Report to the Social Services Appropriations Subcommittee

Report on Vulnerabilities Exacerbated by COVID-19

June 2021

UTAH DEPARTMENT OF HEALTH

Legislative Requirement

This report is submitted in response to the following intent language passed by the Social Services Appropriations Committee during the 2021 Legislative Session:

> The Legislature intends that the Departments of Health, Human Services, and Workforce Services provide a written report to the Social Services Appropriations Subcommittee by June 1, 2021 on vulnerabilities that were exacerbated by COVID that still need to be addressed, including programs that had increased demand, areas where the agency had to deny people services, and recommended areas for further funding; for these programs, agencies should include information on performance metrics and caseload information.

Executive Summary

This report provides a summary of the vulnerabilities exacerbated by the COVID-19 pandemic. Identified solutions come in the form of policy and budget. The Department provides recommendations regarding clarification of policy flexibilities during future emergency periods. The Department identifies three main areas where additional funding is recommended to support public health infrastructure and readiness:

- Investment in workforce
- Investment in data and information technology systems
- The creation of more efficient inter-agency communication channels

Introduction

Since its emergence in late 2019, the COVID-19 pandemic has led to a dramatic loss of human life worldwide and has presented unprecedented challenges to public health. In Utah, the pandemic put a significant strain on public health resources, in particular public health staff and many day to day operations were disrupted.

Government and healthcare leadership provided an abundant amount of information, guidance, and policies to mitigate risk and reduce the burden on our healthcare system, working to provide special consideration and focus on vulnerable populations. However, as we come to acknowledge the impacts of COVID-19, whether epidemiological, cultural, political, or socio-economic, it is understood that the pandemic has exacerbated existing vulnerabilities within the public health system. The differences in COVID-19 infections and outcomes have demonstrated that underlying socio-economic factors significantly influence exposure to the virus, the severity of infection, ability to withstand the economic impacts, and access to healthcare.

This report looks to identify, for the Utah Department of Health (hereafter referred to as The Department), vulnerabilities exacerbated by COVID-19. Public health officials acknowledge that risk factor reduction does not operate in isolation, especially when communities are faced with economic and health disparities. The COVID-19 pandemic highlights the need to take socio-economic risk factors into account when developing response measures and determining priorities. To do this we must 1) better understand the vulnerabilities that were exacerbated by COVID-19 and 2) understand areas that still need to be addressed. The following report focuses on programs that had an increased demand,

areas where the Department had to deny or delay services or where services were disrupted, and recommendations for further funding.

About the Data

The report includes preliminary data from multiple sources including the Utah All Payer Claims Database (APCD) under authority granted to the Department and the Health Data Committee, the Medicaid Data warehouse and data collected specifically by Department programs including participation data. Recognizing that many data sources are not yet available, some data that would be helpful is not collected as of now, and conclusions from current data sources might be premature; the Department recommends that the Utah Legislature commission and fund an independent study of the impacts to Utahns and the public health system by the COVID-19 pandemic.

Vulnerabilities Exacerbated by COVID-19

Programs with Increased Demand

The pandemic provided the opportunity to demonstrate public health staff's commitment to their mission and to excellence. However, during the pandemic public health has faced unprecedented challenges and increased demand. Public health employees have faced criticism, harassment, and complaints all while public health officials continued to focus on transparency and making data-driven decisions and recommendations.

Services

We recognize the pandemic impacted all Utahns served by the public health system. Many faced job losses which led to an increased need for support from public programs. This impacted the Department in a variety of ways. One example includes food insecurity. Food insecurity in Utah has increased by 30% in the past year; currently 18% of Utahns are food insecure including 20% of children in Utah. The Utah Food Bank has tripled its food distribution since the start of the pandemic. [1] The Department operates multiple programs related to food insecurity, and during the pandemic we saw a huge increase in demand for these programs.[2] For example, the Utah Double Up Food Bucks program[3] and the Utah Produce Prescription program[4] have seen an increase in demand from grocers and local markets, particularly in rural communities, wanting to partner with the Department on these types of programs due to the increased need they have observed from their customers throughout the pandemic. From 2019 to 2020, spending on fruits and vegetables through these programs increased 181% and the number of participating markets increased 65% in the past year alone.

[1] https://docs.google.com/document/d/1VSAHoqtudJPcl73ZaHdpZ09kuPYs1j-s/edit#heading=h.gjdgxs

[2] https://choosehealth.utah.gov/healthcare/physician-resources/nutrition.php

[3] https://health.utah.gov/featured-news/double-up-food-bucks-now-available-to-utahns-program-improves-healthy-food-access-supports-local-farmers

[4] https://choosehealth.utah.gov/documents/pdfs/Healthcare/physician-resources/FVRx_info_sheet_final_06142017.pdf

Staff Capacity and Retention

Many staff in the Department were redirected to the COVID-19 response. This resulted in delays for some of the intended objectives of federal funds previously awarded for non-COVID related activities. Many programs experienced increased demand and required staff to work late into the night, on weekends and holidays. This resulted in significant overtime, sometimes upwards of an additional 40-80 hours per pay period for many engaged in the response. Staff capacity was limited and as a result many staff tried to balance both the demand of COVID-19 assignments and still support partners and grant projects. The increased demand on staff directly impacted our ability to meet the need of both the current emergency and delivery of grant-funded objectives. This led to poor morale, burnout, tired employees, early retirements and other retention issues.

Additional Examples of Pandemic Impacts on Public Health Practice

- Social Distancing guidelines led to a demand to implement a "Stay Safe, Stay Active Streets Initiative" to open streets to cyclists/pedestrians to encourage physical activity. In a survey, 76% of respondents stated that they generally support this effort with comments including they hope these changes remain after the pandemic. Department staff collaborated with Local Health Departments and City Officials to implement the program. As of November 2020, all streets participating in the "Stay Safe, Stay Active Streets Initiative" have been returned to normal operation.[5]

- Despite adding funding in late July 2020 to support hiring additional staff to address the growing list of Long-Term Care Facilities (LTCF) in outbreak status, the number of outbreaks in LTCF continued to rise, peaking at 168 open outbreak investigations in December. Data for LTCF outbreaks can be found on the case counts page of the coronavirus.utah.gov website.[6] Notably, there was no change in staffing levels between July and December 2020 despite an intensifying surge.

- An Infection Control Assessment and Response (ICAR) report identified that it did not have adequate Personal Protective Equipment (PPE), so resources were mobilized through the Utah Health Emergency Response Team (UHERT) to provide additional supplies to LTCF with a COVID-19 outbreak.

- There was an increased demand for the need and use of data interoperability (ability of different systems to exchange data) and data integration with other public health and health care systems. The tools such as COGNOS, Redcap and the server were not prepared for the sudden increased use for COVID 19-related work (more than 80,000 students and teachers were accessing the server to enroll in the Test to Stay, Test to Play survey).

- Increased demand for producing several COVID-19 reports included lab result processing and linkage, Test Utah Survey and analysis, the Utah Insurance Department eligibility monitoring, COVID testing costs, adding COVID related questions to the Behavioral Risk Factor Surveillance System (BRFSS), and increased demand for death data and at-risk population analysis. This led to increased work for the analysts.

[5] https://www.slc.gov/transportation/stay-safe-stay-active-streets-bicyclist-pedestrian-volumes/

[6] https://coronavirus.utah.gov/case-counts/

- The Department recognized the need for the public and decision makers to have access to the most up-to-date information possible. Providing this information often led to requests for further information and reports. These included:
    - Healthcare Utilization Trend Reports
    - COVID Drug Class changes
    - COVID-19 Hospitalization and ICU use
    - Flu Vaccine Data Byte
    - RX Trends Data Byte

Telehealth Capabilities and Broadband Access

During the pandemic, healthcare providers and public health programs saw an increased need for telehealth capabilities--for patients to be able to continue to meet with their providers to manage their chronic conditions and also to be able to attend lifestyle change programs. However, challenges and barriers arose for older adults and rural/frontier areas of Utah. Anecdotally, we know that older adults have reported having difficulty registering for vaccine appointments, online classes and participating with virtual platforms. Our aging delivery system partners implementing evidence-based programs on virtual platforms report having to add additional sessions to teach participants and their leaders on how to use virtual platforms. In some areas of the State rural communities did not have the internet bandwidth to support telehealth services.[7]

Telehealth Infrastructure

As part of the effort to increase awareness and access for healthcare providers, the Utah Department of Health, in partnership with the Utah Telehealth Network, created a COVID-19 Telehealth Resource Center.[8] The purpose of the resource center was to assist providers as they rapidly worked to engage in telehealth for the first time or to increase telehealth capabilities.

The December 2020 report produced by the Department shows a dramatic increase in the number of telehealth members Statewide:

- March - December 2019 member count: 34,227
- January - December 2020 member count: 899,246[9]

Telehealth and Medicaid Services

With the potential for Medicaid members to experience decreased access to needed services, Utah Medicaid clarified its policy regarding the delivery of covered services via telehealth. While some components of the guidance reflected Medicaid's ongoing policy, other parts were (are) specific to the COVID-19 pandemic and the time during the declared Public Health Emergency (PHE). Utah Medicaid is currently defining these specific services to extend through the end of the month in which the Emergency Declaration Period ends. Medicaid has broadly covered telehealth services since 2017 at the same reimbursement rate as in person services, with very few restrictions. Any covered Medicaid State Plan service that is clinically appropriate, does not require hands-on care, examination, testing or interaction with the Medicaid member, and can be reasonably accommodated, may be provided

[7] https://drive.google.com/drive/u/0/folders/1ziQBZ4j2qG-e1l2_-39omh3Wd5m5X-8j (Utah State Profile DPP, Slide 12)

[8] https://coronavirus.utah.gov/telehealth/

[9] http://stats.health.utah.gov/wp-content/uploads/2020/12/COVID-19-Report-December-2020.pdf

through telehealth. During the period of the PHE, with the Centers for Medicare & Medicaid Services (CMS) guidance, Medicaid began allowing for telehealth services to be delivered telephonically.[10]

Medicaid Eligibility

The Families First Coronavirus Response Act (FFCRA) granted states a higher Federal Medical Assistance Percentage (FMAP) if states agreed to certain requirements. Among these requirements was a Maintenance of Effort (MOE) provision requiring that states continue providing Medicaid coverage to those eligible or who became eligible during the public health emergency. States would only be allowed to close cases:

- In the event of the member's death,
- If the member moved out of state,
- Or if the member requested the case closed.

After consultation with GOMB and the Legislative Fiscal Analyst's Office, Utah agreed to the Maintenance of Effort (MOE) requirement to secure the additional federal funds and has seen a 33% increase to Medicaid enrollment as a result. Medicaid enrollment has grown from 301,000 in March 2020 to 401,000 in March 2021.

System Challenges

In order to accommodate the implementation of a Medicaid MOE, the Department of Workforce Services (DWS) needed to make several programming changes to their eligibility determination system, eREP. Programming changes were required to override several complex eligibility rules that result in case closures. This typically would have required weeks of time to program and test before implementation. Due to the short timeframe within which these changes needed to be made, the task was incredibly challenging, requiring significant manual intervention by DWS staff to correct errors. Some Medicaid members experienced limited interruptions of coverage.

In Home Support for Medicaid Members (HCBS Waiver Members)

As part of the response to the PHE, Utah sought additional flexibility in the delivery of services through its Home and Community-Based Services (HCBS) waiver programs. These programs service individuals who meet facility-based care in less restrictive community settings. The Federal authority which governs responses to these emergencies is referred to as the 'Appendix K'.

In its request, The Department of Health and Department of Human Services requested additional latitude/flexibility for such items as:

- Caregiver compensation (paying legally responsible individuals to provide care due to disruptions in provider-based supports)
- Usage of telehealth services/performance of services without the waiver participant
- Retainer payments to ensure providers could maintain staff once restrictions were lifted/relaxed
- Allowing additional time to complete fingerprint/background checks
- Modifying eligibility criteria in the New Choices Waiver to prevent displacement of individuals residing in Assisted Living Facilities

[10] https://medicaid.utah.gov/Documents/pdfs/covid/COVID-19_TelehealthFAQ1.21.pdf

- Allowing for the state to be paid for providing PPE when contracted providers were unable to secure their own
- Temporary rate increases to providers
- Ability to delay or perform assessments remotely

Impediments

While these flexibilities provided relief to waiver participants and their families, the service delivery system experienced limitations with direct care staff, both due to provider retention concerns as well as individuals and their families wanting to limit possible exposure to COVID-19. State and local restrictions also impeded individuals from receiving services at congregate care locations. For providers who were able to continue rendering support, they experienced higher costs associated with the provision of PPE and payment incentives/'hazard pay' for direct care staff.

There were delays at the onset of the PHE in Utah's response as Federal guidance continued to evolve. It was also unclear which provisions needed to be submitted as part of the 1135 request vs. the Appendix K which led to several delays/revisions being required.

Programs with Delayed or Disrupted Services

While the Department faced an increase in demand as listed above, there were also disruptions and delays in services. The following is a summary of programs that experienced delays and/or disruptions of services:

- **The Office of Vital Records and Statistics (OVRS)**: Closed their customer service window at the Department's office building and instead depended solely on mail and online ordering. Fewer birth certificates were ordered at the beginning of the school year which led to a decrease in revenue.

- **Tobacco** cessation and compliance check enforcement was interrupted. Quitline registrations were down 23% and online registrations were down 47% during COVID-19 compared to the previous year. Additionally, tobacco compliance check store inspections were down 73% during COVID-19 compared to the previous year.[11]

- **Environmental Epidemiology Program (EEP):** Delays occurred in being able to help the public access information on food handler cards, approvals for food handler training, and provide support to local health departments resolving local pool and food issues.

    - Requests for information on food handler cards (2-3 a week) are normally answered the same day. In the past year, the normal response time has become 3-7 days. Turnaround on processing requests to be a training provider for food handler permits is usually no more than a month. Training applications have been delayed. Overall, in 2020, the Department experienced approximately a 6% decrease in food handler permits issued versus 2019.[12]

- **Healthy Living through Environment Policy and Improved Clinical Care Program (EPICC):** Doctor's office visits declined for hypertension and/or diabetes (and other chronic disease care).

[11] https://docs.google.com/spreadsheets/d/1iT6K8rIE4RE43zUEw6H2gFFYGN-FFbr8/edit#gid=517851785

[12] https://docs.google.com/document/d/1VQmmDu5-49x5pwB9M87e9KBCr9JXxeU8kKBAfML2gL0/edit

While it may take some time for data to reflect the negative impact of lesser clinic visits, EPICC is concerned about unmanaged chronic conditions as a result of the pandemic.[13]

- **Asthma:** There was a notable reduction in asthma home visits due to guidelines and reassignments of staff during COVID-19. Between COVID-19 assignments staff developed a virtual platform to deliver services. Ongoing support for technology training, broadband access for participants and internal approvals are necessary to make the process more efficient.[14]

- **Healthy Aging:** Community access to evidence-based programs (EBPs) were cancelled during a period of the COVID pandemic to meet health guidelines. Staff and partners in the state and across the nation worked together to create virtual platforms. All training opportunities for new leaders also ceased for a period of time impacting delivery of services and access once we began to offer classes again. Virtual delivery increased costs for partners. Physician referrals to community EBPs declined. All Alzheimer's Disease and Related Dementia (ADRD) education opportunities stopped because of limited access to LTCFs and other organizations. ADRD programming was only approved to go virtual in February 2021.[15]

- **Office of the Medical Examiner (OME)**: The impact of the pandemic on the OME was such that increased caseload led to longer turn-around times for families waiting for our reports to settle insurance claims, estate issues, etc. [16]

- **Bureau of Epidemiology (BOE)**: Fear and social distancing requirements delayed health care interventions for communicable disease, injury prevention and childhood vaccinations. As an example, in December of 2020 the Department's Office of Health Care Statistics updated a May 2020 report of Preliminary COVID-19 Healthcare Trends.[17] This report details medical services accessed by the public during calendar year 2020, based on claims data, among the data reported shows a decline in childhood and adolescent vaccinations from 2019.

- **Preventive Screenings.** Programs experienced a reduction in preventive HIV and sexually transmitted disease (STD) screenings, and cancer screenings.

    - It is anticipated that reduced screening resulted in more undiagnosed communicable diseases and potentially increased transmission. Screening for HIV and STDs fell during the pandemic due to closures of screening sites and limited staff capacity at local health departments. [18]

    - Women were not able to receive cancer screening services from April - June 2020. Clinics are opened up for women's health screenings in February 2021.

    - During COVID-19, only 58% of the screening performance measure was met, compared to past years with 90% completion of the goal submitted to CDC. This decrease in women screened impacted the number of women who received health coaching and of those screened fewer received the full benefit of the program. Additionally, the

[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7308780/

[14] https://docs.google.com/document/d/1DrxBW82D9TRMcxlVOkH8jM4pv2RHStGP_iibtl6Iyzk/edit

[15] https://drive.google.com/file/d/1R2IuTXH7BIwQBjth0gm1KtrzlHwNELCe/view

[16] https://drive.google.com/drive/u/0/folders/1ziQBZ4j2qG-e1l2_-39omh3Wd5m5X-8j

[17] http://stats.health.utah.gov/wp-content/uploads/2020/12/COVID-19-Report-December-2020.pdf

[18] https://drive.google.com/drive/u/0/folders/1ziQBZ4j2qG-e1l2_-39omh3Wd5m5X-8j

requirement of women needing to wait 30 days after getting the COVID-19 vaccine before they can get a mammogram is expected to further delay breast cancer screening.[19]

- **Outside Provider Access to Patients in Long Term Care Facilities.** The Executive Director for the Homecare and Hospice Association of Utah, Matt Hansen, reported access issues with skilled nursing facilities, particularly that some communities have been discouraging, or at least limiting the frequency of hospice visits or telling families that they can take care of end-of-life care with their own staff. This was a major issue through the first half of the pandemic despite the guidance released in March of 2020 for the Centers for Medicare and Medicaid Services (CMS) that provided clear language that end-of-life/hospice providers are essential care workers.[20][21] Preliminary data indicates that services rendered in this setting decreased significantly for Medicaid members, validating provider reports. Utah Medicaid data show a decrease of about 50% in provider reimbursement for these services during April 2020 to September 2020 compared to the same six-month period in 2019.

- **WIC.** Utah WIC participation continued to decrease throughout the pandemic; data shows ~11% decrease in participation from March 2020 through April 2021.[22][23] This trend was in place pre-pandemic, and has continued to be the case. Even though electronic WIC benefits were implemented during the fall of 2020, participation rates have continued to decline. This decreasing participation trend has been experienced nationally over the last 10-plus years. Due to physical presence rules being waived during the pandemic, anthropometric data - including height, weight, head circumference, hemoglobin levels, etc. have not been updated as they would normally be. Documentation of these statistics will become accurate once they are able to be collected on regular intervals moving forward, post-pandemic.
    - March 2020 enrollee count: 41,010
    - April 2021 enrollee count: 36,843

- **Integrated Services Program.** Demand for integrated services remained the same; however, the wait list grew exponentially for services as our psychologist was unable to test children with reliability for several months. The Integrated Services Program (ISP) provides care coordination for children with special health care needs across the State. ISP also delivered direct developmental assessment and diagnosis for children residing in rural Utah via a traveling clinic model; the program converted from direct face-to face to telehealth evaluation during the COVID-19 pandemic. The program psychologist had to re-train on ways to elicit consistent responses from test subjects via telehealth. During this time, the Department saw 50% fewer children for care coordination at some rural sites given that our care coordinators are also public health nurses who were working on COVID-19 issues locally.

- **Home Visiting** additionally had difficulties with recruitment of families during the pandemic. OHV-funded home visiting sites were at an expected caseload capacity of 100.3% in January 2020, which dropped to 86.7% in January 2021. Additionally, many program staff were

[19] https://drive.google.com/drive/u/0/folders/1ziQBZ4j2qG-e1l2_-39omh3Wd5m5X-8j

[20] https://www.nhpco.org/wp-content/uploads/COVID-19-Regulatory-Alert-031120.pdf

[21] https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

[22] CSParticipationWICMarch2020

[23] CSParticipationApril2021

redirected to COVID-19 response and unable to increase or maintain service provision levels. This was particularly true for our smaller programs situated in local health departments, which were only able to provide 5 to 45% of normal expected home visits to-date in 2021.

- **Baby Watch Early Intervention.** All in person services were transitioned to be delivered via tele-intervention. This was a new service delivery type for Utah Part C Early Intervention (birth to age 3), and there was a learning curve for providers, children, and families. This approach was successful in some cases but not all. As we were forced to only deliver virtual visits, many inequities and vulnerabilities were identified in communities throughout the state (i.e., no access to devices or internet, communication breakdowns with English language learners). There was a slight decrease in referrals and children served (Baby Watch provided referral intake, evaluation and assessment, and Individualized Family Service Plan (IFSP) services) between SFY 2019 (10374 Referrals, 15838 Children Served) vs 2020 (9502 Referrals, 15039 Children Served). SFY 2020 counts are in line with SFY 2018 (9731 Referrals, 14989 Children Served).

Internal Vulnerabilities Exacerbated by COVID-19

Staffing. The ability of the Department to reassign so many staff and partners to respond to the pandemic reinforces the flexibility and resiliency of the Department's staff. However, capacity and hiring limitations can cause employee burnout, high turnover, and retirements. Telework initiatives provided a pathway for many employees to work beyond their normal schedules to accommodate the increased work demand during COVID-19.

To date, Department employees have contributed over 414,000 hours spread among over 750 employees to the COVID-19 response. Across all offices, increased demand required increased resources. At times the Department did not have funding to immediately hire more personnel to help. Additionally, at times even when funding was available, the Department has had difficulty hiring people with the skill sets needed, based on normal State salary ranges, into time-limited positions.

In addition to the overall strain on staffing, there were several key leaders within the Department who took on additional roles during the response. The Center for Health Data and Informatics Director was asked to take on project management for several projects that were initiated by external entities and then turned over to the Department. The Utah Medicaid Director was asked to take on management of Statewide Testing efforts. The other staff were required to manage both the Medicaid response to the pandemic and day-to-day operations. The Bureau of Epidemiology and Bureau of Health Promotion staff were tasked with oversight of contact tracing, COVID-19 data collection, coronivirus.utah.gov webchat, vulnerable populations wrap-around services, and more. As a result, many employees had to work on both regular job duties and new pandemic focused assignments.

The financial responsibilities associated with the COVID-19 response highlighted the need for increased financial staffing. The Department typically operates as efficiently as possible without any redundancy in accounting/finance responsibilities. With the increased funding, purchasing, federal and state reporting requirements, finance personnel were stretched to address the response efforts and unable to perform regular financial activities for other areas of the department. Financial personnel require specialized skills and the ability to hire and train personnel in a timely manner.

Overtime was not properly charged as entered into the ESS system. The state, when they purchased and implemented the current payroll system, opted to not pay for the ability of the system to allocate

leave automatically in the system as employees charge their time to various coding stings. This requirement and the process to allocate leave was left to the Departments to process individually. As a result of the pandemic, many employees had to work on both regular job duties and new pandemic focused assignments leading to overtime hours.

Contract and Grant Writing and Management. The Department relies heavily on federal funding and contracts with various vendors. Contract and grant writing and management take an incredible amount of staff time and resources and is a vital part of responding to public health needs. This work has traditionally fallen to program managers who have little or no expertise in drafting these kinds of documents and detracts from their work and ability to participate in response efforts. The Department recommends funding for dedicated staff for grant writing, as well as contract specialists.

Purchasing. The approval path for emergency procurements was not very clear once the State shifted to the Unified Command model. The normal process for emergency procurements is typically approved by the Executive Director or a designee. However, under the Unified Command structure the approval process was unclear initially. This confusion caused delays in trying to procure necessary safety and testing equipment. This model also caused an additional layer of review and approval as the Department would go through their process; we then had to also get the review and approval of Unified Command, slowing down the procurement process. The process did improve with the assistance of the State Purchasing Group, who became critical to the process of purchasing PPE and supplies, and with the establishment of a standardized method of bringing funding requests and recommendations to the Unified Command.

Payables Process. The payable program within the Office of Fiscal Operations saw a large increase in contract and service payments. Many of these purchases had to be processed within a certain time frame to ensure the needs identified by Unified Command were being met. Staff was already at high capacity and the volume of payments drastically increased while the staff was expected to keep up with them. Often vendors would call daily for check numbers and status of payment, many of which were prior to the program actually receiving the products or invoices. This increase of workload required staff to work overtime. One of the biggest contributors to the bottleneck of the payable process was and still is the receiving or dealing with paper while teleworking. Invoices are still received in the mail and staff are only in the office one day a week, which can delay payment of these invoices.

A large new warehouse (86,000 square feet) was used to store many of the large purchases, including gloves, PPE, sanitizer, and many other items that were vital for the State's response to the pandemic. This was the first time the Department has implemented a resource of this nature. The paper packing slips and receiving documents were difficult to reconcile. The orders received were extremely large and some items from the same order were received in multiple shipments, requiring a time-consuming process of matching up items received with the invoices. This is still in operation, and will continue to be a core element of disaster readiness.[24]

Information Technology (IT) Systems. Consolidation of IT resources for cost savings was a major contributing factor in response readiness. Shared IT resources were not scaled to handle the increased workloads brought on by response efforts. RedCap and Epitrax were key examples of systems that had to be de-consolidated and put into larger dedicated IT environments.

[24] Utah Distribution Center

GRAMA Requests. As a result of the pandemic, there was an increase of GRAMA requests made to the Department. Many of these requests included large amounts of documents. Because there is no automated system to process and review documents for GRAMA requests these requests were reviewed and processed manually. 63G-2-204 states that responses to GRAMA requests should be made as soon as reasonably possible, but no later than ten business days after receiving the request; or, if the requester has asked for an expedited response, no later than five business days. The receipt, research, document preparation, and redaction of protected information took a lot of personnel time, including many hours of overtime, to review and respond to these requests.

Recommended areas for further funding

Support for Public Health Infrastructure: Public Health in Utah continues to be under-resourced. Utah needs to fill in gaps that exist with our public health infrastructure and we need public health response to operate at the same speed of a disease outbreak by supporting stronger public health infrastructure with increased funding and population health strategies.

The Department recommends immediate budget allocations be dedicated to critical infrastructure needs now and ongoing during public health emergencies including staffing, information technology resources, and communication channels.

The Department also recommends funding for the ongoing Distribution Center needs to ensure that the State can be in a position to support state agencies, healthcare providers, tribes, and first responders with weathering a future shortage.

The Legislature customarily intends that the Department of Health develop performance measures for new funding items. The Department agrees with the importance of establishing metrics that demonstrate the improvement of agency performance and the quality of life for the citizens we serve.

Performance metrics for these recommendations would include state of readiness reporting measures.

Additional, specific recommendations include the following:

- Investment in Workforce: As indicated throughout this report staffing has been a constant source of concern during the PHE. The Department recommends the following with regards to workforce readiness:
    - Ensure we have an agile Human Resources system and personnel for rapid on-boarding
    - Development and access to comprehensive training resources to ensure we have a workforce at the ready.[25]
    - Faster and more efficient access to funding for hiring time-limited staff when appropriate.
    - Investment in IT programmers for the systems that the Department operates.

[25] https://www.cdc.gov/csels/dsepd/strategic-workforce-activities/ph-workforce/action-plan.html

- Focus on better mass fatality planning going forward, so the department can be prepared for future large scale emergencies. The Utah Office of the Medical Examiner (OME) recommends having additional resources to train current staff, funds to hire and train new staff, and provide necessary equipment such as an additional refrigerated trailer in the case of a mass fatality.[26]

- Preventive care visits and screenings for infectious and chronic conditions decreased during the pandemic.[27][28] Some programs are anticipating an influx of chronic illnesses due to the communicable disease impact on the body.[29] It is recommended to provide continued investment and support for staff working on prevention efforts to increase preventative care visits and screenings.

- Community Health Workers (CHWs) have been identified as a necessary component in the public health response to the pandemic to help mitigate the spread and effects of COVID-19 on underserved and underrepresented communities. It is recommended that the state of Utah provide continued investment, expansion, and support for CHWs efforts.[30]

- Funding to purchase laptops and other equipment for all employees that would allow for moving to remote work quickly, and funding for DTS support to troubleshoot issues related to remote work (e.g., The Office of Public Health Assessment (OPHA) had some internet and technical issues due to the shift to telework and caused slowing down of survey work, some collection issues and error in studies.)

- If funded, performance metrics would include an increase in the number of community health workers statewide as well as increased efficiencies and response readiness within various Department programs.

- Data Systems: Upgrade and modernize our public health database systems. This may include upgrading systems and technology, data transmissions and interoperability data exchanges.

    - It is recommended to have surveillance systems in place for vaccinations and chronic disease data, and that these systems be linked. Current data sources for chronic care surveillance and vaccine surveillance are insufficient for public health interventions and disease response. Surveillance systems that integrate clinical data from health systems would greatly improve disease management at a population level. Both of these types of systems will help the Department better understand any barriers to receiving access to care, monitoring disparities, and allow resources to be distributed equitably to all age groups, races, communities, etc.[31]

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[26] https://www.cdc.gov/cpr/readiness/00_docs/capability5.pdf

[27] https://www.ama-assn.org/delivering-care/patient-support-advocacy/preventive-care-pandemic-stretches-no-more-time-wait

[28] https://www.cancer.org/healthy/find-cancer-early/cancer-screening-during-covid-19-pandemic.html

[29] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

[30] http://choosehealth.utah.gov/healthcare/community-health-workers.php; http://health.utah.gov/disparities/data.html http://health.utah.gov/disparities/data/ohd/CCPPilotProjectNov2020.pdf ; http://health.utah.gov/disparities/data/ohd/CCPProject2020.pdf

[31] https://docs.google.com/presentation/d/1XZbi9BMjeVrZlDJqf4fiueTlRNj49Q_P/edit#slide=id.g63114a1166_0_15

- Information Technology Systems: The Department recommends a number of investments to upgrade the technology infrastructure for public health, including the following:
    - The Utah Public Health Lab continues to experience frequent connectivity issues between the Laboratory Information Management System (LIMS) and secondary data systems. LIMS is mission critical to ensure the lab can build usable data warehouse solutions for current and future data needs.[32]
    - Vital Records Application Portal (VRAP) consists of multiple applications to support the Office of Vital Records and Statistics. These applications consist of the birth, dealth, marriage, divorce, fetal death, paternity, adoption registry, and abortion systems. These systems need to be updated to address security concerns due to outdated architecture, to be multi-browser compatible before support for Internet Explorer ends, to eliminate paper-based manual processes, to be accessible to reporters to eliminate duplicate entries, to make them interoperable with EHR systems for easier reporting, to make them mobile friendly for medical doctors who need to certify deaths, and to have failover processes so that the systems are not destroyed if there is a major disaster that were to damage local data centers.
    - Funding for electronic debit/check system for certificate fees to prevent two person requirements to open mail and secure paper handling for OVRS program. Support to be field ready, meaning portable systems, so OVRS is able to issue certificates if required during uncertain circumstances such as an earthquake that may take out infrastructure. For example OVRS may need to do some dry runs including the Office of the Medical Examiner, hospitals, and funeral homes on responding from the field. They also require equipment such as portable printers and tablets to be more mobile.
    - Funding for State Finance to enhance the payroll system with the ability to properly allocate leave and overtime costs accordingly in the system, as they were charged. This would eliminate the need for the manual process, which was very time consuming and costly. Upgrades will decrease errors that inherently come from manual processes and allow proper cost charging to federal grants as outlined in federal grant guidance.
        - Funding to develop an automated process for reconciliation of multiple shipments, invoices, packing slips, and purchase order paperwork would reduce the amount of time it takes for the Payables staff to make payments. As of now, staff must scan through lists of hundreds of documents to monitor them until they are ready to pay.
    - If funded, performance metrics would include a reduction in manual leave and overtime processing, less down time for systems, quicker turnaround times, and greater efficiency.

[32] https://docs.google.com/document/d/1yIRcwPF85ks4dIVWoLfYVbmVApYk6UEp/edit

- Communication: The Department recommends the creation of both an inter-agency coordination team and an internal public health communication and preparedness plan to better prepare to respond to future public health emergencies.[33] [34]
    - The Department also recommends funding for outreach efforts to offset the lost time during the pandemic for preventive services.
    - Funding for more effective, timely communication with Medicaid members is needed. Right now, the Department relies heavily on land-based mail to communicate with members, and more effective communication methods, including SMS texting, email, and robocalls for alerts, are needed.
    - If funded, performance metrics would include reporting mechanisms for the coordination team and preparedness plan, increased delivery of preventive services including immunizations, and more effective outreach to Medicaid members.

Medicaid Enhanced Match. As noted previously, Medicaid enrollment has increased by 33% compared to pre-pandemic levels. This increase was largely due to the MOE requirements. The Department has observed that the 6.2% federal match increase has been sufficient to cover the cost of the increased enrollment thus far. The Department recommends investment in technology solutions to enhance the enrollment capabilities to account for potential future emergencies.

Yet to be Determined Programmatic Impacts. Some aspects of how COVID-19 may have impacted programs are still not yet known. Additional time and resources will be needed to be able to identify the complete impact of COVID-19. For instance, an evaluation will be conducted in the summer of 2021 to determine how COVID-19 impacted implementation of the stock albuterol policy, which was supposed to allow schools as of July 1, 2020 to stock albuterol and distribute to students in need if they have an asthma action plan on file. This is just one example of potentially many unknown impacts that are yet to be fully understood. Many programmatic data to measure outcomes will not be available until IBIS-PH and other data sources are updated with 2020 metrics.

[33] https://storymaps.arcgis.com/collections/caf8b840306d4307a826ea7c19844464

[34] https://docs.google.com/document/d/1-JQccE7Cii7AFP-KjNa4Z0ZmDcprx68xHrL8a4IpcIw/edit?usp=sharing