

Utah Health Status Update

KEY FINDINGS

- Efforts from 11 community-based organizations to address COVID-19 are reaching diverse communities in 12 counties: Cache, Carbon, Davis, Iron, Grand, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber (Figure 1).
- Community health workers attended 87 (91%) of the 96 testing events conducted between May and September where a total of 7,195 individuals were tested.
- Housing, utilities, and food assistance were the most needed resources among participants surveyed when tested for COVID-19. Mental health and employment were also important factors among participants (Figure 3).
- Community-based organizations engaged in 2,117 outreach activities from May to September with an estimated reach of more than one million (1,678,014) individuals.

COVID Communities Partnership (CCP) Pilot Project

Project Background

The COVID Communities Partnership Pilot Project (CCP) was established to support community-based organizations and mobilize their community health worker workforce.¹ This project's focus of using collaborative efforts to address community needs related to COVID-19 has helped address widespread COVID-19 among racial and ethnic minority communities across Utah. This work expanded partnerships among health workers and community-based organizations with new ways for reaching out to communities and using culturally appropriate methods to assess needs. These activities were implemented between May and September 2020.

Main Strategies for Implementation

1. Partnering with Community-based Organizations to Reach Diverse Communities

The Utah Department of Health Office of Health Disparities contracted with 11 community-based organizations. Partnerships with these organizations were strategically selected to increase reach to target populations of racial and ethnic communities in Utah. Efforts from these organizations are located statewide in the following 12 counties: Cache, Carbon, Davis, Iron, Grand, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber (Figure 1).

Community-based Organizations Reach in Diverse Communities in Utah

Figure 1. CBOs located in 12 Utah counties help reach racial and ethnically diverse communities that include 60 subcultures.

Community	*Subcultures	Contracted CBO	County Reach
Hispanic / Latino	11	Alliance Community Services	Davis, Salt Lake, Tooele, Utah, Weber, Washington
		Centro Hispano	Utah
		Community Building Communities	Salt Lake, Carbon
		Comunidades Unidas	Salt Lake, Tooele, Utah, Iron, Grand
		Holy Cross Ministries	Salt Lake, Summit, Wasatch
Refugees & Asylees	20	International Rescue Committee	Salt Lake
		Somali Community Self Management Agency	Salt Lake
Blacks / African Americans	13	Project Success	Weber, Salt Lake, Davis
Asians	25	OCA Asian Pacific Islander American Advocates	Salt Lake, Davis, Utah, Tooele
Pacific Islanders & Native Hawaiians	8	Utah Pacific Islander Health Coalition	Salt Lake, Utah, Davis, Washington, Cache, Weber
American Indians / Alaskan Natives	1	Urban Indian Center of Salt Lake	Salt Lake, Davis, Weber, Utah, Tooele

Total of 60 Subcultures include: Afghan, African American, Arabic, Argentine, Bicol, Bahasa Melayu, Bengali, Brazilian, Burmese, Burundi, Cambodian, Cebuano, Central African, Chad, Chilean, Chinese, Colombian, Congolese, Ecuadorian, Egyptian, English, Eritrean, Ethiopian, Farsi, Fijian, Guatemalan, Hindi, Ilonggo, Ilokano, Iraqi, Ivory Coast, Japanese, Kapangpangan, Karen, Korean, Malay, Maori, Marshallese, Mexican, Native Hawaiian, Nepali, Other Melanesians, Other Micronesians, Pashto, Peruvian, Puertorriqueñas, Rohingya, Rwandan, Salvadorian, Samoan, Somali, Sudanese, Tagalog, Thai, Tongan, Ugandan, Urban Indians, Venezuelan, Vietnamese, White.

* Some subcultures are listed in more than one community so that the sub of the subcultures is greater than the total count of 60 due to duplicate across communities.

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2. Building Community-based Organizations' Capacity

To ensure community health workers had strong knowledge to understand and provide support for COVID-19, building capacity was of primary importance. Community health workers were supported on a weekly basis through updates, education, and training. This support included providing initial onboarding training; bi-monthly Utah Public Health Association (UPHA) Community Health Worker Section trainings; and weekly check-in calls with the Office of Health Disparities support staff.

3. Eliminating Barriers for Free Testing

Access to testing in underserved and underrepresented communities is a barrier faced by community members. Perception of testing cost, employment hours, and transportation are additional barriers. The COVID Communities Partnership Project partnered with the University of Utah's "The Wellness Bus" to provide testing at no cost, with no symptoms required to test, and is available in hot-spot neighborhoods. Community health workers are safely integrated into the testing process as a trusted community member who provides a familiar presence at testing sites. Interpreters are available to assist limited-English speaking individuals. Consent is collected to conduct a social determinants of health (SDOH) screening pre-test and follow up with those who test positive afterward. Community health workers attended 87 (91%) of the 96 testing events conducted between May and September where a total of 7,195 individuals were tested.

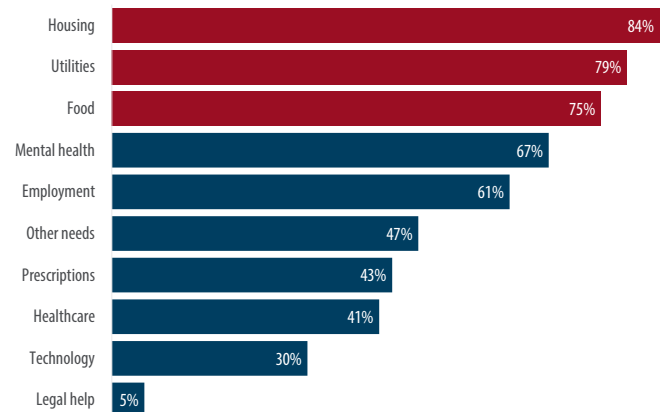
4. Connecting Participants to Resources

During pre-test screenings for social determinants of health, community health workers assess social needs for individuals who are tested gaining more understanding for community level needs. Consent for follow-ups and contact information is collected from individuals who indicate they need assistance with one or more of the needs. After health screenings are conducted, community health workers follow-up

to identify and better understand their social needs connecting participants and their households to resources² (see Figure 2). The purpose of this strategy is to help participants meet their basic needs and help them follow quarantine isolation guidelines and reduce the spread of COVID-19. The average household size of participants screened for social determinants of health was four (4) individuals and ranged from 1-18 household members.

Major Needs Identified by Pre-test Screening for Social Determinants of Health

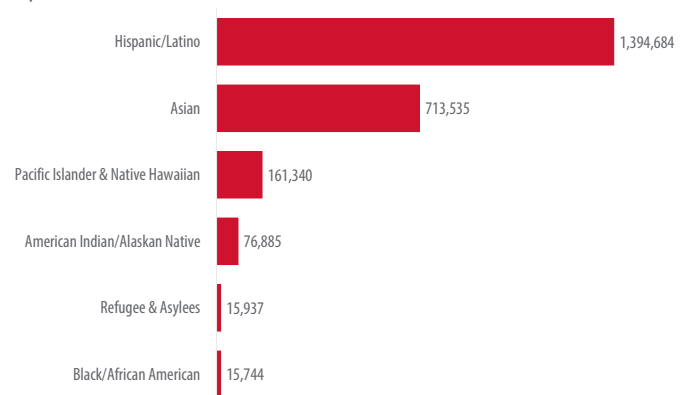
Figure 2. Housing, utilities, and food assistance were the most needed resources among participants surveyed when tested for COVID-19. Mental health and employment were also important factors among participants. Healthcare, technology, and legal help were reported as the lowest social needs.



Utah Department of Health, Office of Health Disparities.

Community Health Worker Outreach Activities by Community, May–September 2020

Figure 3. More than 1.3 million Hispanic/Latino individuals were estimated to have participated in the Social Determinants of Health Needs Assessment between May and September 2020.



Utah Department of Health, Office of Health Disparities.

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5. Community Outreach and Education

Community-based organizations engaged in 2,117 outreach activities from May to September with an estimated reach of more than one million (1,678,014) individuals (see Figure 3). Outreach communication was delivered in nearly 50 different languages. The top outreach methods throughout all communities were social media (Facebook, Instagram, Twitter, LinkedIn, YouTube posts in multiple languages); mass communication (flyers, billboards, WhatsApp, mass emails, Webchat, board group texts, GroupMe); small group/family education (family gatherings, support groups, virtual community gatherings/classes, virtual meeting with church leaders, virtual discussions with youth council, and Utah Black Roundtable discussions).

The COVID Communities Partnership Project Extension and Expansion

In July 2020, the Office of Health Disparities was granted expansion funding for the COVID Communities Partnership Project to extend programming from October to December 31, 2020. The extension of the COVID Communities Partnership Pilot Project was necessary since the COVID-19 pandemic continues. The main goals of the extension and expansion portion of this project focus on: a) increasing and diversifying community health worker capacity by incorporating additional community-based organizations, local health departments, and community-health centers; and b) expanding barriers-free testing capacity in hot-spots by partnering with the Utah Public Health Laboratory, Mobile Testing Team. Efforts are underway to secure funding for the project in 2021.

1. Utah Department of Health, Office of Health Disparities: <https://www.health.utah.gov/disparities/data/ohd/CCPPilotProjectNov2020.pdf>

2. Utah Department of Health, COVID-19 Community Resources Guide: https://coronavirus-download.utah.gov/Health/COVID-19_Community_Resources_Guide.pdf

Utah COVID-19 Involved Deaths and Death Rates, 2019–2020

According to the Centers for Disease Control and Prevention, 94% of COVID-19 involved deaths (defined as deaths with ICD–10 code U071 either as underlying cause code or as any other contributing cause codes) in the United States were combined with one or more additional health conditions; 92% of COVID-19 involved deaths listed COVID-19 as the main cause of death and 6% listed COVID-19 as the only cause of death.¹ In Utah, 97% of COVID-19 involved deaths were combined with one or more additional health conditions; 87% of COVID-19 involved deaths listed COVID-19 as the main cause of death and 3% listed COVID-19 as the only cause of death.

As of 12/08/2020, 919 COVID-19 involved deaths occurred in Utah. 803 (87%) of these deaths reported COVID-19 as the main cause of death. Among these COVID-19 involved deaths, 28 (3%) have listed COVID-19 as the only cause of death; 116 (13%) have listed COVID-19 as one of the contributing causes of death.²

Utah death rates have increased in 2020 compared to 2019 (Figure 1). The crude death rate for all causes was 662.5 from January to November 2020, which is significantly higher ($p < 0.001$) than the crude death rate of 599.0 (not shown in the table) from January to November 2019. The Utah Office of Vital Records and Statistics will continue to monitor this trend throughout the pandemic.

Death Counts, Population Estimate, and Death Rate in Utah, 2019 vs 2020

Figure 1. In the past two years, the lowest death rate was 46.5 in September 2019 and increased to the highest 64.3 in November 2020.

	2019			2020			
	Death Counts	Population Estimate ³	Death Rate (per 100,000)	Death Counts	Population Estimate ³	Death Rate (per 100,000)	
Jan	1,777	3,193,487	55.6	Jan	1,771	3,246,622	54.5
Feb	1,521	3,198,041	47.6	Feb	1,642	3,251,100	50.5
Mar	1,752	3,202,161	54.7	Mar	1,819	3,255,295	55.9
Apr	1,577	3,206,727	49.2	Apr	1,675	3,259,785	51.4
May	1,691	3,211,153	52.7	May	1,715	3,264,135	52.5
Jun	1,524	3,215,733	47.4	Jun	1,699	3,268,637	52.0
Jul	1,576	3,220,171	48.9	Jul	1,916	3,273,000	58.5
Aug	1,530	3,224,612	47.4	Aug	1,861	3,277,343	56.8
Sep	1,501	3,229,060	46.5	Sep	1,718	3,281,691	52.4
Oct	1,612	3,233,370	49.9	Oct	1,943	3,285,905	59.1
Nov	1,621	3,237,829	50.1	Nov	2,117	3,290,265	64.3
Dec	1,750	3,242,151	54.0	Dec			
Total	19,432	3,220,171	603.4	19,876	3,273,000	662.5	

Indicates Higher Death Rate.

- Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm?fbclid=IwAR3-wrg3tTKK5-9tOHPGAHWFVO3DfslkJ0ksDEPOpWmPbKtp6EsoVV2Qs1Q
- Death Counts are from the Utah Office of Vital Records and Statistics and are occurrence data for preliminary use only.
- Both 2019 and 2020 Utah monthly/total population estimates are from the Kem C. Gardner Policy Institute <https://gardner.utah.edu/demographics/population-projections/>

Following COVID-19 Isolation and Quarantine Guidance

A survey designed to help inform Utah leaders of the level of understanding for COVID-19 safety guidelines among COVID-19 cases and their contacts was distributed to known adult cases and contacts in Utah who had recently completed their isolation or quarantine period. This survey looked into their adherence of isolation and quarantine guidance, as well as barriers which kept them from following recommended guidance. As of October 1, 2020, 13,494 responses were collected.

Cases reported how well they followed isolation guidance, such as staying home, wearing a mask around others, staying in a different room, using a different bathroom, cleaning frequently touched surfaces, and using separate personal items. Of cases who responded to these questions, 24% reported full compliance with the guidance.

Close contacts also reported how well they followed quarantine guidance, such as staying home, wearing a mask, not allowing other people to visit, cleaning frequently touched surfaces, and staying at least 6 feet away from others in public. Of contacts who responded to these questions, 29.8% reported full compliance with the guidance.

Logistic regression was performed to identify which barriers increased the odds of non-compliance with isolation and quarantine guidance. Cases reported not having a different room or bathroom, other people not thinking it was important, and having to get food or supplies as barriers to self-isolation. Contacts reported having roommates inviting other people over and not having symptoms and, therefore, not believing they could get others sick as barriers to quarantine. White adults were more than twice as likely to be non-compliant for cases and contacts than other races. There were some differences between cases and controls ages 18-24, and those ages 25 and older (see Figure 1).

Significant Odds Ratios for Non-Compliance with Isolation and Quarantine Guidance

Figure 1. Among COVID-19 cases 18-24 years old and 25 years or older, not having a separate bathroom from other people with whom they lived with increased odds of non-compliance by 16.60 times and 5.72 times, respectively. Among contacts 25 years or older, having roommates or family members who invited people over to their home increased odds of non-compliance by 4.71 times.

Barrier or Demographic Characteristic	Odds Ratio*	95% Confidence Limits	
Among Cases 18-24-year-old (n=1,285)			
I didn't have a different bathroom from other people who live(d) with me.	16.6	5.78	47.63
I had to get food or supplies.	3.2	1.8	5.68
Among Cases 25 Years or Older (n=5,285)			
I didn't have a different room to stay in to be away from other people who live(d) with me.	3.04	1.29	7.17
I didn't have a different bathroom from other people who live(d) with me.	5.72	3.21	10.2
Other people who live in my house did not think it was important for me to self-isolate.	3.64	1.46	9.11
I had to get food or supplies.	2.7	1.74	4.19
White race	2.85	2.33	3.47
Among Contacts 18-24-years-old (n=513)			
I didn't have symptoms and didn't think I could get other people sick.	3.51	1.69	7.28
Among Contact 25 Years or Older (n=1,935)			
I had roommates or family members that invited people over to my home.	4.71	1.82	12.18
I didn't have symptoms and didn't think I could get other people sick.	2.12	1.19	3.76
White race	2.37	1.69	3.33

*Odds ratios represent odds of being non-compliant

Monthly Health Indicators

Monthly Report of Notifiable Diseases, October 2020	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (<i>Campylobacter</i>)	20	42	342	470	0.7
COVID-19 (SARS-CoV-2)	Cases updated at https://coronavirus.utah.gov/case-counts/ .				
Shiga toxin-producing <i>Escherichia coli</i> (<i>E. coli</i>)	8	17	158	124	1.3
Hepatitis A (infectious hepatitis)	1	7	11	49	0.2
Hepatitis B, acute infections (serum hepatitis)	0	2	7	2	3.5
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/influenza .				
Meningococcal Disease	0	1	1	0	5.0
Pertussis (Whooping Cough)	3	19	111	317	0.4
Salmonellosis (<i>Salmonella</i>)	19	27	319	327	1.0
Shigellosis (<i>Shigella</i>)	7	5	41	48	0.9
Varicella (Chickenpox)	4	20	68	169	0.4
West Nile (Human cases)	0	10	2	23	0.1
Quarterly Report of Notifiable Diseases, 3rd Qtr 2020	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV/AIDS†	31	36	81	97	0.8
Chlamydia	2,648	2,558	7,545	7,500	1.0
Gonorrhea	777	660	2,085	1,772	1.2
Syphilis	25	32	76	87	0.9
Tuberculosis	5	6	19	20	1.0
Medicaid Expenditures (in Millions) for the Month of October 2020	Current Month	Expected/ Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance over (under) Budget
Mental Health Services	\$ 21.3	\$ 21.3	\$ 78.6	\$ 79.8	\$ (1.2)
Inpatient Hospital Services	9.7	10.3	52.3	53.5	(1.2)
Outpatient Hospital Services	3.5	2.9	10.9	11.7	(0.8)
Nursing Home Services	22.2	21.5	70.7	71.6	(0.9)
Pharmacy Services	12.3	12.0	41.4	42.9	(1.5)
Physician/Osteo Services‡	4.0	3.2	12.7	13.3	(0.6)
Medicaid Expansion Services	60.5	61.2	241.7	243.7	(2.0)
***TOTAL MEDICAID	302.7	302.3	1,118.8	1,120.4	(1.6)

|| Updates for COVID-19 can be found at <https://coronavirus.utah.gov>. This includes case counts, deaths, number of Utahns tested for disease, and latest information about statewide public health measures to limit the spread of COVID-19 in Utah.

* More information and weekly reports for Influenza can be found at <http://health.utah.gov/epi/diseases/influenza>.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile Virus will start in June for the 2020 season.

‡ Medicaid payments reported under Physician/Osteo Services does not include enhanced physician payments.

***The Total Medicaid Program costs does not include costs for the PRISM project.

Monthly Health Indicators

Program Enrollment for the Month of October	Current Month	Previous Month	% Change\$ From Previous Month	1 Year Ago	% Change\$ From 1 Year Ago
Medicaid	365,284	358,670	+1.8%	288,116	+26.8%
CHIP (Children's Health Ins. Plan)	16,062	16,417	-2.2%	17,217	-6.7%
Commercial Insurance Payments#	Current Data Year	Number of Members	Total Payments	Payments per Member per Month (PMPM)	% Change\$ From Previous Year
Medical	2018	10,355,207	\$ 3,146,492,372	\$ 303.86	-0.9%
Pharmacy	2018	8,195,234	543,507,290	66.32	+3.6%
Annual Community Health Measures	Current Data Year	Number Affected	Percent \ Rate	% Change\$ From Previous Year	State Rank** (1 is Best)
Obesity (Adults 18+)	2019	605,345	29.9%	+10.1%	15 (2019)
Child Obesity (Grade School Children)	2018	38,100	10.6%	+11.6%	n/a
Cigarette Smoking (Adults 18+)	2019	175,800	8.0%	-12.0%	1 (2019)
Vaping, Current Use (Grades 8, 10, 12)	2019	37,100	12.4%	+11.3%	n/a
Binge Drinking (Adults 18+)	2019	240,000	11.1%	+4.4%	1 (2019)
Influenza Immunization (Adults 65+)	2019	223,600	63.9%	+22.8%	22 (2019)
Health Insurance Coverage (Uninsured)	2018	300,300	9.5%	-3.1%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2018	239	7.6 / 100,000	-16.2%	8 (2018)
Drug Overdose Deaths Involving Opioids	2018	404	12.8 / 100,000	-0.9%	24 (2018)
Suicide Deaths	2018	665	21.0 / 100,000	-1.5%	46 (2018)
Unintentional Fall Deaths	2018	262	8.3 / 100,000	+14.8%	31 (2018)
Traumatic Brain Injury Deaths	2018	604	19.1 / 100,000	-6.5%	28 (2018)
Asthma Prevalence (Adults 18+)	2019	219,900	9.9%	+6.9%	29 (2019)
Diabetes Prevalence (Adults 18+)	2019	190,500	8.5%	+1.3%	13 (2019)
High Blood Pressure (Adults 18+)	2019	532,900	27.0%	+10.3%	7 (2019)
Poor Mental Health (Adults 18+)	2019	459,100	20.7%	+10.1%	28 (2019)
Coronary Heart Disease Deaths	2018	1,624	51.4 / 100,000	-5.8%	4 (2018)
All Cancer Deaths	2018	3,262	103.2 / 100,000	+1.3%	1 (2018)
Stroke Deaths	2018	919	29.1 / 100,000	+1.6%	24 (2018)
Births to Adolescents (Ages 15-17)	2018	363	4.9 / 1,000	-15.3%	10 (2018)
Early Prenatal Care	2018	35,975	76.2%	-1.0%	n/a
Infant Mortality	2018	255	5.4 / 1,000	-7.0%	24 (2017)
Childhood Immunization (4:3:1:3:3:1:4)††	2019	49,400	80.0%	+8.0%	7 (2019)

§ Relative percent change. Percent change could be due to random variation.

Figures subject to revision as new data is processed.

** State rank based on age-adjusted rates where applicable.

†† Data from 2019 NIS for children aged 24 month (birth year 2017).