Community Health Workers for COVID Response and Resilient Communities (CCR)

Evaluation and Performance Measurement Plan

Georgia Department of Public Health

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Program Description

Chronic Diseases Prevention Section (CDPS) within Georgia Department of Public Health (GDPH) was awarded the 3-year Community Health Workers for COVID Response and Resilient Communities (CCR) to enhance capacity, increase the workforce, and collaborate with current Community Health Workers (CHWs) throughout the state. CDPS plans to build an infrastructure of success by providing training to CHWs that address public health core competency, COVID-19 prevention, and chronic disease prevention and management. CDPS will achieve this by engaging CHWs in state and local strategic efforts. At the end of this funding period, CDPS intends to increase community resilience to respond to public health emergencies such as COVID-19 and any future emergencies especially among at-risk population, those living with chronic conditions or at risk of developing chronic conditions.

The CDPS intends to implement strategies that aim at building capacity of CHWs. The goals will include integrating CHWs into organizations and care teams and strengthening relevant CHW knowledge, roles, and skills to prepare them to successfully engage their local priority populations communities to manage COVID-19. Priority populations are those with increased prevalence of COVID-19 and are disproportionately impacted by long-standing health disparities related to sociodemographic characteristics or have certain underlying medical conditions and chronic disease risk factors.

By engaging stakeholders to support this initiative, CDPS will intentionally address the needs of rural Georgia and eliminate the disparity between the "two Georgias"[1] to make a collective impact statewide.

DPH with partners will implement six coordinated strategies to scale up and sustain community health worker programs to support COVID-19 response and prevention in populations at high risk and communities hit hardest by COVID-19. The high-level strategy categories are:

- TRAIN: increase the skills, capacity, and roles of CHWs to provide services and support for COVID -19 public health response efforts among priority populations within communities
- DEPLOY: Increase the workforce of CHWs delivering services to manage the spread of COVID-19
- ENGAGE: Increase utilization of community resources and clinical services for those at highest risk for poor outcomes among priority populations within communities

A bilingual community core competency training program for CHWs in the community setting will be utilized and will be the main activity in year 1. Additionally, a Health

[1] Within the state, there is a clear difference not only geographically, but also in terms of health and social services that are available in metro Atlanta (which consists of about 30 counties) versus rural Georgia (which consists of the remaining 129 counties), hence a common term coined, "The two Georgias."

Systems-based (English only) training program will be utilized to train CHWs in the health setting.

- Year 1 activities focus on hiring and training. Year 2 activities will focus on community outreach and education, partnership development, and an effective referral system. **See attached logic model.**

Stakeholder Engagement

Department of Public Health: Since 2016, DPH has been leading statewide efforts, in collaboration with other key partners to train, certify and work towards reimbursement for services for CHWs. This CCR initiative will be guided by the leadership of the DPH Chronic Disease Prevention Section Director and Deputy Director. Christine Wiggins, CDP Deputy Director, and current DPH CHW Initiative Lead and subject matter expert, will provide guidance and oversight to this project and will continue to ensure synergy between similar efforts at the state level. DPH staff are being hired to support this project including two full-time program managers, a full-time evaluator, and a full-time epidemiologist.

Public Health Districts: Twelve districts will receive funding to train, deploy, and engage community health workers. Each funded district is required to hire a full-time CHW to conduct outreach. The CHW should have knowledge of and represent the community(ies) in which outreach will be conducted. Districts will select specific catchment areas (i.e., county, city, zip code, neighborhood) within their health district for targeted outreach and communication. CHWs will be required to participate in trainings, monthly technical assistance calls, and monthly CHW network and CHW Advocacy Coalition meetings. Each district will:

- Integrate CHWs into organizations and care teams to support the public health response to COVID-19 among priority populations within communities.
- Coordinate and/or promote opportunities, such as messaging/education within communities and clinical settings to facilitate the engagement of CHWs in addressing the needs of those at highest risk for poor health outcomes, including those resulting from COVID-19.
- Facilitate engagement of CHWs in the care, support, and follow-up across clinical and community settings of priority populations at highest risk for poor health outcomes, including those resulting from COVID-19.

Atlanta Regional Collaborative for Health Improvement (ARCHI): ARCHI will provide support to the CHW Network by providing a full-time consultant that represents the 30-county Metro Atlanta Area, hire up to two CHWs to be placed in various community-based organizations (CBOs), health systems, faith-based organizations (FBOs) and CBOs throughout the metro region, assist with the planning and

coordination of training and professional development opportunities for CHWs related to COVID, core competencies, and chronic conditions. ARCHI will also provide mini grants awarded to CBOs or FBOs with established outreach methods to provide resources to community members who are experiencing socio-economic hardships.

United Way: United Way will provide CHW Supervisor and Employer training to prepare organizations for the integration of the CHW role into the care management process and outreach; UW will employ two CHWs in the metro region to conduct direct community outreach; UW will provide mini grants to up to 10 community-serving organizations in the metro region to provide necessary resources to patients/community to address SDOH needs. Mini grants will be awarded to CBOs or FBOs with established outreach methods to provide resources to community members who are experiencing socio-economic hardships.

Morehouse School of Medicine/Georgia CEAL will leverage and capitalize upon existing community partners, leaders, and knowledge holders, community resources, and local service delivery settings to enhance education, awareness, access, and inclusion of underserved communities in research and outreach designed to advance the prevention and treatment of COVID-19 and reduce disease disparities.

The Georgia Health Policy Center (GHPC) will support the Georgia Department of Health (DPH) by providing evaluation services for the Georgia Community Health Workers for COVID Response and Resilient Communities (CCR) for the duration of the grant period.

Table 1. Stakeholder Engagement

Stakeholder Name/Type	How and When to Engage
• CDC National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) • GHPC evaluation team • DPH evaluators and staff/program managers	• Evaluation plan development • Data/surveillance data collection and analysis • Evaluation steering committee
• CHW representatives • CHW Steering Team (e.g., DPH evaluators and program managers, CHW representatives, partners (e.g., public health districts, United Way, ARCHI, Grady Health, CBOs, FBOs)) • CHW Advocacy Coalition • CHW Network • Metro Atlanta and rural GA partners, and interested organizations that support/employ CHWs • Care Coordination Systems.	• Evaluation steering committee • Provide data/data collection • Ensure use of evaluation results

• CDC NCCDPHP • DPH evaluators and staff/program managers • GHPC evaluation team • Partners employing and supporting CHWs • CHW representatives • CHW DPH Advisory Board	• Dissemination of evaluation results • Use evaluation findings

Evaluation Plan Overview

In order to assess its success, CDPS will monitor and evaluate the impact of the efforts. To this end CDPS will engage the Georgia Health Policy Center (GHPC) to provide evaluation services for the duration of the grant period. The GHPC evaluation team in collaboration with CDC/national evaluation TA providers and the Georgia Department of Health (DPH), supporting this project's required contributions to cross-grantee evaluation. GHPC will plan, coordinate, and conduct complementary local evaluation. Local evaluation will include both process and short-term outcome evaluation.

Program Components Evaluated:

IR1: Identify and collaborate with community wide efforts to ensure comprehensive acquisition of knowledge, roles, and skills by CHWs so they are prepared to successfully engage with existing state and/or local public health-led actions to manage COVID-19 among priority populations within communities.

IR3: Align training opportunities for CHWs with the primary actions of state and/or local public health led efforts to address the underlying conditions and/or environments that increase the risk and severity of COVID-19 infections among priority populations within communities.

IR4: Integrate CHWs into organizations and care teams to support the public health response to COVID-19 among priority populations within communities.

IR6: Coordinate and/or promote opportunities, such as messaging/education within communities and clinical settings to facilitate the engagement of CHWs in addressing the needs of those at highest risk for poor health outcomes, including those resulting from COVID-19.

IR7: Facilitate engagement of CHWs in the care, support, and follow-up across clinical and community settings of priority populations at highest risk for poor health outcomes, including those resulting from COVID-19.

Evaluation Approach.

GHPC uses the CDC evaluation framework, ensuring an evaluation process that is crafted and executed through a relationship with those who will ultimately apply the findings. The approach creates valuable quality improvement opportunities that refine and sustain projects. The steps applying this framework will be:

1. **Engage stakeholders:** Create an evaluation steering committee that will provide guidance for the evaluation, including its equity orientation. This group will include DPH evaluators and program managers, CHW representatives, and partners (e.g., local health districts, United Way, CBOs, FBOs).
   - This group will act as the conduit for gathering process evaluation data, identifying success story topics and contacts, reviewing findings for quality improvement, and for adapting strategies as needed.

2. **Describe the initiative:** Develop a comprehensive description, including a logic model, to clarify all of the components and intended outcomes of the initiative.

3. **Focus the evaluation design:** Prioritize the most important evaluation questions and the appropriate design for the process and outcome evaluation, incorporating national evaluation requirements.

4. **Gather credible evidence**: The data collected will include performance indicators (every six months) and may include qualitative interviews with key staff involved in implementation and service delivery (end of years 1 and 2).

5. **Justify conclusions:** GHPC will review preliminary findings with the evaluation steering committee to compare evidence with project milestones and goals.

6. **Ensure use and share lessons learned:** Evaluation results will be used to identify ways to improve the initiative.

The evaluation will integrate health equity through the logic model, evaluation questions, data collection, and performance indicators. GHPC will focus on the first three steps during the initial six months of the project, building on the evaluation guidance provided by CDC and Evaluation/TA partners. Steps 4-6 are cyclical to assure opportunities for learning and quality improvement and will continue the involvement of the evaluation steering committee for data review, recommendations, and monitoring.

Evaluation Partners

GHPC will partner with the DPH evaluator and epidemiologist throughout the project period. DPH will facilitate the collection of, and access to, surveillance data needed for the evaluation, align this project's evaluation with other DPH evaluations and provide critical guidance on the design and execution of the evaluation. This collaborative approach to staffing evaluation capitalizes on the agency knowledge and data capacity of DPH internal staff and GHPC external evaluation expertise. This DPH-GHPC team commits to working closely with the national evaluation TA.

Evaluation Purpose

GHPC and DPH will conduct a process and outcome evaluation of the Community Health Worker for COVID Responses and Resilient Communities following the CDC Framework for Evaluation. The process evaluation will focus on the DPH implementation approach to understand the extent to which the activities associated with four selected implementation ready (IR) strategies (IR1, IR3, IR4, and IR7) are being implemented as intended to address COVID-19 and underlying conditions that serve as risk factors (chronic disease, mental health, and the social determinants of health) through the enhanced capacity of Community Health Workers, increased CHW workforce, and enhanced collaboration with CHWs throughout Georgia. The process evaluation will guide necessary adjustments to the strategic activities of DPH and stakeholders to maintain alignment with IR strategies and produce the desired outcomes during the project period.

The outcome evaluation will focus on the effectiveness of the implementation of the IR strategies to build an infrastructure that improves health outcomes among public health district-identified priority populations through training, hiring, and deploying CHWs into varied communities and systems of care, engaging CHWs in local and state strategic efforts, and providing training and support to CHW hiring entities. GHPC and DPH will continuously monitor and evaluate the effectiveness of the infrastructure to understand how it promotes success and to understand barriers to success.

Evaluation Questions

This evaluation will answer the following main evaluation questions.

1. How effectively do CHW trainings equip the CHW workforce with capacities to successfully engage with priority populations within Georgia public health districts?
    a. To what extent are CHWs equipped to address underlying conditions that serve as risk factors for COVID-19 among priority populations?
    b. Are CHWs representative of and/or knowledgeable of their communities?

   c. Under what terms are CHWs hired (e.g., employment status, compensation) and to what extent are these adequate?
2. How do CHW positions, roles, and integration vary by setting (clinical, community-based organization, health district) and by rural/urban status of community?
3. How effective are employer trainings in building organizational capacity to hire, retain, integrate and support CHWs?
4. To what extent does the DPH-supported infrastructure promote the reduction of the disparity in COVID-19 risk demonstrated by the "two Georgias" (rural Georgia and metro Atlanta)? Mitigate undue COVID-risk? Reduce disparities in access to community resources and services?
5. To what extent does the infrastructure built by DPH achieve short and intermediate-term outcomes (increased workforce delivering services, increased integration of and system-level support for CHWs, increased referrals and use of community resources and clinical services)? What are barriers, facilitators, and recommendations?

These questions were determined based on the activities and outcomes that DPH will pursue in alignment with the implementation-ready strategies. These main evaluation questions were prioritized by GHPC and DPH by agreeing upon the IR strategies that the evaluation will focus on and consideration of the aspects of this initiative that GHPC and DPH expect to have the greatest influence on progress towards the long-term outcomes. Given that year 1 activities will focus on hiring and training, evaluation questions pertaining to this will be addressed first.

Performance Measures

GHPC will collect and summarize performance measures semi-annually as outlined by the NOFO. DPH will report measures into AMP. Data collection strategies (outlined in Table 2) will support assessment of process and outcome measures for different populations. Table 2 details the performance measures indicated by the CDC performance measure guidance that GHPC and DPH will collect in alignment with the evaluation questions and strategies IR1, 3, 4, 6, and 7. The information gained through the performance measures will be augmented by the indicators adopted from the CHW Common Indicators Project (as well as possibly qualitative data). Table 2 also details how GHPC and DPH will collect data on each measure or indicator. Data management methods may change as DPH and GHPC collaboratively determine the feasibility of data collection and specify procedures for data management using platforms currently under consideration including REDCap and CATALYST.

Performance measures required by the NOFO are:

- IR1 (Train) # of CHWs successfully completing state/local/tribal public health-led COVID-19 response training efforts as determined by relevant public health-led entities, e.g., skills related to COVID-19 outreach, contact tracing, appropriate use and care of PPE, outreach and referrals for vaccination, navigation to testing and treatment and relevant data collection sufficient for documentation of efforts.
- IR3 (Train) # and type of health conditions and/or social service needs for which CHWs are provided training and/or certification to deliver among populations of focus within communities, e.g., Lifestyle interventions and strategies, management of comorbidities such as hypertension and respiratory conditions, maternal/child health, improving physical activity, improving healthy eating, tracking, referral, and connection of individuals to available social services to address identified needs and advance equity.
- IR4 (Deploy). # and type of organizations/entities that are integrating CHWs to support state/local/tribal public health-led COVID-19 response efforts.
- IR6 (Engage). # of individuals within communities and/or clinical settings reached through messaging and education, including those at highest risk for poor health outcomes, including those resulting from COVID-19, among populations of focus within communities.
- IR7 (Engage). # of patients referred for individual, specific named health and social conditions that increase the risk for COVID-19 for patients at highest risk for poor health outcomes, within clinical and/or community settings. Document referrals for any of the following specific named conditions: housing and shelter; food; healthcare; mental health and addictions; employment and income; clothing and household; childcare and parenting; government and legal.

Data Collection Plan

GHPC will use a range of data sources and collection methods. These include:

District reports: Monthly reports submitted through DPH internal reporting system CATALYST, a software program designed for capturing, recording and reporting of program activities. GDPH and GHPC will coordinate to develop a reporting template that aligns with progress reporting on workplan deliverables and performance measures. Reports in CATALYST will be extracted monthly to assess progress in all program activities. GDPH will work closely with funded public health to implement community-level programs in data collection and reporting. Data reported to GDPH and GTUPP will be synthesized and analyzed by GHPC for reporting to CDC.

CHW surveys: Survey done every 6-12 months with CHWs hired under this initiative. Baseline surveys will include questions about compensation. Surveys will also include questions on the effectiveness of the trainings and training needs. The Common Indicators Project data collection instruments will be incorporated, with additional questions developed by GHPC as needed. Qualtrics or REDCap will be used for these online surveys.

CHW supervisor or employer surveys: Surveys of supervisors/employers of CHWs will be completed every 6-12 months. These surveys may include trainings completed and will also draw on questions from the Common Indicators Project. Qualtrics or REDCap will be used for these online surveys.

Partner quarterly reports: GHPC will work with DPH evaluator to develop a quarterly progress report template for other organizations funded under this initiative to share progress, barriers, and successes on project deliverables.

CCR partner meetings: GHPC will attend partner meetings and keep notes to track discussion of progress, barriers, facilitators, solutions, etc.

Community-level data: descriptive data on communities where CHWs conduct their outreach; this includes demographic characteristics (race, socioeconomic status, etc.), chronic disease rates, COVID rates, and vaccination rates. This secondary data will be reviewed and summarized annually.

Interviews and/or focus groups: with organizations (health districts and others) on integration, challenges, successes and with CHWs. GHPC will try to find opportunities where CHWs may convene (Advisory Coalition annual meeting) and coordinate data collection to be efficient and reduce the burden on CHWs. These opportunities will complement and add deeper understanding to the survey data.

CHW reports on outreach and referral activities: GHPC has not planned a mechanism to capture outreach and referral activities at either the CHW or participant level. GHPC's understanding is that DPH will be working on the deployment of a referral management system; other organizations funded through this initiative to employ CHWs will have varying data systems and capacities to track outreach, referrals, and outcomes of these activities. This data collection strategy needs to be discussed with DPH and include the development of an understanding of data capacity across settings.

Participant experiences and outcomes. As of this draft, GHPC is not planning to field a participant survey to measure participant outcomes like physical, mental, or emotional health, participant social support, participant health care access, social needs being met, or empowerment. GHPC recommends a qualitative approach in partnership with CHWs to collect stories of impact.

Technical assistance. GHPC would benefit from technical assistance on strategies to collect participant impact stories and the tracking of CHW outreach and referrals.

Table 2. Additional Evaluation Data Collection

Evaluation question #	Evaluation question (shortened)	Indicator(s)	Data source, collection method and timeframe	Role responsible
1	How effective are CHW trainings to manage COVID 19 issues?	• # of CHWs successfully completing state/local/tribal public health-led COVID-19 response training efforts	District and partner reports; Monthly	DPH Evaluator and Program Manager
1a	To what extent are CHWs equipped to address underlying conditions?	• # and type of health conditions and/or social service needs for which CHWs are provided training and/or certification to deliver among populations of focus within communities, e.g., diabetes management, hypertension management • Supportive and reflective CHW supervision	District and partner reports; Monthly Surveys/interviews/focus groups of CHWs and CHW supervisors; Annually	DPH Evaluator and Program Manager GHPC
1b	Are CHWs representative of and/or knowledgeable of their communities?	• CHW involvement in decision-making and policy-making	CHW Survey; Annually	GHPC
1c	Under what terms are CHWs hired (e.g., employment status, compensation) and to what extent are these adequate?	• CHWs' Level of Compensation, Benefits, and Promotion • Policy and system change: program/employer level	CHW Survey & CHW Employer Survey; Annually Survey(s) of employer policies and practices; Semi-annually	GHPC UW of Greater Atlanta (UWGA)

		• Policy and system change: state level		
2	How do CHW positions, roles, and integration vary by setting (clinical, community-based organization, health district) and by rural/urban status of community?	• CHW involvement in decision-making and policy-making • CHW integration into teams	CHW Survey; Annually	GHPC
3	How effective are employer trainings in building organizational capacity to hire, retain, integrate and support CHWs?	• # and type of organizations/entities that are integrating CHWs to support state/local/tribal public health-led COVID-19 response efforts. • CHW involvement in decision-making and policy-making • Policy and system change: program/employer level • Policy and system change: state level	CHW Survey; Annually CHW Employer Survey; Annually Survey(s) of employer policies and practices; Semi-annually	GHPC UWGA
4	To what extent does the DPH-supported infrastructure promote the reduction disparities in access to community resources and services?	• # and type of Health care and social needs currently available at community level • # of patients referred for individual, specific named health and social conditions • CHW-facilitated referrals	District and partner reports; Monthly CHW Survey; Annually	Program reports – DPH Evaluator, GHPC External grantees.

5	To what extent does the infrastructure built by DPH achieve short and intermediate-term outcomes?	• # of individuals within communities and/or clinical settings reached through messaging and education	CHW Survey; Annually CHW Employer Survey; Annually	GHPC

Data Management Plan

GDPH will provide oversight and management of district reports through CATALYST and provide data to GHPC. On a monthly basis, DPH will provide these reports to GHPC. GHPC will develop an internal data management system (i.e., Microsoft Teams/SharePoint) to store all data, reports, and documentation. Data will only be stored using the Universities secure systems, will be password protected and accessed only by project staff. All other population-level data such as population characteristics, BRFSS, mortality data, and Covid-19 related data is already publicly available and will be accessed for the evaluation purposes.

Data Analysis and Interpretation

Quantitative: Analyses will be descriptive trend data primarily. Data will be tracked in Excel spreadsheets or internal databases, with "dashboards" of results developed to summarize progress on performance indicators, to represent survey results, and to describe community-level characteristics.

Qualitative: Interviews/focus groups will be recorded and transcribed. Transcriptions will be imported into NVivo for analysis. Initial analysis will begin once the first few key informant interviews are completed. The qualitative data will be coded for preliminary themes. Preliminary themes will be tested and modified by making constant comparisons when coding subsequent interviews and through peer debriefing and coding review. The evaluation team will maintain an audit trail of analytic decisions. Data display analysis techniques, including matrices, charts, networks, and models, may be used to organize and condense the qualitative data to facilitate drawing and verification of conclusions during sensemaking sessions.

Plan for Dissemination and Use of Findings

As named in Table 1 (rows 2 and 3), partners will be engaged in the dissemination and use of evaluation findings. To ensure the use of findings, GHPC will meet with partners that it determines can directly act upon the findings to request their feedback on the reporting format or methods to ensure accessibility to the findings for varied audiences and to ease application.

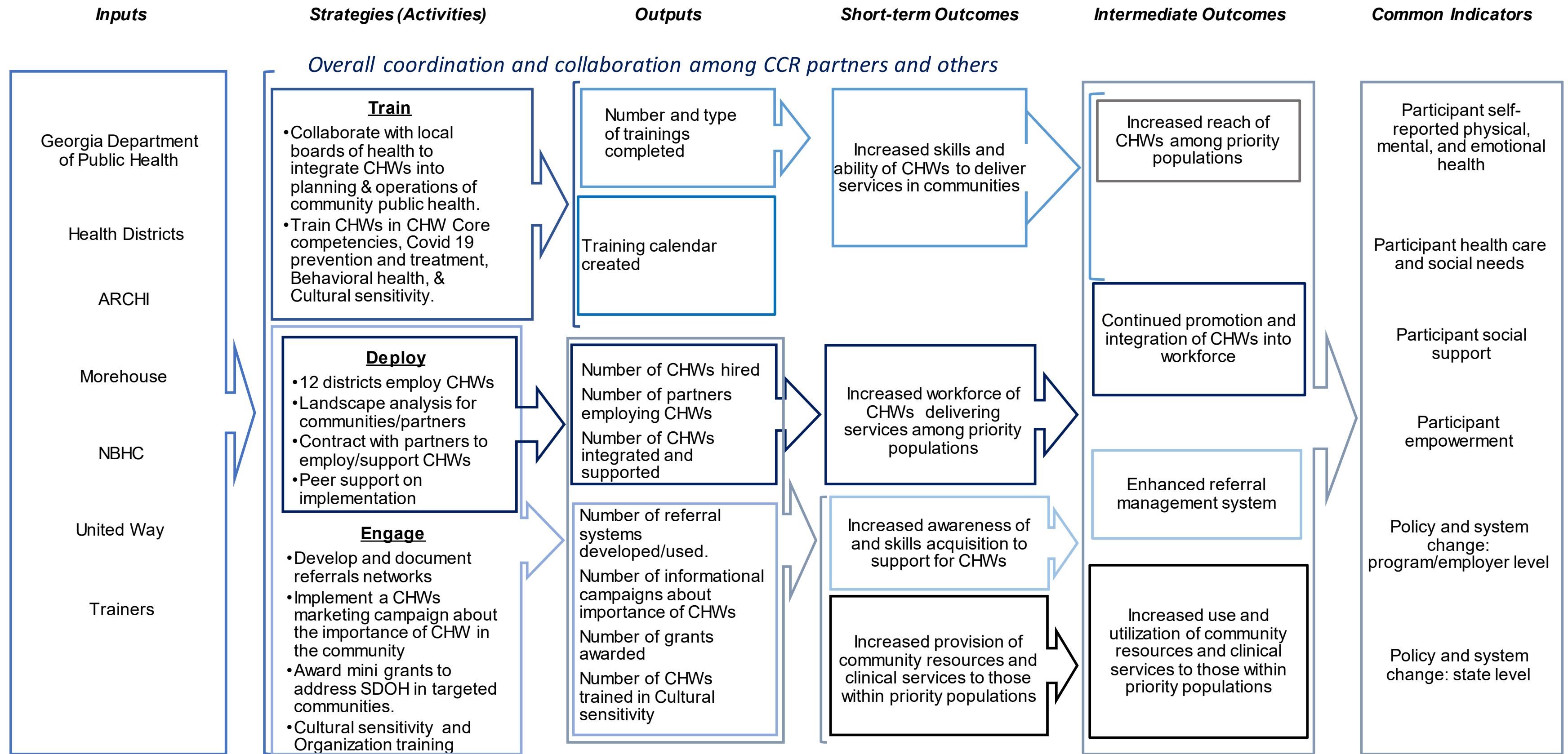
To disseminate findings, GHPC and DPH will coordinate with partners to determine and select channels for dissemination that will direct the findings to the appropriate end-users which will also be collaboratively determined.

Timeline

Table 3. Evaluation Timeline

Timeline	Data Collection & Analysis Activities	Deliverables & Dissemination
Year 1, Q1 (Sept - Nov)	• Program Planning • Evaluation and performance measurement planning phase • Stakeholder engagement	
Y1, Q2 (Dec – Feb)	• Stakeholder involvement • Development of evaluation plan • Development of data collection tools • Implementation of program activities	• Evaluation and Performance Measurement Plan • Data collection tools
Y1, Q3 (Mar – May)	• Revise evaluation plan according to feedback from CDC • Implement evaluation plan	• Monthly progress call meeting minutes
Y1, Q4 (Jun-Aug)	• Collect program data • Analyze program progress reports	• Monthly progress call meeting minutes • Quarterly report
Year 2 & Year 3	• Revise evaluation plan • Collect program data • Analyze program data • Administer surveys • Analyze survey data • Conduct interviews and focus groups • Analyze interview/focus group data • Convene partners selected to inform dissemination and use	• Site visit report(s) • Quarterly reports • Annual evaluation report

This Evaluation and Performance Management Plan is an early draft. DPH established the program parameters for selected health districts to submit workplans in January 2022 and is in the process of contracting with other partners. GHPC's contract was executed mid-January 2022. Because the initiative is in a planning and start-up phase, the evaluation team has not yet had the opportunity to form an evaluation steering committee nor fully develop the evaluation plan or seek technical assistance. Evaluation planning will continue through the next several months in close collaboration with DPH, districts, and other partners.


Community Health Worker for COVID Responses and Resilient Communities
Evaluation & Project Management Plan - Logic Model
Inputs
Strategies (Activities)
Outputs
Short-term Outcomes
Intermediate Outcomes
Common Indicators
Overall coordination and collaboration among CCR partners and others
Georgia Department of Public Health
Health Districts
ARCHI
Morehouse
NBHC
United Way
Trainers
Train
•Collaborate with local boards of health to integrate CHWs into planning & operations of community public health.
•Train CHWs in CHW Core competencies, Covid 19 prevention and treatment, Behavioral health, & Cultural sensitivity.
Deploy
•12 districts employ CHWs
•Landscape analysis for communities/partners
•Contract with partners to employ/support CHWs
•Peer support on implementation
Engage
•Develop and document referrals networks
•Implement a CHWs marketing campaign about the importance of CHW in the community
•Award mini grants to address SDOH in targeted communities.
•Cultural sensitivity and Organization training
Number and type of trainings completed
Training calendar created
Number of CHWs hired
Number of partners employing CHWs
Number of CHWs integrated and supported
Number of referral systems developed/used.
Number of informational campaigns about importance of CHWs
Number of grants awarded
Number of CHWs trained in Cultural sensitivity
Increased skills and ability of CHWs to deliver services in communities
Increased workforce of CHWs delivering services among priority populations
Increased awareness of and skills acquisition to support for CHWs
Increased provision of community resources and clinical services to those within priority populations
Increased reach of CHWs among priority populations
Continued promotion and integration of CHWs into workforce
Enhanced referral management system
Increased use and utilization of community resources and clinical services to those within priority populations
Participant self-reported physical, mental, and emotional health
Participant health care and social needs
Participant social support
Participant empowerment
Policy and system change: program/employer level
Policy and system change: state level
Context: Currently evolving pandemic, differing needs for rural GA and metro Atlanta, funding, infrastructure, partnerships