Report to the Social Services Appropriations Subcommittee

Recommendations to Better Protect our Vulnerable Populations and Prepare our Programs in Times of Crises

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 what the Legislature can do to better prepare our citizens, employees, and most vulnerable populations for times of crises, including identifying programs the agency has determined are effective for preparing citizens that could not operate at full capacity; for these programs, agencies should indicate if this was due to inadequate funding and provide recommendations for how to improve the program.

Executive Summary

Utah Legislature Helping Prepare Citizens for Times of Crisis

COVID-19 has highlighted the significant role that social and economic factors play in our citizens' ability to protect themselves from public health threats. Data show that when crises arise, vulnerable and underserved populations[1] are the most affected and their health suffers more than other populations. The challenges that these populations face is related to long-standing systemic barriers rooted in the social and structural drivers of health. Some of these barriers include lack of access to healthcare, food, personal and environmental hygiene products and practices, first aid resources, unemployment resources, stable/reliable internet connections, language/cultural barriers, mistrust due to historical mistreatment, discrimination in many forms, and complex technological systems and applications for support.

Throughout the COVID-19 pandemic, we have witnessed how our vulnerable communities within Utah were more exposed to COVID-19, more likely to be sick or die from COVID-19, in greater need for social and health resources, met with greater barriers to access health and crisis care (such as testing and vaccines), and at higher risk for more severe complications related to COVID-19 due to untreated underlying health conditions. This is a trend experienced across our nation and globe.

The Utah Legislature is instrumental in assisting with the preparation of our citizens, employees and those most vulnerable for times of crisis. The Utah Department of Health receives two cooperative agreements (CDC Public Health Emergency Preparedness Program and HHS ASPR Healthcare Preparedness Program) annually from the federal government for public health and healthcare preparedness, but the funding is inadequate for all the

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[1] These populations include people living in areas with a high health improvement index (HII) score, racial and ethnic minority communities, people who are experiencing homelessness, people with disabilities, people who are refugees, older adults, people living in rural areas, people living in congregate living settings (people who are incarcerated, residential treatment of mental health and substance use disorders, long term care facilities, etc), and American Indian or Alaska Native (AI/AN) communities.
Note: The HII is a measure of health equity based on nine key indicators including age, education, income, unemployment, and more. Areas with high or very high HII scores indicate less health equity. For more information, go here)

needs in Utah. Currently, the Legislature does not allocate state funding for public health and medical preparedness and response. This gap leaves Utah vulnerable during crises; however, additional support and funding from the Legislature would better position the Department and State of Utah to prepare Utahns and protect their health. These investments should also help programs and initiatives that can make communities less vulnerable moving forward and build resiliency for future crises.

In order to better prepare and protect our most vulnerable communities, this document outlines the impact and needs of our vulnerable communities during times of crises, the programmatic and funding structures to better support our communities and employees working with these populations, and policy recommendations for systemic and large-scale changes to prevent health disparities and inequities that will further burden Utah's most vulnerable individuals.

Section I: Vulnerable Populations and their needs: What did we learn from COVID-19 about the needs of Vulnerable Populations?

Utah Health Improvement Index (HII)
- Utah's Health improvement Index (HII) is a composite measure of social determinants of health by geographic area.[2]
- Over the course of the pandemic, Utah has seen a statistically significant difference in case rates between the HII categories, with the "Very High HII" group having the highest case rates.
- Additionally, areas with high health disparities -- where HII score is high or very high -- have statistically higher case rates than areas with no significant health disparities.
- Hospitalization rates were the highest among the "Very High HII" group[3].
- ***Needs:***
    - Integrate Utah HII into data reports.
    - Focus crisis-relief efforts in areas we know have increased barriers and poorer health outcomes.

Rural Health

- Higher poverty rates exist in rural areas, compared to urban areas (10.8% poverty rate in rural counties vs. 8.8% in urban areas)[4] in Utah. This is a known barrier to quarantine and isolation.
- Rural communities reported difficulty in accessing necessary healthcare services, including transportation to testing and vaccination sites, especially when they don't feel/see the value of it.
- ***Needs:***
    - Improve data monitoring within rural areas to connect stakeholders with resources to address needs.
    - Increase resources in rural communities (i.e. Rural Health Clinics, Critical Access Hospitals, Community Based Organizations) related to personnel and facility capacity.

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[2] Utah Health Improvement Index includes nine indicators that describe important aspects of demographics, socioeconomic deprivation, economic inequality, resource availability, and opportunity structure.
[3] https://www.cdc.gov/mmwr/volumes/69/wr/mm6938a4.htm
[4]"Retrieved Mon, 12 April 2021 from the Utah Department of Health, Indicator-Based Information System for Public Health Web site: http://ibis.health.utah.gov"

○ Improve communications specific to incredibly remote areas, language barriers and lack of availability of technology.

Racial and Ethnic Minority Communities

● Racial and ethnic minority communities in Utah have less access to resources, such as testing and the COVID-19 vaccine, while suffering a disproportionate share of cases, hospitalizations, and deaths.
  ○ Native Hawaiian/Pacific Islanders (NH/PI) have the highest case and mortality rates in the state.
  ○ People who are Hispanic or Latino have the second highest case rates and American Indian / Alaska Natives (AI/AN) have the second highest mortality rates in the state.
  ○ All racial and ethnic minority groups experienced higher hospitalization rates than statewide.
  ○ Vaccination rates for all racial and ethnic minority groups lag far behind those of the white alone group.
● Despite representing only 24% of Utah workers in the employment sectors, Hispanic and nonwhite workers accounted for 73% of workplace outbreak-associated COVID-19 cases.[5]
● Multiple factors contribute to the disproportionate impact of COVID-19 on racial and ethnic minority communities, including intergenerational housing, inability to telework, and lack of access to health services.
● *Needs:*
  ○ Improved access to healthcare and public health resources (ie testing, vaccine, etc)
  ○ More efficient and inclusive systems for resource connection and health needs
  ○ More paid time off and prioritization of resources (PPE, vaccine, etc) for essential frontline workers (hospitality, restaurant, grocery stores, construction workers, etc).
  ○ Increased funding for Community Health Workers and Community Based Organizations who serve the communities

Data captured on May 24, 2021*

Race / Ethnicity	% of Total Utah Population	% of All Persons Tested	% of COVID-19 Cases	% of All Vaccinated People	Case Rate / 100,000 Population	Hospitalization Rate / 100,000 Cases	Mortality Rate / 100,000 Population
American Indian / Alaska Native	2.2%	1.1%	1.3%	0.9%	7373	91	106
Asian	3.7%	2%	1.9%	2.9%	6525	49	58
Black / African American	2.1%	1.4%	1.4%	0.9%	7979	51	30
Hispanic or Latino	14.6%	12.8%	20.4%	9%	17,206	44	65

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[5] For more information on racial/ethnic disparities at workplace https://www.cdc.gov/mmwr/volumes/69/wr/mm6933e3.htm

Native Hawaiian / Pacific Islander	1.6%	1.5%	2.4%	0.6%	18,659	88	127
White alone	75.6%	69.2%	64.9%	73%	10,535	41	63
Statewide					12,301	41	70

*Note that in the beginning of the pandemic, the disparity was even larger amongst populations. In June 2020, cases in the Hispanic/Latino population accounted for over 40% of cases in the state.

American Indian/ Alaska Native[6]

- American Indians/Alaska Natives (AI/AN) accounted for 5,320 cases in Utah as of April 30, 2021. There was a 5.78% positivity among AI/AN compared to 3.22% positivity among all of the Utah population.
- When compared to the non-Hispanic or Latino white population, AI/AN diagnosed with COVID-19 have 2.25 times more risk of being hospitalized.
- Mortality rates are highest among the AI/AN population, with a mortality rate of 14.6 people per 1,000 cases. In comparison, the non-Hispanic or Latino white population has a mortality rate of 5.9 per 1,000 cases.
- Greatest barriers observed amongst the AI/AN populations include:
  - Geographic isolation, intergenerational families living in homes
  - Access to health service
  - High mobility
  - Food insecurity; access to clean water
- The AI/AN program uses a model that consists of three prongs to support Indian health statewide, including dedicated office and staff, standardized formal consultation/communication policy and process, and Indian Health Advisory Board. Maintaining support for this model through executive, legislative, agency levels is essential.
- ***Needs:***
  - Increased staffing for the AI/AN program who serve as liaisons with the tribal nations

Refugee Health

- According to data from April 30, 2021, there have been a total of 1,665 cases within the refugee population.
- The majority of cases (77%) are in those who have been in the U.S. for more than five years.
- The refugee community reached a 34% peak of positive COVID-19 tests twice during the pandemic – in May 2020 and again in November 2020, exceeding the state's average rates.
- The percentage of refugees who had documented neuro-behavioral complexities or other mental health issues increased by at least 10% over the last year.
- Loss of employment has had a significant impact on refugee communities. Many live paychecks to paycheck and do not have the savings to provide a safety net in times of economic hardship.

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[6] If outside agencies or organizations want to work with tribes, they should work through the Utah Department of Health Office of American Indian/Alaska Native Health Affairs (AI/AN) or tribal governments. The state partners with tribal governments and tribal health when developing vaccination distribution strategies and outreach events.

- Low computer/IT literacy, inability to pay internet/phone bills, and loss of a walk-in-waiting room to speak to an eligibility worker or job developer increased hardships for clients.
- ***Needs:***
  - Improve telephonic interpretation to work with the refugee population.
  - Increased staffing for the Refugee Health Program
  - More efficient systems to connect clients to needed resources
  - Prioritize immunizations of frontline public service workers, including those in the Refugee Center to allow ongoing direct physical interactions by eligibility workers and job developers.

Disabilities and Health

- People with Access and Functional Need (PAFN)[7] were some of the most impacted by COVID-19.
- People with intellectual and developmental disabilities had mortality rates three times the national average, including people with Down Syndrome having rates ten times higher[8].
- Long-term care facilities, where many PAFN live, saw a much higher rate of infection than the general public[9], and rates of those in community-based services were much lower.
- The specific needs of PAFN (accessibility, accommodations, digital divide) are often overlooked in disasters.
- There is a lack of resources in certain geographical areas of Salt Lake County and Utah County that have a higher percentage of poverty and consequently a higher number of PAFN (42% of PAFN live below the poverty level).
- ***Needs:***
  - Improve access to healthcare.
  - Improve systems of transportation, communication, and data monitoring.
  - Increase preparedness supplies, such as emergency kits to sustain PAFN for 72 hours.
  - Provide targeted services to Students with Access and Functional Needs, who will need more help because of the time lost due to the pandemic.
  - Require employers to provide continuous accommodations for PFAN, which may include permission to work from home, laptop computers, telephones, and in some cases, at home personal assistants.

Long-Term Care Facilities (LTCF) and Older Adults

- 76% of all COVID-19 deaths in Utah occurred in people 65 years and older (12% of the population)[10].
- The COVID-19 pandemic has disproportionately affected residents and patients of long-term care facilities (LTCFs) in Utah.

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[7] Persons with Access and Functional Needs (PAFN) are those individuals with function-based needs (related to a restriction or limited ability to perform activities normally considered routine) that may require assistance before, during, and /or after a disaster or an emergency. PAFN also includes people with Limited English Proficiency (LEP), children and elders (people under the age of 18 and over the age of 64 may or may not have an access and functional need but they are included in the federal definition of people with disabilities and are thus included as PAFN), people with neuro-behavioral complexities, people who are homeless or facing food and housing insecurity or lack of employment, and people who are incarcerated.

[8] Clift, Coupland, Keogh, et al., COVID-19 Mortality Risk in Down Syndrome: Results From a Cohort Study Of 8 Million Adults, Annals of Internal Medicine (Oct. 2020), available at, https://www.acpjournals.org/doi/10.7326/M20-4986

[9] Chidambaram, Garfield, and Neuman, COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff, Kaiser Family #Foundation (Nov. 25, 2020), available at https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/

[10] https://healthcare.utah.edu/healthfeed/postings/2020/12/covid19-impact-older-adults.php#:~:text=As%20of%20December%203%2C%202020,hospitalization%20rate%20is%20much%20higher.

- At its peak, the case fatality ratio for cases associated with a long-term care facility was >22%, while the overall Utah population never passed a case fatality ratio > 1.5%.
- Fourteen percent of all the residents who tested positive eventually died due to complications from COVID-19, compared to less than 1% in the general Utah population.
- Of all the COVID-19 confirmed deaths in Utah, 32.5% are attributed to residents in LTCFs.
- COVID-19 dedicated LTCFs were utilized as a key success strategy for hospital decompression and lateral transfers between LTCFs to minimize the spread of COVID-19.
- Early vaccine prioritization and widespread vaccine uptake promptly halted an exponential increase in deaths of LTCF residents during the Fall 2020 surge.
- *Needs:*
  - Improve outreach to those who are homebound, intellectually and developmentally disabled, and the elderly, especially related to technological access, testing/vaccine resources, and education.
  - Include LTCFs in planning for alternate sites of care for hospital surge.
  - Support policies that incentivize vaccination by healthcare workers to ensure the highest risk patients they care for are protected against infectious disease threats.

Incarcerated Populations *(persons held in a prison, jail, detention center, or other custodial setting)*

- Nationally and locally, incarcerated populations have seen at least a 50% attack rate of COVID-19 once introduced into the facility.
- As of April 7, 2021, the Utah State Prison facilities in Gunnison and Draper have seen 64.7% and 55.7% of residents diagnosed with COVID-19 among the incarcerated population, respectively.
- COVID-19 associated deaths in Gunnison and Draper are 0.3% and 0.8% of diagnosed cases, respectively.
- *Needs:*
  - Provide staff to support COVID-19 testing, contact tracing, active monitoring, clinical documentation and public health reporting, and vaccination administration.
  - Prioritize correctional settings and non-LTCF congregate settings early for vaccine allocation, due to the ongoing increased risk for large outbreaks.

Mental Health

- Reports of suicidal ideation and suicide attempts remained stable throughout the pre-COVID-19 period and during the COVID-19 interventions period.[11]
- The number of suicide deaths did not increase in the first 39 weeks of 2020; the number of suicide deaths in Utah is consistent with the previous three years.
- Calls to the Suicide Prevention Crisis Line increased throughout the first 10 months of 2020, but this growth is similar to increases in previous years.
- During a crisis such as the COVID-19 pandemic, it is common for everyone to experience increased levels of distress and anxiety, particularly as a result of social isolation.
- The COVID-19 pandemic exposed long-standing gaps in access to mental health services and innovative programs such as the Utah Department of Health and Human Services' Utah Strong Recovery Project expanded virtual access to essential crisis services.
- *Needs:*

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[11] Social and Behavioral Health During COVID-19: https://coronavirus-download.utah.gov/Health/COVID_Mental_Health_Report_.pdf

- Ensure culturally-appropriate mental health providers, including affirming mental health providers for Lesbian, Gay, Bisexual, Trans and Queer communities.
- Invest in rapidly expanding the mental health workforce to meet demand.
- Continue to advance innovative delivery models that support virtual access, especially in rural communities.
- Increase access to mental health services for lower socio-economic populations, including adequate health insurance coverage for mental health services, .

Homelessness

- As of April 14, 2021, 980 people experiencing homelessness in Salt Lake County had tested positive for COVID-19.
- There was an 11.9% increase in homelessness in 2020 compared to 2019; 9.8 in every 10,000 people were experiencing homelessness in 2020.[12]
- The number of unduplicated individuals who were enrolled in Homeless Management Information System (HMIS) from March 6, 2020- April 28, 2021 include:
  - 12,699 individuals enrolled in projects that indicate literal homelessness (emergency shelter, transitional housing, and street outreach)
  - 23,345 individuals enrolled in any project
- ***Needs:***
  - Provide more resources for shelters, transitional and permanent housing.
  - Increase staff in shelters to connect and support people when they move into housing.
  - Increase access to needed supplies (PPE and hygiene support).
  - Increase access to essential services (healthcare, testing, vaccinations).
  - Increase staffing and resources for street outreach programs throughout the state.

Food Insecurity

- Since the beginning of the pandemic, food insecurity in Utah has increased from 11% (2019) to 18% (2020).
- Black, Asian, Latinx, Pacific Islanders and Native American populations experienced food insecurity at much higher rates.[13]
- Since January 2020, the Utah Food Bank has increased their deliveries by 21% and has seen a 113% increase in households served over the same time period last year.[14]
- The Utah Food Bank reported that demand for food assistance is up 300%.
- In 2020, several community-based organizations identified an increased need for food security in their communities and created their own programs to address hunger. This included the International Rescue Committee (IRC) and Comunidades Unidades creating their own weekly food box programs. This also included the Farmers Feeding Utah program (FFU).[15]

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[12] https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf
[13] https://www.ipr.northwestern.edu/apps/economicindicators.html
https://www.feedingamericaaction.org/the-impact-of-coronavirus-on-food-insecurity/
[14] https://www.utahfoodbank.org/covidresponse/
[15] www.farmersfeedingutah.org

- FFU has served more than 21,000 families. The project has supported 28 farmers and distributed over 1.1 million pounds of nutrient dense food.

- *Needs:*
  - Increase funding for programs like Double Up Food Bucks.
  - Increase funding for food pantries (increasing capacity, offering culturally relevant, healthy food, more staff time).
  - Fund the creation of a Utah Food Pantry Association.

Uninsured

- Through the Health Resource and Service Administration (HRSA) program for the uninsured, as of April 2021, Utah providers have been reimbursed close to $12 million dollars for testing and close to $16 million dollars for treatment.[16]
- *Needs:*
  - Provide access to free and easily accessible healthcare resources, like testing and vaccination.
  - Sustain funding to provide treatment for those who are underinsured or uninsured.

Chronic Disease

- 40% of people who were hospitalized during COVID-19 had an underlying chronic condition[17].
- Of those who reported complete data on COVID-19, 31% of cases had an underlying chronic condition.
- Chronic conditions negatively impact outcomes, including risk of hospitalization and death, for infectious diseases like COVID-19.
- *Needs:*
  - Increase investment in prevention and management of chronic diseases (like heart disease, diabetes, obesity, cancers, asthma, etc.) to reduce morbidity and mortality from infectious disease threats like COVID-19
  - Improve data/reporting systems to monitor disease outcomes and complications during crises.
  - Increased access to telehealth services and technology to facilitate ongoing chronic disease management in times of crisis.

Section II: Preparing for the time of crisis (vulnerable populations, citizens, employees): Identifying programs the agency has determined are effective for preparing citizens that could not operate at full capacity.

Programs that are effective to prepare and support vulnerable populations and citizens

Throughout the pandemic response, UDOH struggled with surge capacity (community health workers, epidemiology, informatics, preparedness, communication, Office of Medical Examiner, Utah Public Health Laboratory, etc.) and being able to rapidly pull people in to do critical response pieces (e.g., testing, contact tracing, surveillance and data requests, outbreak response).

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[16] https://data.cdc.gov/Administrative/Claims-Reimbursement-to-Health-Care-Providers-and-/rksx-33p3/data

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

Community Health Workers (CHWs)

- The demand and need for CHWs have been astronomical during this COVID-19 pandemic. CHWs are trusted members on the ground who are culturally and linguistically competent, support their communities by linking them to resources, provide outreach, and help community members navigate complex systems (i.e. Medicaid enrollment) and public health processes (i.e. testing and vaccine appointments).
- As part of the COVID Community Partnership, nearly 100 CHWs were funded and mobilized at community-based organizations (CBOs) to support their communities during COVID-19. CHWs worked long hours, supporting their communities during intense situations.
- Due to the trust and intricate understanding of the community, CHWs have been able to help inform public health efforts and provide stakeholders such as government, healthcare, and other groups critical information related to what is happening within the community.
- CHWs help to combat mistrust and misinformation related to emergencies and governmental services. It is essential to keep this workforce infrastructure strong to be able to stand up for community outreach and education in an efficient manner during an emergency or crisis.
- The mental health of CHWs is directly tied to their ability to support their communities and to have the resources to help their community members in need. The physical and mental health of the CHW is intricately linked to their community's wellbeing.
- Resources to support communities (housing, food, utilities, etc) must be available for CHWs to do their jobs effectively.
- Resources are required to support CHW paid time off and CHW mental health support.
  - Through the COVID Community Partnership, CHWs were provided Support Groups to help them navigate their jobs and increased stress. When asked if the support groups were helpful, 96.43% responded yes.
- Legislation is needed for Community Health Worker certification to continue to build the workforce, as well as increase opportunities (such as Medicaid reimbursement for CHW work).

Public Information Office (PIO) Communication Efforts for Preparedness

- PIO is a critical piece in getting our citizens prepared, especially getting materials and messaging "translated" into plain language and other languages (currently up to 32 other languages).
- Without all of the work from PIO, all the work we do for preparedness goes nowhere.
- The PIO team provides the capacity for agile, flexible, evidence-based messaging to help Utahns make the best decisions to effectively protect themselves and their families from crises and emergencies.
- Not only is it imperative to translate and interpret preparedness information into other languages, but it is also important to counter misinformation and false information quickly and effectively. The spread of misinformation and false information severely hampers public health crisis management work, likely leading to relaxed, or even contrary, behaviors that those polarized against public health will push in the absence of responses or balanced messaging.
- There is a need for resources that can be funneled into PIO for sustained staff support and translation services.

Office of Health Disparities (OHD)

- The OHD has been working with vulnerable communities (with special emphasis on racial and ethnic minorities) since 2006.
- Because of its work, the OHD has an already trusted relationship with CBOs. That trust and expertise were key to responding quickly to the pandemic, contracting with CBOs, and developing and implementing the COVID Communities Partnership (CCP) program, which integrates Community Health Workers in response to the pandemic.
- The OHD team has been gathering data, monitoring, and evaluating the progress of the CCP program since May 2020.
- The OHD team has been collaborating with the Surveillance Team to analyze and report COVID-related data by race/ethnicity and local health district.
- The OHD team led the development of the Vaccine Equity Roadmap.
- The OHD website hosted the first COVID-related information available in multiple languages and the first version in Spanish.
- There is a need for sustainable resources to maintain the capacity of Utah's public health systems to integrate health equity into the public health emergency response. These resources will mitigate the effects of future public health emergencies and build resilience among vulnerable communities in our state.

Epidemiology & Health Informatics

- In the background, epidemiology and informatics work to collect, clean, digest, and communicate surveillance/outbreak data with local health departments, partners, and the public. Much time is spent monitoring aberrations and investigating any unusual disease activity to contain/reduce outbreaks.
- Because of a lack of personnel, a lot of the routine activities were postponed in favor of emergency pandemic response.
- Epidemiologic investigations, surveillance, testing reports, and data visualizations/dashboards rely on UDOH server capacity and the ability for IT systems to scale up as demand increases.
- Server space and the ability to increase IT resources were a limitation throughout the response.
- Both epidemiology and informatics are traditionally underfunded to meet the constant stream of data requests. There is a shortage of staff to meet demand. Public health needs additional funding for informatics and epidemiology so that these teams can build sustained capacity.
- Sustainable surge capacity is needed for large-scale responses to immediate public health threats. This surge capacity requires individuals who are trained in emergency response and able to rapidly provide response support for a range of public health threats, from communicable diseases to violence and injury prevention. This additional support ensures that programs can continue to operate at full capacity during large responses. Surge capacity should include staff for contact tracing and case investigations, mobile testing sites, mobile vaccination sites, and any other need identified during a response.

Healthcare-Associated Infections and Antimicrobial Resistance Program (HAI/AR)

- HAI/AR was the hub of a comprehensive rapid response supporting LTCF administrators, staff, and the patients they serve with expertise, protocols, and resources, such as PPE and testing.
- During the pandemic response, HAI/AR hired an additional four infection preventionists, three epidemiologists, and a health educator to support response and mitigation efforts. There were no

staffing increases during the steepest part of the surge from November 2020 to January 2021 and capacity was inadequate to sustain a reactive response without significant overtime throughout the pandemic. For a period of several months, a full-time position was required to manage reporting requirements to the Disability Law Center alone, an unfunded mandate.

- The HAI / AR was established in 2011 by HB 355 with statutory requirements for an annual HAI report, a governance committee, and program manager to begin activities to support Utah's healthcare facilities in improving their infection prevention and control practices. There have been no state funding increases since that time.
- Preparedness for the future will require sustained investment in staffing and programming to build infection prevention and control capabilities in healthcare facilities, especially LTCFs, and local health departments across the state.
- The LTCF Subcommittee of the COVID-19 Community Task Force was a critical cross-sectoral, multi-disciplinary collaborative that needs to be codified as a permanent task force for addressing healthcare-associated infections and preparedness issues unique to LTCFs.

Utah Public Health Laboratory (UPHL)

- UPHL required more resources and staff to keep up with testing demand.
- There were issues with the interoperability of data systems and UPHL's Lab Information Management System (LIMS).
- Investment is needed to improve UPHL's LIMS and to build data warehouse infrastructure for better data sharing with secondary data systems.
- Mobile testing resources were essential to responding to LTCF, prison, and worksite outbreaks and increasing access to testing in community hotspots, especially in communities of color.
- Close coordination between mobile testing and UPHL was required throughout the pandemic to ensure adequate laboratory capacity to meet testing demand. Executive leadership decisions in a vacuum can have serious unintended consequences. For example, when it was decided to do screening testing of all LTCF staff, testing resources were diverted away from LTCF outbreaks, resulting in larger outbreaks with more cases and deaths.
- Widespread testing required moving testing supplies into the hands of schools, LTCF and other congregate settings, and businesses to perform their own testing. Timely and accurate reporting of test results, essential for surveillance and outbreak response, posed immense challenges for those locations performing their own testing. Streamlined systems for ordering and reporting laboratory data are needed.

Bureau of Emergency Medical Services and Preparedness (BEMSP)

- The cache of PPE and the ability to store and ship this to community partners was essential during the pandemic response.
- As a result of COVID-19, many community partners needed PPE. This resulted in unprecedented demand across healthcare, CBOs, schools, and individuals. CBO, school, and individual demand became an additional impact on an already compromised PPE supply chain.
- To mitigate these impacts, the Unified Command partnered with the Division of Purchasing to establish a supply chain system for PPE and other critical supplies. As of March 2021, 44.5 million units of PPE and supplies have been distributed to Utah partners.

- To effectively receive, store, and distribute this material, the Unified Command leased an 86,000 SF warehouse.
- In order to maintain this effort, the Department of Health BEMSP program needs $1,000,000 annually to continue this effort for future crises.

Office of the Medical Examiner (OME)

- The OME plays a crucial role in disasters that result in mass fatalities since this office conducts death investigations and certifies death certificates.
- The impact of the pandemic on the OME was such that the increased caseload led to longer turn-around times for families waiting for official OME reports to settle insurance claims, estate issues, etc.
- A lack of personnel contributed to increased turnaround times and strain on the existing OME staff.
- OME turnaround time went from 90% in 60 days for report completion to 85% early on and dropped further as the pandemic increased.

Quarantine & Isolation (Q/I) Sites and Wraparound Services

- Providing safe places for vulnerable communities to stay (i.e. a hotel, supporting existing shelters) is essential to mitigating the spread of COVID-19.
- Throughout the first year of response, almost 50-100 Q/I beds were in use, with an estimated $180,000 per month required to prepare for Q/I sites to host vulnerable populations.
- This service is especially crucial for people experiencing homelessness who are affected by COVID-19.
- Support for wrap-around services to safely quarantine and isolate
- Within the COVID Community Partnership, CHWs began linking community members to wrap-around services in August 2020.
- Since beginning this wrap-around funding system in August 2020, the Association of Utah Community Health (AUCH) has helped coordinate over $1,000,000 in wrap-around services funding to those who are cases or contacts of COVID-19 to support their quarantine and isolation.
- The top three needs for wrap-around services have been: rental/mortgage support, utilities support, and food.

Utah's Local Health Departments

- Local Health Departments are crucial in the "boots on the ground" response and support for crises within communities.
- Ensuring adequate funding at the local level for protecting and preparing vulnerable populations increases the efficiency and effectiveness of the emergency response.
- Continuous and constant coordination between state and local officials is critical, including amongst programs (e.g Emergency Response, Health Promotion, Epidemiology).
- For a more in-depth report on LHD needs, please see Appendix A below.

Healthcare Systems

- UDOH is the recipient of cooperative agreement funding from HHS Assistant Secretary for Preparedness and Response to conduct health and medical planning, organizing, equipping, training, and exercising.
- Throughout the response, the UDOH and the Unified Command focused on four main areas of support for health and medical response.

- - Space - support for healthcare to establish and utilize contingency spaces for medical surge.
    - Supplies - establishment of a support system for PPE, supplies, and medical equipment to support medical surge.
    - Staff - establishment of a coordination group, in partnership with medical providers, to address healthcare staffing shortages.
    - Systems - Establishment of a Medical Command Response Team (to manage ICU diversions and load leveling), a Medical Operations Coordination Cell (to manage crisis support for overwhelmed healthcare providers), facilitating numerous policy coordination groups (CMO, CNO, health policy), and the refinement and approval of Utah's Crisis Standards of Care Guidance (to facilitate effective allocation of scarce healthcare resources).
- Home health and LTCFs are important partners with hospitals to optimize use of all resources in the continuum of care during a medical surge. They need to prioritize resources for preparedness in the future to be better positioned to fully support hospital decompression at the levels required during a surge.
- Strengthening team preparedness to be more effective and engaging vulnerable populations is needed.
- Funding for organizations that help communities support the International Rescue Committee and the Association of Utah Community Health (AUCH) Community Health Centers needs to be prioritized.
- At-risk personnel (training, resources, etc) need to be infused directly into communities.
- People with medical fragility are among some of the most vulnerable. Outreach to these populations is needed.

Preparing Employees

- In order to best prepare employees, all employees should complete annual training courses on Personal & Family Preparedness and Workplace Preparedness.
- For Department staff that are expected to participate in large-scale responses to disasters, annual training courses on disaster response should be required. These courses should be modeled after the FEMA disaster response training (ICS 100, 200, and 700), but developed by the Department to improve accessibility and reduce the amount of time spent completing the training.
- All Department employees should take a required training on Health Equity and the Social Determinants of Health that explains these concepts, why they are important, and how they relate to disaster response.
- Each year the Department of Emergency Management (DEM) hosts the Be Ready Utah Conference. The Department of Health should encourage and support attendance by all employees.
- The Department needs to take steps to ensure that all employees have an emergency kit and supplies at the office. This includes, but is not limited to, extra clothing, food and water, and flashlights.

Preparing Citizens and Community

- We need to increase outreach programs and bolster partnerships with community leaders to establish communication and open dialogue with these communities before the next crisis happens.
- Having key members of those communities (i.e., community health workers) be the predominant voice communicating reliable information and working with community members to best protect their health/recovery is essential.

- This work is already happening throughout the different programs within the UDOH, but there is a need for more support to build and maintain these relationships.

Section III: Policy responses and recommendations: What the Legislature can do to better prepare our citizens, employees, and most vulnerable populations for times of crisis?

Funding for resources, programs, and staff is essential to protect and prepare vulnerable populations for future times of crisis. In addition, policies that target and benefit vulnerable populations and shift systemic inequities that create burdens within these communities are essential in preparation and readiness moving forward. Recommendations for policies include:

- *Paid Sick Leave*
  - Employers may consider providing paid sick leave to all employees, including non-benefited employees, so that workers may stay home if they are sick.[18]
  - Flexible leave policies help stop the spread of disease, including to healthy workers.
  - Mental health resources should be available open to all employees. Time off for non-benefited employees is needed during personal tragedies.
  - Low-wage essential workers (manufacturing jobs, grocery stores, hospitality) who cannot stay home and work in settings with increased risk of transmission of a disease or exposure to a crisis are a critical area of focus for inclusive policies that protect all workers.

- *Digital Literacy and Access*
  - Provide resources for access of technology to support education.
  - Provide structured training on digital literacy to be readily available to everyone who needs it to update their skillset.
  - Ensure access to high-speed Internet (mobile hotspots, family stipends for internet access).
  - Ensure availability of electronic devices to improve the effectiveness of distance learning.

- *Food Access and Food Security*
  - As referenced above in the Needs section of Food Insecurity (Section I: Page 6)

- *Rental/Mortgage Support*
  - Provide adequate funding and efficient application processes; activate as a part of a response to a crisis.
  - Continue funding for the Utah Rent relief program.
  - Sustain funding for the Housing First Program in Utah.

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[18] Protecting Workers during a Pandemic, OHSA Fact sheet. https://www.osha.gov/sites/default/files/publications/OSHAFS-3747.pdf

- *Care Provider Support*
  - Personal aides, hospice attendants, nurses, and occupational or physical therapists who deliver medical or support services to the older population and to patients coping with disabilities were not prepared during the pandemic and faced challenges to access protective gear that could shield both care providers and clients from infection.
  - Provide for an adequate supply of PPE.
  - Increase flexibility in Medicare regulations that govern person-to-person contact at patients' homes since Medicare does not reimburse home care providers for appointments conducted remotely by phone or video.
  - Ensure Medicaid allows for reimbursement for any services that are clinically appropriate to be conducted via telehealth, regardless of provider type.

- *Telehealth Expansion*
  - Service parity and payment parity[19] for telehealth across all insurers would help increase access for patients and incentivize providers to offer these services, though it would also increase spending.[20]
  - Promote and optimize the use of telehealth services.
  - Use tele-triage[21] methods for assessing and caring for all patients to decrease the volume of persons seeking care in facilities, especially during times of high transmission of contagious diseases[22].
  - Provide outreach to patients with limited technology and connectivity and offer flexibility in platforms that can be used for video consultation, or non-video options, when possible[23].
  - Ensure interpretation services are always available and accessible.
  - Provide ongoing training to public service, health and healthcare workers on the use of telephonic services and how to work with an interpreter.

- *Effective and Timely Communication for Medicaid Members*
  - Creating an opportunity for opt-in SMS texting or robocalls for Medicaid members would allow the Department to keep members informed with important updates to eligibility policy, reminders about telehealth, and access to other vital information during an emergency period.

- *Expanded Support for a UDOH Vulnerable Populations Readiness Team*
  - Engage CBOs in development of continuity of operations and emergency response plans, training, equipping, and exercising.
  - Increase employment of staff to work with Vulnerable Populations and citizens.
  - Continue and expand Vulnerable Populations Workgroup and collaborations.

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[19] Fully-insured private plans cover and reimburse for telemedicine services equally to how they would for in-person care

[20] https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/

[21] Tele-triage is like traditional triage but uses technology to supplement or replace elements of the patient interaction. Tele-triage involves screening patients remotely to determine the patient's condition and the care needed. https://telehealth.hhs.gov/providers/telehealth-for-emergency-departments/tele-triage/

[22] https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html

[23] https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html

- ***Development of a grant program to allow community-based organizations (CBOs) to apply for preparedness and response funding.***
- ***Ensure telephonic interpretation is a standard practice and available at all public facing facilities. Provide resources to contract these services and train staff***
- ***Additional areas for consideration:***
    - Virtual support for all public services.
    - Support for people who are undocumented.
    - Transportation subsidies.
    - Funeral subsidies.
    - Healthcare access through medical bills subsidies.
    - Childcare subsidies.

Conclusion

During a crisis, the challenges and needs of vulnerable populations are exacerbated. Preparing and protecting Utah's most vulnerable communities requires funding, coordination, and communication across all levels of a crisis response (state, local, and community).

There is also an increase in skepticism and mistrust among this population of the good intentions and efforts of public service professionals to mitigate their challenges. Public service officials must engage in thoughtful and responsible emergency planning and implementation. We need to educate, inform and provide tailored communication to reach vulnerable populations. We also need to implement measures to assess these populations' needs and prioritize resource allocation and policy measures accordingly. Encouraging collaboration and partnerships among public agencies with members of vulnerable populations is a crucial approach for addressing their needs.

Understanding that vulnerable populations already are burdened with long-standing health disparities and poor health outcomes, we must continue to focus on the social and structural drivers of health, understanding the intricate link of economic health with physical health. Prioritizing these populations helps to protect the health and wellbeing of *all* Utahns.

A legislative commissioned study to further understand the in-depth funding needs and barriers of each population and program working with these populations is strongly recommended.

Appendix A: Local Health Department

Health District	During COVID did your health districts have programs that experienced change in demand for services? [Nursing Services]	During COVID did your health districts have programs that experienced change in demand for services? [WIC Services]	During COVID did your health districts have programs that experienced change in demand for services? [Environmental Health Services]	During COVID did your health districts have programs that experienced change in demand for services? [Health Promotion Services]	During COVID did your health districts have programs that experienced change in demand for services? [Substance Abuse Prevention Services]	During COVID did your health districts have programs that experienced change in demand for services? [Substance Abuse Treatment Services]	During COVID did your health districts have programs that experienced change in demand for services? [Mental Health Services]	During COVID did your health districts have programs that experienced change in demand for services? [Aging Services]
San Juan	Diminished Demand	Diminished Demand	Stable Demand	Diminished Demand	Diminished Demand	Not Applicable	Not Applicable	
Weber Morgan	Increased Demand	Stable Demand	Increased Demand	Increased Demand	Stable Demand	Not Applicable	Stable Demand	Not Applicable
Southeast	Diminished Demand	Increased Demand	Stable Demand	Stable Demand	Increased Demand	Not Applicable	Not Applicable	Not Applicable
Central	Increased Demand	Diminished Demand	Increased Demand	Diminished Demand	Stable Demand	Not Applicable	Not Applicable	Not Applicable
TriCounty	Increased Demand	Stable Demand	Increased Demand	Diminished Demand	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Bear River	Diminished Demand	Stable Demand	Stable Demand	Diminished Demand	Diminished Demand	Increased Demand	Increased Demand	Not Applicable
Wasatch	Diminished Demand	Diminished Demand	Diminished Demand	Diminished Demand	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Davis	Increased Demand	Stable Demand	Increased Demand	Diminished Demand	Not Applicable	Not Applicable	Not Applicable	Increased Demand
Salt Lake	Stable Demand	Diminished Demand	Diminished Demand	Diminished Demand	Diminished Demand	Not Applicable	Not Applicable	Not Applicable
Utah	Diminished Demand	Stable Demand	Stable Demand	Stable Demand	Stable Demand	Not Applicable	Not Applicable	Not Applicable

Health District	During COVID did your health district have alter services in any way? [Nursing Services]	During COVID did your health districts have programs that experienced change in demand for services? [Other Public Health Services]	During COVID did your health district have alter services in any way? [WIC Services]	During COVID did your health district have alter services in any way? [Environmental Health Services]	During COVID did your health district have alter services in any way? [Health Promotion Services]	During COVID did your health district have alter services in any way? [Substance Abuse Prevention Services]	During COVID did your health district have alter services in any way? [Substance Abuse Treatment Services]	During COVID did your health district have alter services in any way? [Mental Health Services]	During COVID did your health district have alter services in any way? [Aging Services]	During COVID did your health district have alter services in any way? [Other Public Health Services]
Summit	Stable Demand	Increased Demand	Increased Demand	Stable Demand	Increased Demand	Increased Demand	Increased Demand	Not Applicable		
Tooele	Increased Demand	Stable Demand	Increased Demand	Increased Demand	Stable Demand	Not Applicable	Not Applicable	Stable Demand		
San Juan	Offered Services Virtually	Not Applicable	Offered Services Virtually	Services Stayed Open	Temporarily Shut Down Services	Temporarily Shut Down Services	Not Applicable	Not Applicable		Not Applicable
Weber Morgan	Reduced Access to Services	Increased Demand	Offered Services Virtually	Reduced Access to Services	Reduced Access to Services	Reduced Access to Services	Not Applicable	Reduced Access to Services	Not Applicable	Reduced Access to Services
Southeast	Reduced Access to Services	Stable Demand	Reduced Access to Services	Services Stayed Open	Reduced Access to Services	Reduced Access to Services	Not Applicable	Not Applicable	Not Applicable	Reduced Access to Services
Central	Offered Services Virtually	Stable Demand	Offered Services Virtually	Services Stayed Open	Reduced Access to Services	Offered Services Virtually	Not Applicable	Not Applicable	Not Applicable	Offered Services Virtually
TriCounty	Services Stayed Open	Increased Demand	Offered Services Virtually	Reduced Access to Services	Temporarily Shut Down Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Bear River	Services Stayed Open	Stable Demand	Offered Services Virtually	Services Stayed Open	Offered Services Virtually	Offered Services Virtually	Offered Services Virtually	Offered Services Virtually	Not Applicable	Services Stayed Open

Health District										
Wasatch	Services Stayed Open	Stable Demand	Services Stayed Open	Services Stayed Open	Reduced Access to Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reduced Access to Services
Davis	Reduced Access to Services	Increased Demand	Reduced Access to Services	Services Stayed Open	Services Stayed Open	Not Applicable	Not Applicable	Not Applicable	Reduced Access to Services	Reduced Access to Services
Salt Lake	Services Stayed Open	Diminished Demand	Offered Services Virtually	Reduced Access to Services	Reduced Access to Services	Reduced Access to Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Utah	Reduced Access to Services	Increased Demand	Offered Services Virtually	Offered Services Virtually	Offered Services Virtually	Offered Services Virtually	Not Applicable	Not Applicable	Not Applicable	Temporarily Shut Down Services
Summit	Reduced Access to Services	Increased Demand	Offered Services Virtually	Services Stayed Open	Reduced Access to Services	Offered Services Virtually	Offered Services Virtually	Offered Services Virtually	Not Applicable	Offered Services Virtually
Tooele	Services Stayed Open	Increased Demand	Offered Services Virtually	Services Stayed Open	Reduced Access to Services	Reduced Access to Services	Not Applicable	Not Applicable	Reduced Access to Services	Reduced Access to Services

Health District	How did COVID impact your local health department programs?	How did COVID impact your local health department programs?	Were there resources that could have assisted in keeping services open and available?
San Juan			More staffing.
Weber Morgan	Many services were reduced in areas that we could in order to reassign staff to contact tracing and vaccination efforts. All staff in the department had normal work loads reduced and received covid assignments. Additionally, 35 temporary employees, national guard and medical reserve corps volunteers are being utilized to meet the demands. Routine public health inspections, home visitations and interventions have been reduced in areas that did not have an immediate demand.		Yes, we need access to improved technology and web services support, additional; funding for temporary staff, and access to facilities for temporary expansion.
Southeast	WIC, Suicide prevention, Opiate prevention, Parents as Teachers		Yes

Central	Some environmental services increased in demand, such as wastewater (septic) reviews, installations, and inspections. Subdivision reviews also increased in demand. Epi, surveillance, disease investigation all increased in demand due to COVID.		Some additional staff could have helped in reducing services in some areas. All staff were needed to help with COVID response activities, such as disease investigation, contact tracing, vaccination, and PPE distribution. Some programs were closed or scaled back due to increased risks to staff and the public from COVID infection. There was no way to mitigate these changes.
TriCounty	Many services were temporarily modified		The ability to hire temporary staff quickly would have helped with some programs

| Bear River | Overall, most employees were involved in the COVID response at some point during the past 18 months. The Department implemented the Incident Command System, repurposing several employee job descriptions. Employees were reassigned from their regular program duties to various COVID response functions including duties in disease investigation, contact tracing, active monitoring, case management, testing, mass vaccination clinics, answering phone calls, volunteer management, data entry, and incident command staff functions.
Nursing Services: Demand for services decreased. Immunizations were offered curbside. Home visits were conducted virtually. TB, STI, and other communicable disease programs continued as needed with COVID mitigation strategies implemented. Nursing staff have played a major role in disease investigations and vaccine administration.
WIC Services: Federal guidance allowed for extension of certifications. Visits were conducted virtually or curbside as needed. WIC staff were trained in disease investigations and vaccine clinic support functions.
EH Services: Complaints regarding public health orders, compliance to orders, and mask mandates were channeled to the EH staff. Food service establishment inspections decreased for a short time. Other EH services were stable. EH staff were trained in disease investigations and vaccine clinic support functions.
Health Promotion and SA Prevention Services: Demand for several health promotion services decreased during the COVID response period. Health education classes have been conducted virtually. Health Promotion staff have played a major role in disease investigations, school-based case management, and vaccination clinic support.
Mental Health and SA Treatment Services: Demand for behavioral health counseling services has increased during the last several months. SA counseling services were conducted virtually and group sessions were cancelled through much of 2020. With the decrease in COVID cases and the availability of vaccine, Individual and group sessions resumed regular operations. SA staff were trained in disease investigations, data entry, and vaccine clinic support functions.
Other Public Health Services: Administratively, BRHD has been able to facilitate day to day operations throughout the pandemic. Several | | Most BRHD services were available and adequately funded. Several programs across the Department funded through categorical state and/or federal grants did not expense out the FY2020 and/or 2021 contract amounts due to decreased program activity, demand, and/or repurposing of staff to COVID job duties.
Sufficient funding for COVID activities was provided through a combination of federal CARES Act contracts and CARES County funds. BRHD would not have been able to adequately meet the demands of the COVID response without the CARES Act resources. |

	projects including accreditation, capital improvement projects, leadership training, policy updates, and strategic planning procedures were put on hold to allocate resources to more immediate COVID response efforts.		
Wasatch	Community activities and involvement was reduced. COVID guidelines reduced our ability to do some activities. Staff assignments changed in some cases. Meetings with community and state partners were held virtually. Staff were busy with COVID response and some contract activities were reduced or delayed. Services were still provided.		Resources were there but slow in some cases - temporary staff earlier would have been helpful in some cases.
Davis			More Virtual services could have been implemented.

Salt Lake	All staff were reassigned to COVID response.	Only responding to critical needs.	There is not an epidemic trained supply of public health professionals just waiting to be needed. Therefore, the existing workforce is needed to respond to emergencies. This has been the plan with public health emergency response. COOP plans call for such.
Utah	We established the new Community Health Worker Program that has been an essential part of our local response effort. The Pandemic also reduced services, changed the way we provided services (virtual visits), increased demand for vaccination & epi staff, reassigned staff to new COVID response roles, and increased school nursing services ten fold. Our staff were required to do things they were trained for, but never had to do in the past. We increased community outreach services to the greatest extent in our history. Coordinated vaccination clinics for underserved and underrepresented populations as we continued to focus on our efforts with high throughput vaccine clinics. Greatly increased need to recruit, train and manage COVID volunteer staff (MRC). The overall demand for regular and travel immunizations decreased significantly. It also greatly increased demand on our Local Medical Director on a daily basis.	Some programs ceased to operate as all staff reassigned to contact tracing or vaccine clinics. Only carried essential public health services at the bare minimum at the height of the pandemic. Now starting to slowly reassign staff to dual roles COVID + prior role.	We were happy with support from our local EOC, Hospitals, CNS, State Health Department, National Guard, MRC, Emergency Services, NOMI, School Districts, and our local IT, Public Works, Police/Fire, BYU/UVU, Cities/local Mayors, and businesses. We have not seen this level of community collaboration since the 2002 Olympics.
Summit	In every way. The majority of staff was redirected to COVID response.		In some cases but by necessity we had to shift resources and had to go to remote services
Tooele	Most staff was reassigned to COVID-19 response, with reduced activities in other PH programs.	Most services were reduced due to reallocation of staff and resources, inability to provide in-person services.	Funding early on to bring on additional staffing.