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Reducing COVID-19 Pandemic Morbidity and Mortality in the Minority Population through Education and Training of Diverse Community Health Advocates/ Ambassadors

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ABSTRACT

This paper summarizes a successful community-academic collaboration to provide education and training for 60 community health advisors/advocates (CHAs) to prevent or reduce the impact of the COVID-19 pandemic on populations with disadvantage (Midwest, Omaha and Douglas County, Nebraska, USA). African American and Latinx CHAs were the majority, but CHAs also represented the Maya community. The project's basis was a prior project that empowered CHAs to enhance community physical activity in the African American community. The education/training sessions were exclusively virtual, combining group presentations with discussion and small breakout groups for case study review (examples provided). The paper summarizes curriculum content, organizational structure, diverse information dissemination approaches, and how the project successfully met evaluation objectives. CHA trainees were diverse. However, the model employed might not translate to other communities with different histories, culture, and persuasions.

Keywords: Collaboration; Partnership; Ethics; Health equity; Community; Academy

Introduction

The COVID-19 global pandemic is harming and killing more and more people. The United States of American (USA) is sadly a leader in both infection and mortality rates. Moreover, African American (AA) and Hispanic/Latinx (H/Lx) populations have even higher infection and death rates. Native Americans, Pacific Islanders, and other indigenous populations probably have comparably adverse pandemic outcomes, although less data on these latter groups exist [1-3].

As Kullar and colleagues (2020) recently summarized, reasons for these racial/ethnic minority COVID-19 disparities are well documented, including unjust inadequacies in multiple social determinants of health, worse healthcare access, and inferior healthcare on average [1]. Specifically, transgenerational structural racism is a possible cause. Consequently racial/ethnic minorities with disadvantaged status experi- ence greater chronic disease rates and severity.

Further, several of those chronic diseases like cardiovascular diseases, diabetes, obesity, cancer etc. predispose COVID-19 infected individuals to worse health outcomes [4]. Also, recent immigrants and people with English language challenges face further barriers [2]. These adversities translate into multiple specific reasons for disproportionate racial/ethnic minority deaths and morbidity. Numerous publications cite service positions and living conditions that require close interpersonal contact, greatly enhancing viral transmission.

Clearly, ameliorating these racial/ethnic COVID-19 health disparities and inequities requires changes at multiple levels in social determinant arenas. But action at community levels by community members is another vital step in reducing mortality from Covid-19 comparable to what community member participation has achieved for reducing many health disparities generally [5,6]. Such racial/ethnic community individuals' efforts are crucial for "Prompt, effective, and sustained health communication and outreach to inform COVID-19 prevention efforts in the Latinx population that is linguistically and culturally congruent, sensitive to histories, legacies, prevailing attitudes, and beliefs across this community" [2]. And in African American communities, Kullar et al. (2020) recommend: "engaging key community leaders (including faith based leaders, thought leaders, and regional or national celebrities) early on to disseminate information regarding infection transmission and prevention and promote evidence-based best practices for preventing COVID-19 transmission and avoiding cultural stigmatization" [3].

Readers no doubt know that an extensive literature shows that trained community members generally can help reduce health inequities among our populations at greatest risk and at greatest disadvantage regarding social determinants of health and access to high quality healthcare [7]. Common names for these personnel are community health workers, community health advisors or advocates (CHAs), promotoras, and navigators, with varying roles and responsibilities. However, a minimal literature thus far addresses how such community members can be prepared to ameliorate the COVID-19 pandemic and what programs have accomplished.

The purpose of this paper is to begin filling the literature gap on how community members can help reduce COVID-19 disparities and inequities. We summarize a training and implementation program for CHAs that aims to reduce the impact of the COVID-19 pandemic, with a special focus on chronic disease. Targeted populations are primarily

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AA, LX, immigrant individuals, and those suffering economic hardship identified by residence in public housing, in the Douglas County/ City of Omaha area of Nebraska. The setting is urban, with varying residential density.

Our approach applies a community academic collaboration built on a successful, longstanding community academic partnership and a very successful prior offshoot team effort to enhance physical activity in the same geographic area [5]. Given the model's major prior success, our current train-the-trainer program for CHAs to pre- vent and reduce COVID-19 inequities for racial/ethnic minorities and economically challenged people is a promising approach.

The paper proceeds as follows: We first summarize the background partnership and the prior successful project that is the basis for our COVID-19 CHA education and training approach. The paper then describes actions leading to current project funding, project organization and key partners, targeted populations, and curriculum design for the train the trainer approach. The paper also details subsequent CHA field work and reporting, continued education efforts, and CHA and public information dissemination strategies. Finally, the evaluation approach and continuous quality enhancement strategies are addressed.

Background

The foundational partnership was an offshoot physical activity project which involved the following: (1) the Center for Promoting Health and Healthy Equity (CPHHE), a center without walls sponsored by Creighton University, and (2) the Center for Promoting Health and Healthy Equity Racial and Ethnic Approach to Community Health (CPHHE-REACH). Figure 1 depicts CPHHE and CPHHE-REACH organizational development and elements.

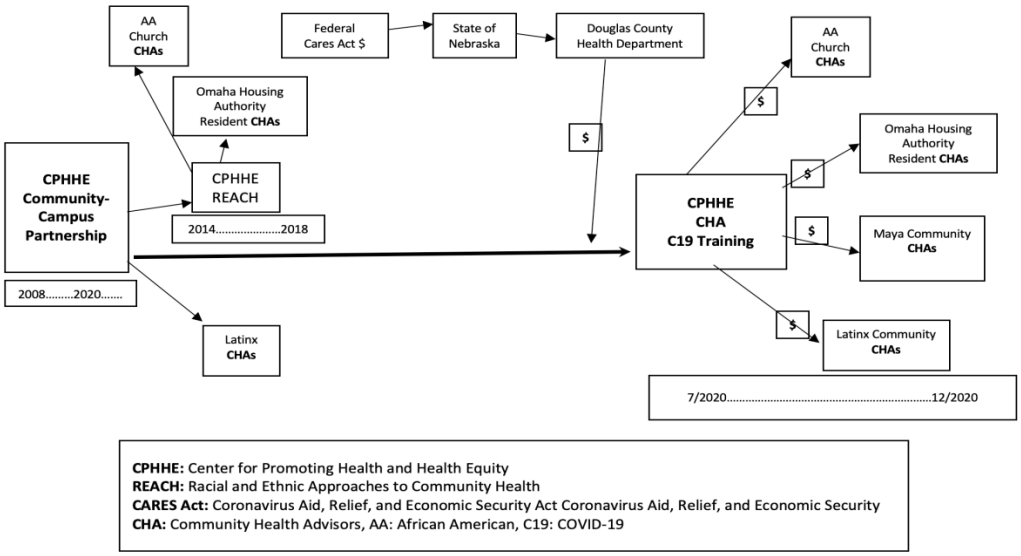

Figure 1: development and organization CPHHE & COVID-19 training project

We have previously summarized CPHHE and different aspects of CPHHE-REACH in several publications [5-7]. In summary, CPHHE is a community academic partnership formed in 2008. Creighton University provides CPHHE operating funds through allocations from state of Nebraska Tobacco Settlement fund LB692, directed toward elimination of health disparities. This continuing financial support, now annually renewable, supports a full time, MPH trained, Program Supervisor/community outreach provider. Authors Kosoko-Lasaki and Stone are CPHHE Co-Founders and Co-Executive Directors. Both are physicians (Ophthalmology and Cardiology, respectively). Also, Kosoko-Lasaki has master's degrees in public health and business. Stone has a PhD in philosophy with social justice and bioethics focus. Both have significant experience addressing health inequities through programs, projects, and research.

CPHHE, the voting partners, are 12 community and 11 university members. A community member is always the Center's chair. Other community members and academic personnel can be non-voting associate partners, at CPHHE's partners' discretion. Community partners are representatives of key community organizations. Others provide special expertise and experience. For example, community partners include representatives from two federally qualified community health centers (one primarily serving African Americans, the other especially Latinx individuals), the Douglas County Health Department, the Omaha police department, the Nebraska Urban Indian Health Coalition, the Urban League of Nebraska, faith based community (mainly African American churches) and the Omaha (Public) Housing Authority. Academic partners have varied in discipline and areas. They have included or now represent the Graduate Program in Bioethics, Department of Sociology and Anthropology, Program in Negotiation and Conflict Resolution, Spanish, Health Sciences Library, College of Nursing, Community Outreach, Department of History, and others.

In 2014, CPHHE-REACH, through a cooperative agreement with the Centers for Chronic Disease and Prevention (CDC), with a train-the-trainers approach, prepared community members to enhance and promote physical activity. These CHAs learned how to enhance sys- tems, environments, and policies in conducive ways to reduce cardiovascular disease and its risk factors in Omaha African Americans. The focus was on preventing or improving chronic diseases, especially

cardiovascular and its risk factors. From 2014-2018, this $ 1.8 million project trained 60 CHAs. These community members impacted 42,000 individuals in the African American community in Omaha. Concrete outcomes include signage for in and out door walking trails and stairwell messaging, exercise advice in public housing towers, a community health center, and in the predominantly African American churches.

CPHHE-REACH also initiated an annual physical activity day event that continues after CDC project funding ceased. CPHHE-REACH collaborators continue in relationship through their roles as partners in the parent CPHHE organization. CPHHE-REACH collaborators were an organization of 12 AA churches and 11 low income Omaha (Public) Housing Authority towers. Partners from Douglas County Health Department and the Creighton University School of Medicine provided CHA training.

Then came the COVID-19 pandemic with exploding rates of infection and deaths, and significant disparities among the populations noted above. Fortunately, the federal Coronavirus Aid, Relief, and Economic Security Act (CARES) included an allotment to the state of Nebraska [8]. Some of the CARES funds went to Douglas County that includes most of Omaha. The County Health Department Director and CPHHE leadership agreed that further training of CPHHE REACH certified CHAs and some new CHA recruits from the Hispanic/Latinx, Maya, and Somali communities could significantly ameliorate the pandemic impact among our most at risk populations in the community. CPHHE leadership thus drafted and submitted a proposal to the Douglas County Health Department that included the elements we detail below.

Methods

Leadership and structure

The project employed the leadership and structure that Figure 2 depicts. Key leaders met weekly for coordination, planning, and problem solving. Author Kosoko-Lasaki again served as Principal Investigator. She and key personnel addressed all project features and challenges.

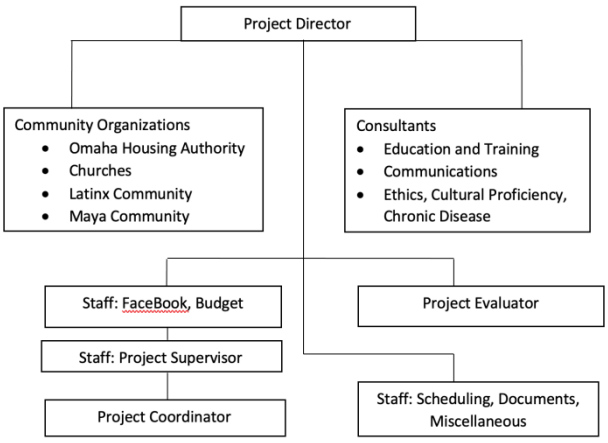

Figure 2: COVID-19 CHA training project organizational chart

Attending were the lead curriculum developer and educational presenter (author Lassiter); Director (author Issaka) and Assistant Director of the Omaha Housing Authority; Project Coordinator; Project Publicist for drafting and disseminating multimedia communications (author Brown), Project Consultant for Ethics, Culture, Chronic Disease, and Editing (Author Stone); project day to day coordinator, and the Project Coordinator, Project Supervisor and Social Media Liaison.

We again employed the CPHHE-REACH education and training model, but used Zoom video conferencing to maintain social distancing. Leaders were recruited for each partner subgroup: African American churches, Omaha (Public) Housing Authority towers, Latinx, and Maya communities. Each subgroup leader coordinated the reporting of CHA activity, stipend distribution, and problem solving. Partner arrangements with the projects and partner CHA groups were as follows:

Omaha Housing Authority (OHA)

Stipends went to OHA leaders and CHAs. OHA leaders determine stipend arrangements with CHAs. OHA developed a memorandum that each prospective CHA signed to affirm their "commitment to meeting the (document's) requirements." The stipulations included participating in eight weekly trainings; disseminating materials at OHA properties (towers); educating and motivating others about COVID-19 prevention; providing information about community resources like health screenings and constructive approaches to chronic disease; completing reports about numbers of people educated; and demonstrating cultural competency and proficiency. Further, signees were to meet "the highest standard of ethics" and "produce the best quality effort possible," including positively adding to the team environment. Through funds provided by the project, OHA would compensate each CHA with a monthly stipend.

Arrangements with African American churches

Funds were provided to each of the 12 churches to compensate the CHAs as a stipend. Formal written agreements were signed by each church's leadership and the project director.

Author Lassiter was the senior leader for African American Churches.

Arrangements with Latin and Maya community leaders

Funds were also provided to the previously trained CHAs in the Hispanic/Latinx and Maya communities through their individual leaders. The latter helped coordinate activities and provide translation for newsletters, flyers, posters, and banners developed by the COVID-19 project.

Goals and objectives

The project's two overarching goals were to increase communication of CDC and DCHD COVID-19 Prevention messaging and educate and train the CHAs to magnify the COVID-19 communication messaging to local residents in the North (African American concentration) and South Omaha (Latinx concentration) communities.

The objectives derived from the larger goals were more specific, as follows:

- **Objective one:** Increase direct CDC, COVID-19 Prevention messaging to minority Communities in Douglas County.
- **Objective two:** Recruit CPHHE's existing cadre of 50+ trained CHAs for this project.
- **Objective three:** Provide CDC/DCHD COVID-19 Education Training Workshops.
- **Objective four:** Educate and train CHAs to disseminate COVID-19 Prevention Guidelines to local community members.

- **Objective five:** Provide education about contact tracing. Revised: Provide Contact Observational Tracking System (COTS) Training to CHAs to support DCHD in contact tracing when the need arises. (See later in Methods)*
- **Objective Six:** Infuse cultural competence and ethical considerations into CHA training.

*Leaders realized that contact tracing would require personal health information (PHI) about people infected with COVID-19. Since CHAs would generally not have such PHI, Objective Five was revised as above to COTS training.

Education and training aims

Given the goals and objective, specific educational and training aims for CHAs were as follows:

- Inform community peers about best practices for avoiding or spreading COVID-19, relying primarily on CDC sources, but also on Douglas County Health Department guidance (with regular updates on Nebraska State and local county COVID-19 infection and death rates).
- Advise community members about how and when to get health and healthcare advice for COVID-19 issues and their usual health issues.
- Alert peers to special needs or hazards that chronic diseases pose regarding the pandemic and their continued needs to maintain prescribed medications and anticipate refill needs, keep healthcare appointments, and maintain general care strategies.
- Educate community members about importance of flu vaccination and needs to dispel myths about potential COVID-19 vaccination.
- Treat everyone according to ethical guidelines with cultural sensitivity and proficiency.
- Anticipate and address mental health issues in community members and potentially in themselves.
- Execute field observations, and complete and file related reports.

During the educational/training sessions, background aims were to continue building teamwork, including through information sharing and mutual problem solving. Interactive video conferencing greatly facilitated achieving all aims. In educational/training sessions, leader presentations always included major question and answer elements.

Case studies and examples

Leaders supplemented presentations with related case studies and associated questions. CHA participants then discussed and chose one among possible answers, explaining reasons for choices. Case studies were usually conducted in video breakout small groups, followed by reporting to the whole group, conjoined with whole group comments. Occasionally cases were discussed only in whole group because the leadership judged preferable in the moment.

During breakout group sessions, leaders fluent in (1) English, (2) English and Spanish, and (3) English, Spanish, and a Maya language, were deployed where needed. Groups discussed the cases and then collected into the whole group, reporting on their views and other groups' contributions. The following selected cases illustrate our approach.

Case: Outdoor Barbecue

You, a CHA, call a friend socially isolating at home with food delivery. You learn her brother is recovering from COVID-19 infection. On medical advice, he's home with his wife because he has a mild case. The friend's family plans an outdoor barbecue next weekend, social distancing required. Her brother is coming and will keep his infection secret. "I don't want to worry others and I'll keep my distance."

Questions: What should you do? Why?

Case: Safe Conversation or Privacy Breach? Grocery Store

Kerri (a CHA) sees Orlando at the supermarket with his son and another man. She remembers Orlando called her two weeks ago about advice to contact his doctor about his heart medication. Kerri hasn't heard back from Orlando since. So, she walks over to Orlando.

"Orlando, hi, it's so nice to see you." "Hi Kerri, how are you?"

"I'm well, thanks for asking. I've been meaning to ask; did you talk to Dr. Evans about your heart medication?"

Questions: Were Kerri's actions okay or a possible breach of privacy? Violation of confidentiality? Permissible? Why?

Case: Chronic Disease and Mental Health

A 75 year old man lives alone. A retired electrician, his wife died 3 years ago. You know him as a church member. You are the CHA for your church, and you have helped to develop a program of outreach communications to people living alone and the elderly, given the COVID-19 pandemic. Reasons include reducing loneliness and guiding people toward any needed services or assistance.

As part of your CHA duties, your pastor has asked you to call the members of the congregation to inquire about their wellbeing. You called the gentleman. You know him well enough to ask about his blood pressure and heart condition.

Questions:

1. What general greetings, comments, and questions might be good starters for the conversation?
2. How will you ask about his health?
3. If he tells you he has a heart condition and high blood pressure, what questions will you ask?
4. He asks you if his chronic condition is related to COVID 19, what will you say to him?
5. He tells you he takes his own blood pressure every day, but his machine stopped working last week. He says he is afraid to go to Walgreens, Walmart or CVS where they have machines. What other options does he have?

Suddenly he starts to cry. You asked him what is going on. He says and is lonely and depressed. Questions

1. What should you do?
2. How might you get help through your church or from OHA?

Case: Pregnant Daughter Visits

Your pregnant daughter wants to visit you because she needs some TLC (Tender Love and Care) that only you can provide. You tested positive for COVID 10 days ago.

Questions:

1. Should she visit you?
2. Why?
3. Why not?
4. When is it safe for her to visit you?

Case: Thanksgiving

On Thanksgiving Day, your neighbor (who just lost his wife and has no children) knocks on your door because he noticed that your siding was falling on the side of your house. You have five people at home with you, including your 80 year old mother.

Questions:

1. Should you answer and open the door?
2. Why?
3. Why not?

You answered but did not let him in. However, while he was still there you went out without a mask, to see the damage. You thanked him and shook hands with him. The next day, he contacted you, stating he is COVID positive.

Questions:

4. Who should quarantine?
5. Should you get tested for COVID? When should you get tested for COVID?
6. You test positive, but all others in your house tested negative.
7. How long should you quarantine?
8. When should you check on your neighbor?

The above case examples show how the education/training program aimed to expose CHAs to diverse possible scenarios regarding the pandemic. The narratives and questions address primary prevention (masks, social distancing, etc.), chronic disease aspects, mental health issues, and strategies when people test positive for COVID-19. Through the training sessions, cases repeatedly involved CHAs in discussing these many aspects they might encounter.

Information dissemination

The project developed multi-dimensional community communication methods to educate the community about COVID-19, building on CPHHE-REACH experience. Weekly COVID-19 updates and advice (as Newsletters) went electronically to CHAs and the broader community.

The coronavirus environment increased community stress, fear and uncertainty. Consequently, our CHA efforts became more relevant and necessary than ever. Both community health problems and the pandemic's economic impact touched millions of Americans across income levels, industries, and geographies. However, communication strategies included the message that life gets better when we get on the other side (of the pandemic's threat). In short, we viewed COVID-19 as a "setback in preparation for a comeback."

To deliver education and information on resources to help fight the pandemic, we designed a six (6) month plan to work with community based organizations and communication media across Douglas County. The communication network aimed to (1) strengthen efforts to educate community members about, and link them to, COVID-19 testing, healthcare, and social services; and (2) to share and explain how to implement effective response, recovery, and resilience strategies.

Specifically, CHAs were trained on communicating to their peers, COVID-19 knowledge and information and the concept of contact tracing. Further educational aims included content informing CHAs about improving community health by promot- ing healthy lifestyles, and addressing chronic health conditions like hypertension, diabetes, heart disease, obesity, cancer, and depres- sion. CHAs also learned about attending to medication needs and the importance of contacting healthcare providers about questions and needs. They were also informed taught how to navigate through the healthcare delivery system and other support services such as locationof food pantries and places to shelter in place if infected. Empowered with this knowledge, CHAs reached out to community members of fifteen (15) churches and thirteen (13) Public housing towers. CHAs taught peers about preventionmeasures regarding COVID-19.

Educational information was also disseminated to the Douglas County community through social media, radio, TV, newspaper, newsletters, public bulletin boards, banners, pamphlets, a documentary video, music CD, and zoom meetings. The objective was to ensure COVID-19 messages reached Douglas County minorities disproportionately affected by the virus. To this end, CPHHE staff established relationships with various organizations that serve the Omaha community including Omaha Public Housing (as noted earlier), Omaha 100 Black men of Omaha, fraternities and sororities, select churches (also see above), the African American Empowerment Network, Charles Drew Community Health Center, One World Community Health Center (Federally Qualified Health Centers), NAACP, Urban League, Hispanic/Latinx newspapers, Native American newspapers, other community based organizations, and some elected officials. Staff utilized the networks of these and other appropriate community based organizations to provide messaging to the target population.

An online retail company was used to produce T-shirts and hats detailing the COVID-19 Project Logo and creating uniformity with the COVID-19 Project team and Community Health Advocates. As an essential element of advertising, the COVID-19 Project promotional materials aimed to create a sense of professionalism, knowledge, and trustworthiness within the community.

Additional branding and outreach efforts were promoted through social media platforms. A Creighton University COVID-19 Project Facebook page was created to disseminate information, educate, and engage people reached on all facets on COVID-19. Facebook engagement is any action someone takes on your Facebook Page or one of your posts. The most common examples are likes, comments, and shares, but engagement can also include checking in to your location or tagging you in a post. Facebook engagement helps extend organic reach.

With a total of 231 followers on Facebook, both video and photo informational posts reached an average of 25 people daily. As an example of increasing Facebook communications, the following details Facebook insights from September 18 to October 15, 2020 (28 days): 1404 People Reached (562% increase), 218 Post Engagements (230% increase), and 28 Page Likes (300% increase).

Evaluation

Evaluation for this COVID-19 CHA Training Grant used standard research evaluation methods. Because the purpose of evaluation for this grant was to assess and document the initiation and completion of all grant objectives, systematic aggregation was used to document the start, maintenance, and completion of all grant objectives. Systematic aggregation is the process of assessing daily, weekly, and monthly project activities to ensure activities lead to overall project outcomes. For this COVID-19 CHA Training Grant, two broad goals, accompanied by five (5) objectives, were evaluated.

The evaluation focus centered on two wide goals designed to increase communication of CDC and DCHD COVID-19 Prevention messaging and educate and train the CHAs to magnify the COVID-19 communication messaging to local residents in the North (African American concentration) and South Omaha (Latinx concentration) communities. The objectives derived from the larger goals were more specific, listed above under Goals and Objectives.:

- Objective one: Increase direct CDC, COVID-19 Prevention messaging to minority Communities in Douglas County.
- Objective two: Recruit CPHHE's existing cadre of 50+ trained CHAs for this project.
- Objective three: Provide CDC/DCHD COVID-19 Education Training Workshops.
- Objective four: Educate and train CHAs to disseminate COVID-19 Prevention Guidelines to local community members.
- Objective five: Provide education about contact tracing.
- "Objective six: Infuse cultural competence and ethical considerations into CHA training.

Results

Attendance

The video approach apparently facilitated a high percentage of CHA class attendance. On average, 80% of CHAs attended. Generally, CHAs in small group breakout sessions were very engaged. In later whole group case discussions and presentation question and answer sessions, many CHAs contributed.

Information dissemination to communities and CHAs

Communications were crafted for the primary audiences of African Americans (North Omaha) and Latinx individuals (South Omaha). As summarized below, communications were extensive and involved diverse mechanisms. Examples were weekly COVID-19 updates in newsletters (that also went to CHAs), music jingles, pamphlets, banners, television and radio appearances, and public presentations. Author Brown was the leader and primary developer and drafter.

Message Development. The program focused on condensing COVID-19 information for the targeted audiences. We created more than 20 different slogans during the project period, as new information was learned about the virus. Slogans appeared in our newsletters, radio announcements, flyers, posters, and social media messages. The two slogans used most often were: (1) "The coronavirus is real. Its only mission is to kill." (2) "Wash your hands and sanitize, as often as you can, avoid large crowds and wear a mask. Protect your fellow woman and man.

." Public Appearances Discussing COVID-19. A leader addressed 200 people at the Drive in Comedy (August 15, 2020) and 150 at the Love of Arts and Music Festival at Turner Park (October 3, 2020). As summarized above, he announced and reported on our COVID-19 program at the Empowerment Network weekly meeting since July, 10 times (average audience 45). He also announced and reported on our COVID-19 Program at 5 meetings of the 100 Black Men (Average attendance 60)

The following media sources and message frequency were employed (July to December 2020):

- Published Articles: local newspapers (8) in the Omaha Star, 95% minority readership, circulation 30,000; 1 in the *Omaha World Herald* (predominant majority readership); 1 in a magazine (Revive); 6 in *Mundo Latino Omaha*, a weekly newsletter, circulation 5000.
- TV (2) and Radio appearances (3), Radio Ads (prevention strategies) (25)
- Neighborhood Association Newsletters (3)
- Weekly e mail list distribution to 300 community organizations and individuals of varying missions and causes related to the minority population.
- Church Bulletins weekly
- Social media (50) Facebook (2-3 messages/week, 432 followers), Twitter, Instagram etc.
- CPHHE Website (6 months continuous)
- Newsletters: CPHHE and CHA audiences: (20 articles, 300 recipients), Creighton University Health Sciences Multicultural and Community Affairs audiences (3 articles).
- Music: Jingle (English and Spanish); 20 COVID-19 slogans, disseminated throughout the community.
- Pamphlets and Banners (#13, 6' x 4' banners for display in common areas of Omaha Housing Authority facilities; #150, 11" × 17" flyers for distribution to the churches, Omaha Housing Authority, Latinx, and Maya communities; 300 pamphlets on COVID-19 prevention to comedy show audience; 100 pamphlets to churches and Omaha Housing Authority)
- Public testimonials (4) in a Drive in Comedy Show, a Love of Art and Music Festival, to the 100 Black Men organization, and to the Empowerment Network
- Facebook dedicated page to COVID-19 Prevention strategies 668 people reached, 450 "followers." Posts were placed two to three times weekly.
- COVID-19 Video with testimonials
- COVID-19 Prevention banner for 13 facilities, Omaha Housing Authority.
- Flip chart, pocket sized, for COVID-19 Prevention Strategies, distributed to CHAs.
- Series of brochures and flyers with COVID-19 Prevention Strategies, distributed to churches, public housing, urban league, south Omaha, and the general public.
- Music CD

Evaluation outcomes

- **Objective one:** The Communication Plan was successfully implemented. COVID-19 Prevention information was presented in Print Media (Omaha World Herald Omaha Star and South Omaha Spanish newspaper), Television Omaha (local stations and Channel 9), Radio (95.7 and 101.3 FM), Direct Mail, Electronic (Facebook), Banners, Newsletters, flyers, brochures, caps, and T shirts. Local gatherings with social distancing were also offered.
- **Objective two:** Successfully, over 50 CHAs were recruited, contracted, and signed to participate in the grant project. The CHAs represented faith Based organization churches in the North and South Omaha communities. The Omaha Housing Authority (OHA) provided CHAs as well as from the Latinx and Maya communities of North and South Omaha.
- **Objective three:** Grant leaders (see above) successfully conducted a 10 session COVID-19 Education and Training for CHAs. The educational training sessions began in August 2020 and ended in October 2020.
- **Objective four:** Grant leaders successfully employed ZOOM technology to teach, assess, and monitor CHAs' ability to disseminate COVID-19 Prevention Guidelines to others. The trainers used the principles of small group process, case studies, cultural competency, ethical consideration, leadership coaching, pre/post testing, and conflict resolution simulation to assess CHAs' readiness to disseminate COVID-19 information.
- **Objective five:** Grant leaders successfully trained CHAs to conduct community surveillance, as opposed to contact tracing. Contact Observational Tracking System (COTS) is a CDC inspired process where CHAs surveille personal and public space to determine three (3) things: How many people are sharing the identified space? Are people social distancing them? Are people wearing masks? When conducting COTS surveillance, CHAs can determine if people in the space are practicing COVID-19 Prevention Guidelines and if the shared space is safe for themselves and others.

Evaluation summary: The COVID-19 Executive Committee successfully implemented every objective prescribed by Douglas County Health Department. The evaluation of the project remains in an ongoing status; however, it is expected that when the systemic aggregation of activities concludes in December, the individual and aggregated evidence will support the success of this COVID-19 Community Health Ambassador Education and Training Grant.

Discussion

The project clearly met its objectives. Also, basic features of the CPHHE-REACH training model, which employed in person sessions, readily transferred to zoom interactions. The technical option of breaking into small groups and then reforming was quite helpful. Weekly leadership meetings helped identify and address needs.

A challenge was the different CHA educational levels. Some were high school graduates (and perhaps some had not completed secondary school), while others probably had master's degrees. We know of one CHA with a PhD in science. Nurses and a physician were also CHAs representing their churches. However, formal content and informal comments during the education and training were kept at levels not requiring advanced education. Further, CHAs with more knowledge about science and healthcare issues regarding COVID-19 often had important contribution in group sessions.

To maintain social distancing those pandemic guidelines, all training and education sessions employed video, participants electronically participating at a distance. Of course, the guidelines aim to reduce and prevent person to person coronavirus transmission. CHA participants were thus socially isolated. However, the video interactions also provided a social outlet and interaction opportunities that safety concerns otherwise prohibited. In the initial CHA educational session, a behavioral health specialist stressed the importance of CHA mental and emotional health and wellness. Enhanced social exchange quite likely helped support related CHA needs.

In person meetings can be intimidating for some who lack subject matter experience. However, small group Zoom break out rooms seem to facilitate everyone's comments about case studies. Also, breakout discussions in virtual rooms seemed to confer a sense of ownership among group participants about decisions reached—evident when members chimed in during large group reporting.

Conclusion

Community member involvement is essential for combating the ravages of the COVID-19 virus, especially for populations with disadvantage. This paper summarizes a community academic collaboration to provide education and training for 60 community health advisors/advocates (CHAs) to prevent or reduce the impact of the COVID-19 pandemic on populations with disadvantage in a midwestern city and county (Omaha and Douglas County, Nebraska). African American and Latinx CHAs were the majority, and their community members the intended audiences of their new COVID-19 expertise. The project built on a prior successful project that empowered CHAs to enhance community physical activity in the African American community. The education/training sessions were exclusively virtual, combining group presentations with discussion and small breakout groups for review of case studies. The paper summarizes curriculum content and organizational structure. Evaluation showed successful achievement of objectives.

Limitations

This project involves some 60 CHA trainees in a midwestern city and county. Although participants were diverse, the model might not translate to other communities with different histories, culture, and persuasions.

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