverse organizations that have mobilized health-care and wellness initiatives throughout the County. Key strategies adopted by the Institute are 1) to collaborate for structural competency awareness and community partner programs and 2) broaden joint efforts for health policy and systems, and environmental change. Current priorities include substance use and access to care. To address these priorities, the Institute established 1) the Opioid+360 Committee to increase access to medication-assisted treatment and stigma related to substance use disorders and 2) the

Integrated Care Collaborative working group to implement a community-wide system of care to improve patient outcomes and decrease inappropriate use of healthcare resources. Psychiatric residency and COVID-19 have also been key focal points of their body of work.

In partnership with New Mexico State University, the Wellness Institute collected and analyzed data about the impact of COVID-19 on rural and colonia communities. They also provided guidance to the local Office of Emergency Management to assist with setting policies related to quarantine, isolation, and return to work decisions. Moreover, in partnership with the State of New Mexico Department of Health, the Wellness Institute established a COVID to Home/Hotel program to care for people in the community and reserve hospital beds for critical care needs. The collaboration included telephonic medical appointments with physicians, daily calls from health-care providers, and electronic in-home monitoring of health indicators.

The Wellness Institute will engage residents by providing agenda items for discussion and updates about the project to the *Convivio* committees, CHW-run community sessions at community resource centers. Attendees are from the community and receive CHW-led programming. They will be able to inform the CHWs of their desire for changes, provide suggestions, and share case studies to ensure that the Wellness Institute further leverages this information as the project progresses.

2. Target Populations and Health Disparities



This project will serve residents of Doña Ana County, a part of the "Paso del Norte" region, which consists of El Paso and Hudspeth counties in far west Texas, Doña Ana, Luna, and Otero counties in southern New Mexico, and the municipality of Ciudad Juárez, Chihuahua, Mexico. Specifically, the project will target **County residents with long-standing health and social disparities, with emphasis on rural areas in the northern catchment area.** At 80.5 years, life expectancy from birth in Doña Ana County is slightly higher than the rest of the state and nation. But this average belies large differences in life expectancy between neighborhoods in the county. Discrepancies in life expectancy within the catchment area reach 4.2 years. **Moreover, zones with the lowest life expectancy are southern and central Las Cruces, Sonoma/Butterfield/ Moongate, and Fort Selden and will also be targeted in this project**.

The region has a combined estimated population in excess of 2.4 million and covers a land area that encompasses an estimated 13,352 square miles (34,581.5 km^2). The Paso del Norte region is located at the midpoint of the 1,954 mile border shared by the United States and Mexico.

The County encompasses nearly 4,000 square miles and has the second largest population of any county in New Mexico, with an estimated 218,195 residents in 2019 (Census Quick Facts, 2020). Of the county's 218,195 residents, 144,274—66%—currently receive services and benefits from

New Mexico Human Services Department such as Medicaid, Temporary Assistance for Needy Families (TANF) Program, Supplemental Nutrition Assistance Program (SNAP), Child Support Program, and/or Behavioral Health Services.[4] Approximately half of County residents live in the County seat and urban center of Las Cruces, one of the fastest growing communities in the United States, while the other half live in various semi-urban, rural, and frontier communities.
One out of four people in the County is a child aged 18 or younger; 16.2% of the population is older than 65 years. The population is 68.8% Hispanic or Latinx, primarily of Mexican descent; and 26.7% of the population is non-Hispanic White. About 8% of the population is Black (2.4%), American Indian (2.3%), Asian (1.3%), Native Hawaiian (0.2%), or of other ethnic backgrounds. Slightly more than half (51%) of the population is female.

Health Disparities. In New Mexico, Latinx populations have been affected by COVID at twice the rate of Whites and 1.7 times that of Blacks[5]. Census tracts with a poverty rate of 40% or greater show rates of COVID-19 hospitalizations nearly three times (11.12% vs. 4.73%) those of areas with a poverty rate of 5% or less.[6] New Mexico's COVID-19 case fatality rate for high poverty zones is 3.35%, compared to 1.36% for wealthier communities. These disparities correlate with a lack of access to culturally appropriate, accurate, health-literate information and key medical resources. The majority (72%) of the region's population speaks Spanish at home, and 28.5% of adults do not have a high school diploma[7], increasing the risk that they will have difficulty accessing, understanding, and acting on health information and increasing their susceptibility to misinformation as well documented by the World Health Organization and others regarding the intersection between health literacy and education levels.

CDC data from 05/23/21 for the week May 14-20, 2021, indicates the **7 day total reported cases per 100,000 population was 13.75**. Seven-day total reported deaths is suppressed. At the peak of the pandemic in November 2020, CDC reported a weekly average of 386.83 cases. As of 5/23/21, only 34.5% of the total population had been fully vaccinated..

The County's Social Vulnerability Index (SVI) .9841, reflecting the multiple challenges faced by residents in their everyday lives. **More than one out of four individuals (27.7%) live in poverty; among children 18 and younger, 41% live in poverty**.[8] Only 73% of households have access to a broadband internet subscription. These factors have been shown to increase risk of COVID-19 infection and poor outcomes.

The County, like other regions in the U.S./Mexico border, has been designated by the Health Resources and Services Administration as a medically underserved area since 1994. Residents in

[4] New Mexico Human Services Department. (2021). *Unique HSD customers, May 2021.* https://www.hsd.state.nm.us/
[5] New Mexico Department of Health. (2021). *New Mexico COVID-19 cases update demographics April 12th, 2021.* https://cv.nmhealth.org/wp-content/uploads/2021/04/State-Report_demographics_04.12.21.pdf
[6] New Mexico Department of Health. (2021). *New Mexico COVID-19 cases update: Health and social characteristics April 12th, 2021.* https://cv.nmhealth.org/wp-content/uploads/2021/04/State-Report_healthsocial_04.12.21.pdf
[7] New Mexico Department of Health. (n.d.). *Health indicator report of New Mexico population—Education, no high school diploma*. https://ibis.health.state.nm.us/indicator/view/NMPopDemoEduc.Sarea.html
[8] United States Census Bureau. (2019). *2014-2018 poverty rate in the United States by county.* https://www.census.gov/library/visualizations/interactive/2014-2018-poverty-rate-by-county.html

rural areas of the County must travel long distances to care and struggle with multiple barriers to improved social determinants of health. Border Patrol checkpoints represent significant barriers to COVID-19 testing, treatment, and vaccination for many families of mixed documentation status.

A total of 90,000 residents live in the 37 colonias (unincorporated communities with little to no infrastructure such as sewage, water, paved streets, and in some cases, electricity, often characterized by extreme poverty) in the County. One in four live in poverty in these 4,000 miles of wild brush and isolated rural areas and have higher poverty (e.g., Sunland Park at 34%, 48.6% in Anthony) than other areas of northern New Mexico. Outreach for mental health needs is complex given that the area includes small towns, villages, and cities with a unique culture that are disconnected from a larger, dense urban center. Leading causes of death include cancers, heart disease, and unintentional injury (e.g., falls).

Specifically, the County's northern region's population is 84% Hispanic (primarily of Mexican descent) and has been disproportionately affected, with 14% of residents testing positive for COVID-19. Poverty, which reaches 58% in the rural community of Salem, and Hispanic ethnicity render this population vulnerable to COVID-19. Other vulnerable populations supported in this application include those living in poverty, of LatinX ethnicity, and lower educational attainment. Specific locations in the catchment area also include the urban areas of south and central Las Cruces.

In a county of such socio-economic, cultural, demographic, and geographic complexity, CHWs are essential partners in reaching the most vulnerable residents. These communities are so sparsely populated, remote, and closed—i.e., suspicious of outsiders—that trusted community members are often the main source of information. People who interact with many other people each day—barbers, hairdressers, grocery store clerks, librarians, pastors, teachers, child-care workers—dispense information with each encounter. However, they need accurate, culturally relevant, health-literate information to share with clients and customers, as well as family, friends, and neighbors. **HHS will leverage its current connections given its community resource center programming in the targeted areas, its relationship with jurisdictions, and partnerships. CHWs will be geographically deployed to these areas for increased impact.**

C. Evaluation and Performance Measurement Plan

Program participant inclusion in the evaluation. HHS will collect data via its Data Coordinator and consult with its third party evaluator, Crimson Research, to be responsive to the CDC Evaluation and Performance Measurement Plan requirements and six-month reporting period. HHS agrees to work with organizations funded through the companion NOFO DP21-2110 on training, technical assistance, and evaluation HHS will complete a data collection and management process that includes (1) a review of the survey instruments and other data collection vehicles to ensure they align with CDC guidelines and if they are subject to IRB approval; (2) create data collection mechanisms on a quarterly basis to report on performance metric outcomes to share with the community coalition and other stakeholders; and (3) refine both outcome and process evaluation efforts with Crimson Research. The data collection plan will house a schedule for collection, data analysis, reporting, team meetings, community coalition presentations, process to refine the strategy based on the evaluation and where any physical and digital documentation will be housed, protected, and accessed.

TRAIN Evaluation Measures:

1. Recruitment effectiveness of CHWs to complete the self-paced online modules, versus those who take the course via live instruction.
2. Number of CHWs recruited quarterly versus the quarterly recruitment goal.
3. Ratio of recruited to enrolled.
4. Identification of how CHWs learned about the online training.
5. Completion rate.
6. Satisfaction with the recruitment process, online learning management system, instructors, and overall training experience.
7. Feedback on the use of stipends to support the training process.
8. Satisfaction rates on Dona Ana County COVID-19 Community Corps training modules.
9. Achievement of learning objectives via pre- and post-tests for each module.

Available data sources include survey distribution, pre- and post-tests for knowledge gained, recruitment numbers collected. Long-term analysis on the application of the CHWs new skill sets will also be included via one-to-one interviews and case studies collected every six months of the grant application. A series of at least five case studies each year will be collected.

DEPLOY Evaluation Measures include participation rates of CHWs in focus groups and organizations in focus groups, number of organizations with increased awareness of the benefits of CHWs and number of organizations expressing interest in CHW engagement. Available data sources include sign-in sheets from focus groups, surveys that indicate level of awareness as a result of outreach materials, and organizations declaring interest in engagement via a tracker maintained by the Data Coordinator and Program Coordinator, similar to a customer relationship management platform.

EMPLOY Evaluation Measures include the number of organizations engaging CHWs formally (e.g., through employment, internships or other means of embedding into care teams) and number of individuals supported with resources for COVID-19 testing and treatment of support on secondary effects. Available data sources include data sharing agreements with participating organizations to share patient referral outcomes on a monthly basis. Information will be de-identified and aggregated by type of referral (e.g., food security, housing, workforce development, counseling, clinical care, specialty care).

Key evaluation questions include the following: (1) Did the training increase the participating CHW competencies, skill sets, and abilities in COVID-19 support? (2) Did the outreach campaign increase the awareness of organizations regarding CHW value? (3) As a result of this program, were CHWs placed/embedded into care teams to support COVID-19 education, prevention, and treatment? (4) Did this program increase referrals for key priority populations into support services applicable to COVID-19 aftereffects?

D. Organizational Capacity of Applicants to Implement the Approach

Previous experience in CHW models. CHWs have been an integral part of the health care, social services, and community advocacy landscape in the County since the 1980s, when one of the local federally qualified health centers—La Clinica de Familia—adopted the CHW or "promotora"

model from neighboring Mexico. HHS has identified an extensive network and body of CHWs working in various organizations to support disadvantaged communities, using key tenets to engage remote, hard-to-reach populations. The urgent and novel requirements of COVID-19 mean that additional training is needed for County HHS CHWs. As CHWs continue to play a role, it is also urgent that sustainable funding mechanisms be developed to ensure CHWs' work can be compensated.

HHS oversees court compliance; outreach and education; and program operations to address border-area health status indicators in New Mexico communities. HHS' key strengths include the following: (1) combined administrative and volunteer staff of nearly 60; (2) experience overseeing an annual budget of $8.8 million and administering contracts totaling $5.8 million; (3) deep-rooted collaborative connections with other local and regional organizations involved in public health issues; (4) access to six rural community centers that continue to function as operational hubs during the pandemic despite closure to routine activities, as well as access to County facilities for meetings and planning; and (5) advanced data collection and analysis capabilities to ensure accurate assessment of outcomes.

HHS has had an active CHW program since the department's inception in 2001. Specifically, it has worked with CHWs to utilize community resources centers to bring health education to various participants in County rural areas. Partners Ben Archer Health Center and La Clinica de Familia, both federally qualified health centers, were entities that deployed CHWs to teach curricula on nutrition, parenting, and behavioral health.

In 2012 a partnership between HHS and Memorial Medical Center, a local hospital, was established to create the Doña Ana County Nuestra Vida Program. CHWs were hired to learn about the program, provide input on logistics, and handle the outreach component. The Nuestra Vida Program experienced great success since the first year, and it is often credited to the CHWs' work. Notable achievements include the 2017 Nuestra Vida program that leverages CHWs to improve community consciousness that supports individual health lifestyles, improves preventative behaviors for people with pre-diabetes, and promotes healthy eating and increasing physical activity and decreasing sedentary behavior. The program continues to be a success with individuals exhibiting 84% reduction in hemoglobin A1c levels; 83% decreased cholesterol levels' 54% weight loss; 65% decrease in systolic blood pressure levels; and 51% decrease in systolic pressure levels. In addition to these quantitative results, focus groups with program participants indicated that many have made significant lifestyle changes, such as meaningful change to family eating habits and developing a new appreciation for regular physical activity.

The management of the community resource centers originally was done by AmeriCorps VISTA members and upon finalizing the timeframe an organization can be assigned AmeriCorps VISTA members in 2012, HHS started hiring CHWs to manage the community resource centers' daily operations. HHS currently has 11 certified CHWs (3 in health promotion, 1 in contract administration and 7 in community outreach) and 4 (outreach) are waiting their state certification. ***Plans to supervise the project.*** As emphasized in the staffing plan, HHS will have a new mini-division created to provide a concerted focus on the work being completed. The individuals assigned have experience overseeing CHW work to include the Outreach and Education Division Manager, Mr. Eric Bransford. Newly hired staff will be nestled under the Community Outreach

Division of which Mr. Bransford oversees. Formalized in 2003, the Outreach and Education Division houses both a network and mechanism to reach residents of rural communities and colonias in Doña Ana County. Moreover, this division can mobilize seven community resource centers that are operated in rural communities and allow HHS providers to deliver direct services as well as community organizing. Finally, the Community Outreach and Education Division hosts the monthly "Convivio" planning sessions as described in the Strategies and Activities section.

Readiness and ability to begin implementation and data collection within 1 month of award. HHS has a data collection system in place and is well acquainted with data entry to include federal level systems such as SAMHSA's Performance Accountability and Reporting System. Prior to hiring a Data Coordinator and Program Coordinator, HHS will leverage the current Health Promotion Coordinator and their system for data coordination should reporting be required in the first 30 days. HHS staff will conduct a meeting as soon as it receives a notice of award and identify the use of Excel spreadsheets to capture the grant's key performance measures.

Budget management and administration capacity to establish financial procedures and track, monitor, and report expenditures. Upon award and acceptance, the Doña Ana County Financial Services Department would be responsible for the financial management of the proposed project. The department comprises five major components: general ledger compliance, finance operations, budget, purchasing, and grant administration. Specifically, grant administration ensures financial and programmatic compliance with federal, state, and local laws as well as regulations, contracts, and grant agreements. Asma Dawood, Financial Services Director and certified public accountant (CPA), maintains responsibility over the various departments and oversees grant administration. Ms. Dawood has over 20 years of experience within her field, ranging from overseeing the accounts of major universities to companies within the manufacturing industry. She holds a Master of Business Administration in Financial Management and a Master of Accountancy. A copy of Ms. Dawood's resume is included in the proposal.

Contract management to manage the required procurement efforts, including the ability to write, award, and monitor contracts. HHS has a Grants and Contract Administrator, Ms. Anabel Conchela, available to manage contracts associated with this grant as well as adhere to the stated procurement requirements set forth by the County. Hired by Doña Ana County in 2009 as an Administrative Assistant to the Director, she became knowledgeable about the County and border community needs and a resource for social service referrals. Then she was promoted in 2012 as Program and Contract Administrator to administer the County Healthcare Assistance program and the Nuestras Emociones program. She is a certified mental health first aid instructor in the adult and youth English and Spanish curriculum since 2013 and is certified as a New Mexico CHW since 2019. Data management to design collection and evaluation strategies to produce useful data that demonstrate impact, program improvement, and sustainability

Partnership development and coordination. The Wellness Institute will act as the hub of coordination across the various sectors. During the meetings, members will be asked to leverage their own respective networks (e.g., networks of businesses/organizations interested in employing or engaging CHWs) as well as opportunities to promote the initiative. Given that there are no tribal land areas within the catchment areas, only state and local jurisdictions will be approached for participation at the Wellness Institute level