

Addressing Health Disparities Among Racially & Culturally Diverse Populations in Utah During COVID-19

December 2020



Since the earliest stages in the COVID-19 pandemic, Utah recognized that there were significant disparities in case, hospitalization, and mortality rates between the majority white populations and ethnically diverse populations in Utah. These disparities were mirrored across the country and follow long-standing patterns of health disparities that pre-date the current pandemic. These populations play a pivotal role in Utah’s economic prosperity, providing a workforce for important industries in the state. At the same time, racially and ethnically diverse communities have been hardest hit by unemployment, healthcare insecurity, and other adverse impacts from the COVID-19 pandemic.

The state took early actions to address these disparities by forming a Multicultural Advisory Committee, deploying Community Health Workers (CHWs) that have a long tradition of serving as a health advocate for historically underserved communities, and tracking data broken out by race to identify trends. The state also commissioned Leavitt Partners to analyze the national landscape of health disparities during COVID-19 and interventions being deployed to address these disparities. The end goal of this work is to identify interventions to be implemented in Utah to address health inequities so that stakeholders—lawmakers, healthcare leaders, community-based organizations (CBOs), public health experts, and other partners—can work together in the short- and long-term.



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- Infection, hospitalizations, and mortality are higher in racially and ethnically diverse communities.
- Occupational trends among this population put them at increased risk for infection and unemployment.
- Health disparities were present before the pandemic.
- Social determinants of health factors contribute to COVID-19 disparities.
- Negative experiences associated with race exacerbate effects of COVID-19.

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- Establish a targeted testing and vaccine plan.
- Develop accessible resources and education.
- Involve community health workers.
- Increase financial support and lengthen funding cycles.
- Elevate racially and ethnically diverse leadership and workforce.
- Install accountability measures that evaluate health disparities.
- Strengthen and leverage partnerships to address disparities.
- Leverage the Utah Medicaid program.
- Advocate components of a state racial equity plan that decrease health disparities.

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Health Disparities. Differences in health outcomes closely linked to economic, socio-cultural, and environmental disadvantage. A disparity implies that the difference is avoidable, unfair, or unjust.

Health Equity. Principle behind the commitment to pursue the highest possible standard of health for all while focusing on those with the greatest obstacles.

THE LANDSCAPE OF HEALTH DISPARITIES

Systemic health disparities have exposed Utah’s racially and ethnically diverse populations to an increased risk of not only getting COVID-19 but experiencing more severe illness as a result. To better understand this imbalance and drive toward change, the Multicultural Advisory Committee was convened as part of the State of Utah’s COVID-19 Response to address disparities, increase equity, and better coordinate support for these communities during the COVID-19 pandemic. The purpose of the committee is to work in collaboration with existing frameworks to amplify efforts and alleviate the growing disparities faced by systematically marginalized and underrepresented communities. Leavitt Partners, in partnership with the Multicultural Affairs Advisory Committee, conducted a literature review related to health disparities in COVID-19 to identify key trends, barriers, and interventions that could better illuminate health disparities in Utah and move to greater health equity.

Infection, hospitalizations, and mortality are higher in racially and ethnically diverse communities.



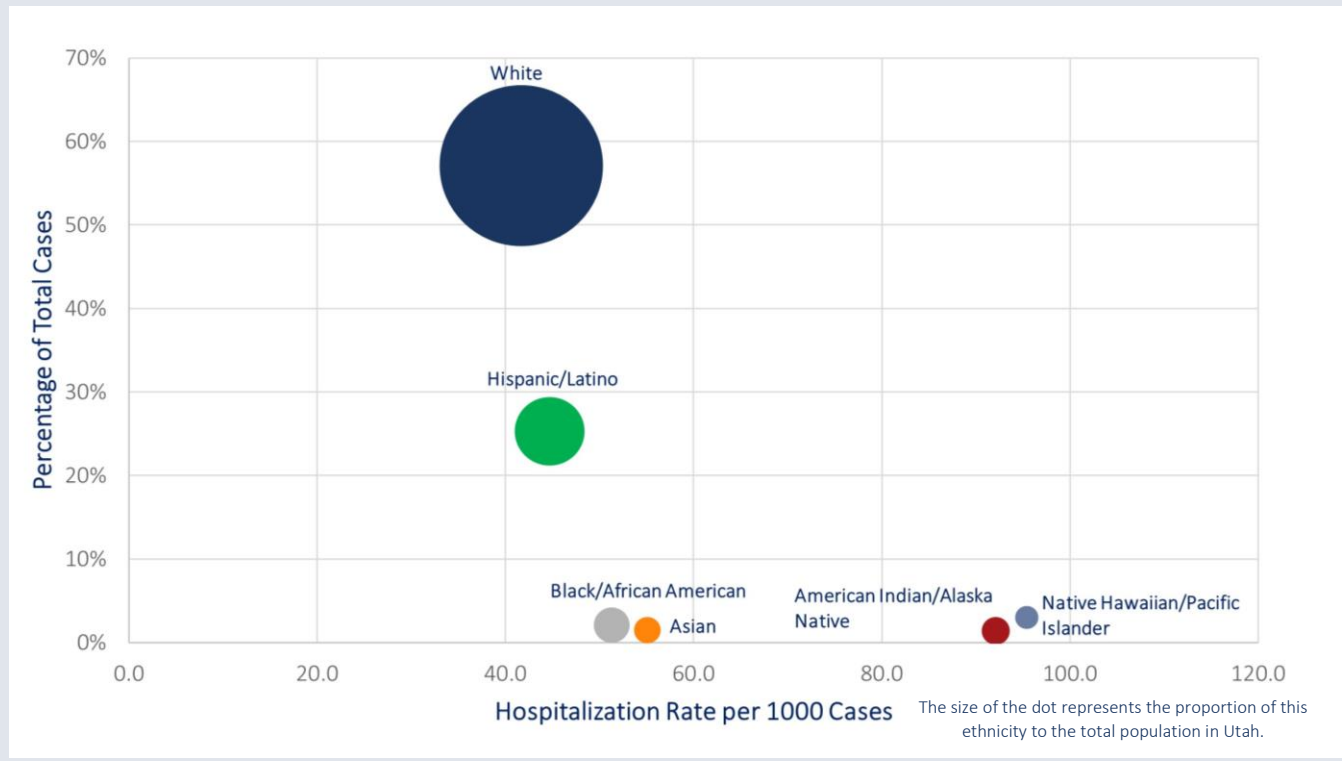
Racially and ethnically diverse communities are experiencing a higher proportion of COVID-19 infection and mortality than white populations at a national level and across many states, including Utah.¹ While the white population in Utah bears the largest total number of COVID-19 cases, ethnically diverse populations in Utah bear the largest percent proportionally, and these communities tend to experience more severe cases of COVID-19. For example, communities of color—while making up a much smaller percent of Utah’s total population and total cases—have significantly higher hospitalization rates than whites, indicating that these communities are experiencing more COVID-19 severity (see Figure 1). Rates of infection in Utah’s refugee population are tracked by the Utah Department of Health’s Refugee Health Program. According to their most recent report, refugees are experiencing infections at a relatively low rate, likely due to ongoing investments in

¹ Rogers, T.N., Rogers, C.R., VanSant-Webb, E., Gu, L.Y., Yan, B. and Qeadan, F. (2020), Racial disparities in COVID-19 mortality among essential workers in the United States. *World Medical & Health Policy*, 12: 311-327. DOI:10.1002/wmh3.358

programs that provide coordinated assistance to these communities, resources not available to other multicultural communities, particularly immigrants.² Although rates of infection have been low, organizations serving the refugee community have stated they are suffering physically, mentally, and financially.³ Additionally, the aggregation of many racial and ethnic groups under the “Asian” category hides disparities in infection, hospitalization, and mortality rates that exist between these specific communities.⁴

The percent of cases among communities of color in Utah have fluctuated throughout the pandemic. For example, Utah’s Hispanic/Latino case percentage reduced from over 45 percent early in the pandemic to 21.1 percent in late November 2020,⁵ highlighting the vital response from public health professionals, community leaders, and community health workers (CHWs). These improvements indicate that interventions can decrease disparities over time.

Figure 1. Percentage of Cases and Hospitalization Rate per 1000 Cases by Population Size in Utah (retrieved November 29, 2020)



Although white individuals make up a much higher percentage of cases in Utah (and a higher proportion of the Utah population in general), those from racially diverse populations make up a higher hospitalization rate, indicating that these communities are experiencing more severity.

² Utah Department of Health Bureau of Epidemiology (2020). Refuge COVID Report, November 20th, 2020.

³ McCombs, B. (2020, May). Refugees in Utah struggle to find their footing during the coronavirus pandemic. *The Salt Lake Tribune*. Retrieved from <https://www.sltrib.com/news/nation-world/2020/05/13/refugees-utah-struggle/>

⁴ Ko Chin K, Avey H, D’Avanzo B, and Andres E. (2020) Addressing AAPI Health Needs in the Context of COVID-19. *AAPI Nexus: Policy, Practice and Community: 2020*, Vol. 17, No. 1 & 2. Retrieved from <https://www.aapinexus.org/2020/09/18/addressing-aapi-health-needs-covid-19/>

⁵ Utah Department of Health (2020, Nov). Race/Ethnicity Specific Case Rates per 100,000 Population by Report Dte. Retrieved from <https://coronavirus.utah.gov/case-counts/>

Occupational trends among this population put them at increased risk for infection and unemployment.



Workplace exposure is a significant driver of COVID-19 infections in Black and Hispanic populations. Nationally, Black and Hispanic populations make up significant portions of critical infrastructure workforce—transportation, healthcare support, food service, and other occupations.⁶ These are occupations in which remote work is not possible, hours tend to be inflexible, and sick leave policies may be more punitive, creating an environment conducive to outbreaks and putting employees at high risk for infection.⁷ Undocumented workers are also disproportionately concentrated in these essential positions, more likely to be living below the poverty line, and face significant barriers to receiving federal support.⁸

In Utah, Hispanic and nonwhite workers account for 73 percent of COVID-19 cases transmitted in the workplace, despite making up only 24 percent of workers in impacted sectors. More than half of these workplace cases took place in three trade sectors: manufacturing, construction, and wholesale. While continued activity in these sectors likely buffers Utah from a portion of the pandemic’s economic fallout and ensures residents of the state have continued access to essential supplies and services, it risks the health and lives of many Hispanic and nonwhite individuals. With the vital role that communities of color play in Utah’s businesses and the state’s economic wellbeing, keeping these communities healthy will continue to be crucial. In fact, in 2018 the Kellogg Foundation estimated that the US economy could grow by \$8 trillion by 2050 if racial disparities, in health and in other aspects of life, were to be eliminated.⁹

Not only do their jobs put them at increased risk of exposure, the nonwhite population is also more likely to experience unemployment during the pandemic (which might also mean they lose access to health insurance). While Utah’s unemployment rate rests below the national rates, certain industries in Utah have been hit harder, such as the leisure and hospitality industry that has seen a nearly 16 percent decrease in employment compared to the same time last year.¹⁰ Utah and Idaho had the highest unemployment rates for Blacks and Hispanics relative to white populations in Q2 2020.¹¹ Undocumented workers, who make up a considerable portion of the essential workforce, are ineligible for many safety net programs, including unemployment benefits.¹²

Black and Hispanic Americans not only saw the steepest employment losses initially but are continuing to see a slower recovery than white Americans, further exacerbating inequalities and health disparities.¹³



Nonwhite populations tend to work jobs that don’t translate to remote environments. Their hours also tend to be inflexible and often don’t offer sick leave, hazard pay, or health insurance.

⁶ Rogers, Racial Disparities in COVID-19 Mortality Among Essential Workers.

⁷ Bui DP, McCaffrey K, Friedrichs M, et al. Racial and Ethnic Disparities Among COVID-19 Cases in Workplace Outbreaks by Industry Sector — Utah, March 6–June 5, 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69:1133–1138. DOI: <http://dx.doi.org/10.15585/mmwr.mm6933e3>

⁸ Hinojosa-Ojeda R, Robinson S, Zhang J, et al. (2020). Essential but Disposable: Undocumented Workers and Their Mixed-Status Families. *UCLA North American Integration and Development Center and the Mexican Instituto Nacional de Estadística y Geografía*. Retrieved from http://www.naid.ucla.edu/uploads/4/2/1/9/4219226/essential_undocumented_workers_final.pdf

⁹ Turner, A (2018). The Business Case for Racial Equity: A Strategy for Growth. *W.K. Kellogg Foundation*. Retrieved from <http://www.wkkf.org/resource-directory/resources/2018/07/business-case-for-racial-equity>

¹⁰ Kem. C. Gardner Policy Institute. (October 2020). 2020 Economic Summary. *The University of Utah*. <https://gardner.utah.edu/wp-content/uploads/October-2020-Economic-Summary.pdf>

¹¹ William, J. (2020). State unemployment by race and ethnicity. *Economic Policy Institute*. <https://www.epi.org/indicators/state-unemployment-race-ethnicity/>

¹² Gould, Latinx Workers.

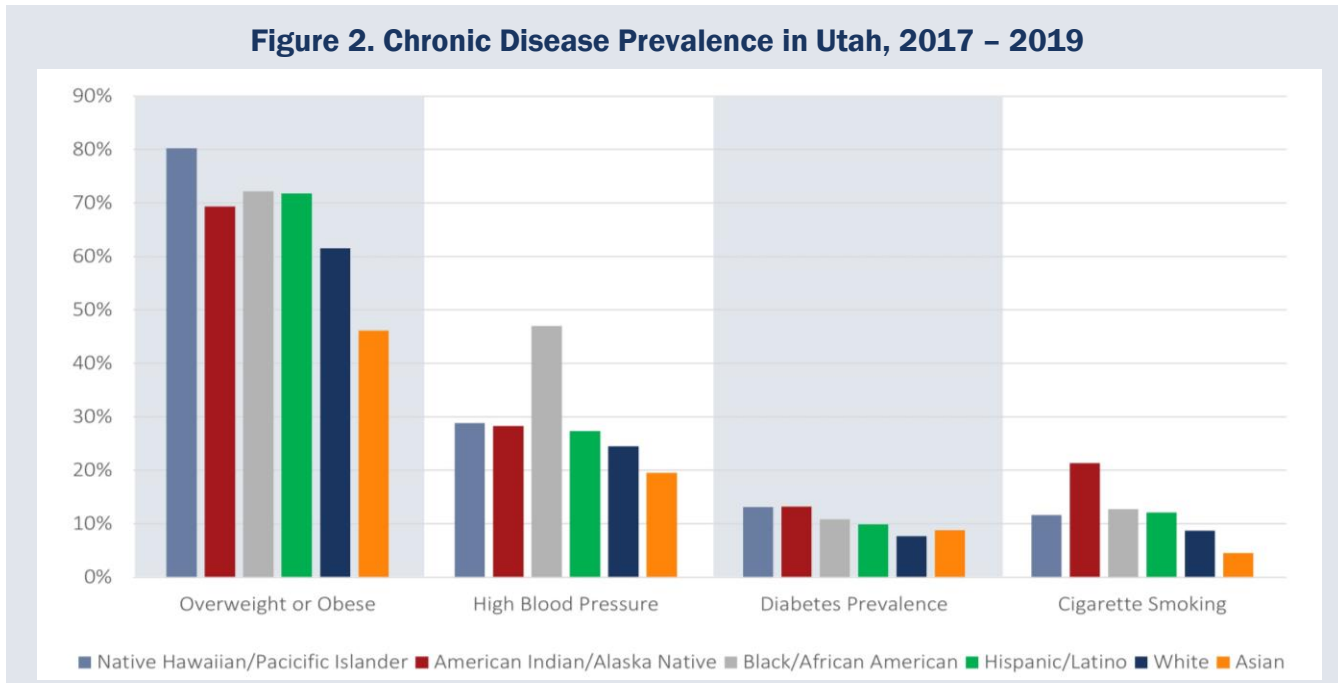
¹³ Long, H., Van Dam, A., Flowers, A., and Shapiro, L. (2020, Sept). The covid-19 recession is the most unequal in modern U.S. history. *The Washington Post*. Retrieved from <https://www.washingtonpost.com/graphics/2020/business/coronavirus-recession-equality/>

Health disparities were present before the pandemic.



Individuals with certain underlying medical conditions are at increased risk for severe illness from COVID-19, including obesity, heart conditions, diabetes, hypertension, asthma, and cancer, as well as those that smoke. Long before COVID-19, communities of color in the United States have suffered from a disproportionate burden of disease as compared to white populations.¹⁴ This is a result of several factors such as lower access to healthcare, lower socioeconomic status, and other social determinants of health (outlined in the next section). Though the trend does not hold for every health indicator or every sub-population, generally populations of color suffer from more chronic disease and higher rates of mortality than white populations.¹⁵ In Utah, communities of color have a higher prevalence of chronic disease and health comorbidities (see Figure 2),¹⁶ which puts them at higher risk of severe disease and death from COVID-19.¹⁷

During pandemics, these disparities typically become even more pronounced. While the entire country suffered during influenza pandemics and the HIV/AIDS pandemic, populations of color suffered disproportionately. Native American populations had the highest mortality rate of any ethnic group during the 1918 influenza pandemic and suffered a mortality rate four times that of the national average during the H1N1 pandemic in 2009.¹⁸ Additionally, despite engaging in similar rates of risk behaviors, Black American men suffer from more cases of HIV/AIDS than any other racial group.¹⁹



Chronic disease prevalence tends to be higher in racially and ethnically diverse communities, even before the pandemic. These disparities are due to a number of factors, including lower access to healthcare, lower socioeconomic status, and other social determinants of health.

¹⁴ Pandemics and minority populations.

¹⁵ Økland, Race and 1918 influenza pandemic.

¹⁶ Utah Department of Health. (December 2019). Public Health Outcome Measures Report. *Public Health Indicator Based Information System (IBIS)*. Retrieved from <https://ibis.health.utah.gov/ibisph-view/report/phom/introduction.html>

¹⁷ Centers for Disease Control and Prevention. (2020, Nov). People at Increased Risk: People with Certain Medical Conditions. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

¹⁸ Kakol, Susceptibility of Southwestern.

¹⁹ Poteat T, Millett GA, Nelson LE, Beyrer C. Understanding COVID-19 risks and vulnerabilities among black communities in America: The lethal force of syndemics. *Ann Epidemiol.* 2020; 47:1-3. DOI:10.1016/j.annepidem.2020.05.004

Social determinants of health factors contribute to COVID-19 disparities.



Several additional factors drive racial and ethnic disparities in COVID-19, including increased utilization of public transportation, barriers to healthcare access, congregate living situations, lower socioeconomic status, language hurdles, and racial discrimination. The nonwhite population’s heavy reliance on public transportation for commuting results in higher COVID-19 cases and mortality rates among these populations.²⁰ In addition, housing factors (such as congregate living situations) make it difficult to follow prevention strategies such as social distancing and allow for the spread of COVID-19. Unemployment rates for racially and ethnically diverse populations may lead to a greater risk for eviction, homelessness, sharing of housing, and lack of insurance.²¹

In order to better identify and address the social needs of communities during the pandemic, particularly underserved and underrepresented communities, the Utah Department of Health Office of Health Disparities launched the COVID Community Partnerships (CCP) Project. Part of this effort included screening community members for social needs when they received a COVID-19 test and conducting a follow-up with some participants a week later. Of households participating, 24 percent indicated they had unmet social needs, and of those, 66 percent indicated their need was caused by COVID-19.²² In populations already experiencing higher rates of unmet social needs, challenges presented by COVID-19—including economic challenges and barriers to following public health guidelines—can exacerbate these hardships.

The burden of COVID-19 is not limited to morbidity and mortality from infection. In a recent survey, Black and Hispanic populations reported higher rates of mental and behavioral health symptoms than white and Asian populations. Further, 35 percent of Hispanic respondents and 30 percent of Black respondents reported trauma or stressor-related conditions induced by COVID-19, a greater percentage than any other racial or ethnic group included in the survey.²³ With racially and ethnically diverse populations already experiencing lower access to healthcare—particularly mental health services—they are especially impacted by COVID-related changes to healthcare.²⁴

Negative experiences associated with race exacerbate effects of COVID-19.



Negative experiences associated with one’s race—felt on the personal and systemic level—also impacts health. Researchers have suggested that health issues under conditions of social inequality likely result in disproportionate COVID-19 outcomes among communities of color.²⁵ Racial trauma is connected to higher rates of depression, anxiety, psychological stress, and poor general and physical health, which could compound the effects of a COVID-19 infection.²⁶ Additionally, several historical and present-day factors—such as mortgage redlining, employment discrimination, and healthcare provider bias—have contributed to the conditions in which Black Americans are experiencing the pandemic.

²⁰ McLaren, J. (2020). Racial Disparity in COVID-19 Deaths: Seeking Economic Roots with Census Data. Cambridge, MA: National Bureau of Economic Research. Retrieved from <https://doi.org/10.3386/w27407>

²¹ Centers for Disease Control and Prevention. (2020). Health Equity Considerations and Racial and Ethnic Minority Groups. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>.

²² Okada B, Espinel C, Cowdell A, et al. (2020). COVID Community Partnership Pilot Project: Integrating Community Health Workers (CHWs) into COVID-19 Response Efforts. *Utah Department of Health Office of Health Disparities*. Retrieved from <https://www.health.utah.gov/disparities/data/ohd/CCPPilotProjectNov2020.pdf>

²³ Czeisler, M.É., Lane RI, Petrosky E, et al. (2020) Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24-30, 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69: 1049-1057. DOI: https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm?s_cid=mm6932a1_w

²⁴ SAMHSA. (2020). Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the US. Retrieved from <https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf>

²⁵ Poteat, Understanding COVID-19 risks and vulnerabilities.

²⁶ Paradies, Y., Ben, J., Denson, N., et al. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS ONE*, 10(9). DOI: <https://doi.org/10.1371/journal.pone.0138511>

Systemic barriers refer to structural patterns of behavior, policies, or practices that are part of the social or administrative structures in the state that perpetuate a position of relative disadvantage for marginalized persons. When combined with other social determinants of health, pre-existing comorbidities, and occupational risk factors, these barriers can be difficult to overcome and compound health disparities during COVID-19. A systemic barrier in Utah is English as the sole language of the state government. Although there are exceptions, this statute generally prevents legal, public health, and other official information from being translated in written materials. Early in the pandemic, information was being translated by different organizations, but there was no singular or official repository, sowing confusion among these communities. The Utah Department of Health, seeing this barrier, began translating information into Spanish and disseminating this information to these communities. This translation, however, is the exception and not the rule.



Negative experiences related to one's race contribute to poor health outcomes. Systemic barriers refer to structural patterns on the social or administrative level. Policies—such as English-only requirements—can inadvertently create health disparities by preventing information being communicated to people who need that information the most.

INTERVENTIONS TO ADDRESS COVID-19 HEALTH DISPARITIES

In addition to reviewing the literature on health disparities during the COVID-19 pandemic, Leavitt Partners also performed an intervention scan to catalog actions being taken to reduce disparities and then conducted interviews with front-line workers in the state to pressure test the feasibility of these interventions in Utah.

Short-term interventions aim to immediately serve communities of color specific to challenges surrounding COVID-19. Many of these challenges, however, reveal underlying health disparities not bound by COVID-19. Given the evolving nature of the country's pandemic response, many interventions have been short-term. Such strategies include increasing access to testing, awarding grant funding, producing more COVID-19 education, allocating important resources like PPE, and increasing focus on data collection.

Long-term interventions geared toward systemic change—such as focusing on social determinants of health (SDOH) initiatives, establishing accountability measures, and providing policy recommendations—are less common. Common proposals for change include addressing disparities in education, increasing access to healthcare and affordable housing, combating food insecurity, addressing disparity in chronic conditions, and providing additional protection for workers.

Regardless of the interventions or activities chosen, consider the following:

- Include clear and actionable steps with specific target goals and timelines to guide the work and to ensure accountability.

In April, the Utah Division of Multicultural Affairs released a report detailing the social, cultural, economic, and resource needs of Utah's multicultural communities during the COVID-19 pandemic. Included in the report are Utah-specific, actionable recommendations to address the challenges underserved communities are facing due to COVID-19.²⁷

²⁷ Peña, N., Hor, J., Benally-Sagg, R., Loayza, C., and Kum, E. (2020). Local Needs Among Utah's Multicultural Communities during the COVID-19 Pandemic. Salt Lake City, Utah: Utah Division of Multicultural Affairs. Retrieved from <https://multicultural.utah.gov/wp-content/uploads/2020/04/MCA-COVID-19-Multicultural-Needs-Report.pdf>

- Recognize the different stakeholders that should partner together to implement an intervention. Many of the solutions will likely require public-private partnerships, legislative action, coordination with community-based organizations (CBOs), and clear communication.
- Make policies inclusive, including immigrant and refugee populations, and adaptable.

Establish a targeted testing and vaccine plan.



Organizers of COVID-19 testing events and vaccine plans targeting diverse communities should engage with the community partners who understand the social and cultural dynamics of these populations. These community partners can help identify how to overcome barriers, how to engage in culturally specific ways, and how to best communicate these plans to each community.



Immediate needs

Organizers and participants should see testing events as opportunities to build trust between racially and ethnically diverse communities, the medical community, and state and government agencies. Including community partners and leaders (both informal and formal) in testing events and vaccine distribution plans is critical to gaining widespread buy-in.



Long-term needs

In the state’s vaccine distribution plan, include specific, intentional, and culturally responsive plans for communities of color. Including and implementing such plans will ensure messaging is distributed simultaneously in multiple languages and customized for particular community needs.

Develop accessible resources and education.



Often, underrepresented populations do not have a clear understanding of available COVID-19 resources and support services or, if they do, how to access them. When they do understand where to access resources, the process can be confusing or difficult to navigate (*e.g.*, complicated application processes).

There is an opportunity to provide a clearer understanding of available COVID-19 resources and support services, where and how to access them, and additional support language and technical support.



Immediate needs

Launch a “know your rights” campaign to help community members understand their rights related to the COVID-19 pandemic and how to access available resources and support services.



Long-term needs

Build a language access plan to disseminate culturally and linguistically appropriate materials when engaging with systematically marginalized communities. Systems and institutions should work to meet people where they are and utilize platforms and resources these individuals are already familiar with.

Involve community health workers.



Community health workers (CHWs) are powerful resources for building trust between these communities and larger organizations, institutions, and government agencies. During the COVID-19 pandemic especially—in which disinformation has proliferated quickly and resources are not centralized—CHWs have been the key to targeting communities and helping to connect communities with the right information. However, CHWs are often grant funded, limiting the sustainability of related programs.



Immediate needs

Continue to partner with CHWs in efforts to mitigate the spread of COVID-19 among multicultural communities, including increased and longer-term funding opportunities.



Long-term needs

Utilize CHWs to ensure communities of color receive the right access to resources and health services beyond the COVID-19 pandemic.

Increase financial support and lengthen funding cycles.



Another intervention that the state could introduce to reduce health disparities is to increase financial support in frontline workers and lengthen funding cycles. Frontline workers—including grocery store workers, healthcare support, transportation services, CHWs—rarely have access to sick leave or hazard pay to offset the health risks.

Short grant cycles allow little time to invest in infrastructure, ramp up services, and then measure success. Longer funding cycles can sustain efforts in a way that produces meaningful and long-lasting positive change. This will also help to bolster trust between communities of color and state institutions, a crucial component that can only be built over time.



Immediate needs

Implement a state-level hazard pay program. Examine opportunities to lengthen funding cycles that may expire at the end of 2020.



Long-term needs

Allocate funds to programs, initiatives, and research with the goal of addressing racial health disparities. Lengthen funding cycles for CBOs and CHWs.

Elevate racially and ethnically diverse leadership and workforce.



When businesses, state electives, and community leaders reflect communities of color, multicultural communities feel more confident that their needs will be reflected. Including different perspectives in the workforce—especially decision-making and leadership roles—ensures that gaps in understanding can be filled efficiently. This is crucial in public health emergencies when decisions need to be made quickly and then immediately communicated to a diverse population. There are leaders—often informal—that already garner respect and trust in their communities; they should be sought out, leveraged, and supported with resources.



Immediate needs

Increase the number of leadership positions among racially and ethnically diverse communities and ensure more of these leaders are involved in making decisions. Increase workforce diversity, particularly among mental health and clinical providers, and provide culturally responsive and inclusive professional development training among government agencies and employees.



Long-term needs

Build and support systemic infrastructure that gives voices to community leaders from different racial backgrounds. These community leaders are often informal, volunteer leaders. Consider how to compensate and incentivize culturally and ethnically diverse individuals to engage in leadership roles.

Install accountability measures that evaluate health disparities.



Agencies, leadership, and programs are motivated by what is measured. Installing accountability measures that track health discrepancies within work plans, grant applications, and program evaluations can help organizations prioritize reducing disparities. Testing programs, vaccine initiatives, communication plans, for example, should be held accountable for disparities and be given the data and problem-solving tools to address them.



Immediate needs

Review current policies, determine the appropriate accountability measures, and make a plan to implement them into current programs.



Long-term needs

Institutions should hold themselves independently accountable to outcome metrics by including such measures in work plans and program evaluations.

Strengthen and leverage partnerships to address disparities.



Utah is unique in its culture of volunteerism and community engagement. With that, however, comes the challenge of advancing streamlined, non-duplicative efforts. With many Utahns, community-based organizations, and community leaders dedicated to supporting its communities, Utah has an opportunity to be more strategic in our partnerships and activities.



Immediate needs

Increase collaboration among COVID-19 efforts and stakeholders involved in responding to the ongoing public health crisis. Avoid duplication of efforts, while acknowledging the unique contributions of diverse partnerships.



Long-term needs

Improve coordination with private- and public-sector organizations to implement interventions, including CBOs, policy institutes, grant-making organizations, local and state universities, and legal advocates.

Leverage the Utah Medicaid program.



Traditional healthcare reimbursement arrangements make it difficult to address multi-faceted needs. Much can be done to address racial and ethnic healthcare disparities in Utah within our healthcare systems and state healthcare payment and delivery policies. One such avenue is through Utah’s Medicaid accountable care organizations (ACOs).



Immediate needs

Increase coordination efforts between the Medicaid and public health departments to plan for disparities in screenings exacerbated by COVID (e.g., breast, cervical, and colorectal cancer). Further the integration of behavioral health, which has begun under the ACO plans, and include culturally responsive mental health programs such as peer-to-peer mentoring. Finally, maintain the expansion of telehealth



Long-term needs

Expand program benefits to meet social needs of enrollees (e.g. social risk screening and referral, transportation, food, and housing support). Consider mandating a reimbursement mechanism for CHWs through Medicaid to support this work. Further the program’s commitment to value-based payment by adopting payment levers outlined by CMS in its letter to State

coverage throughout the public health emergency and beyond.

Medicaid Directors.²⁸ Hold providers accountable for closing gaps in quality outcomes.

Advocate components of a state racial equity plan that decrease health disparities.



Building on the recommendations in the Utah Division of Multicultural Affairs April 2020 report,²⁹ state policymakers can advance inclusive policies and practices in the laws that govern our system. Developing a state racial equity plan could reverse adverse health outcomes that historical and existing policies have created, such as the association between neighborhoods with greater redlining practices and health conditions (e.g., asthma, chronic obstructive pulmonary disease, diabetes, hypertension, and obesity).³⁰ Publicly acknowledging the far reaching impacts of racism—by declaring racism a public health crisis as several cities, counties, and states have recently done—is necessary to fully eliminate racism.³¹



Immediate needs

Include racial equity policies in the upcoming legislative session or incoming gubernatorial policy priorities.



Long-term needs

Develop an actionable state racial equity and social justice plan in collaboration with state commissions, divisions, departments, and community stakeholders.

MOVING FORWARD

Through extensive research into health disparities during the COVID-19 pandemic and discussions with key experts in the state familiar with Utah’s multicultural communities, Leavitt Partners found that significant disparities in case, hospitalization, and mortality rates exist between majority white and ethnically diverse populations. Our research has made clear that Utah’s racially and ethnically diverse communities have been hardest hit by unemployment, healthcare insecurity, and other negative impacts from the COVID-19 pandemic. In response, Leavitt Partners identified several recommendations to address the immediate and long-term needs of Utah’s multicultural communities. Through collaboration and targeted efforts, lawmakers, healthcare leaders, public health experts, CBOs, community leaders, and other partners can begin to work strategically on interventions to address health disparities both in the short- and long-term.

This report was produced in collaboration with the Multicultural Advisory Committee of the State of Utah’s COVID-19 Response and was written by Leavitt Partners, a family of healthcare-focused intelligence businesses. Contributions to this report were made by Patricia Auxier Doxey, Brooke Zollinger, Krisana Finlay, Zoë Heins, Hannah Darrington, and Emilie Ebert.

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²⁸ Centers for Medicare and Medicaid. (2020). Value-based Care State Medicaid Directors Letter. Retrieved from <https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter>

²⁹ Peña, Local Needs Among Utah’s Multicultural Communities.

³⁰ Richardson, J., Mitchell, B.C., Meier, H.C.S., Lynch, E., Edlebi, J., Nelson, R.K., and Madron, J.M. (2020). Redlining and Neighborhood Health. *National Community Reinvestment Coalition*. Retrieved from <https://ncrc.org/holc-health/>

³¹ Vestal C. (2020). Racism Is a Public Health Crisis, Say Cities and Counties. *Pew Charitable Trusts*. Retrieved from <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/06/15/racism-is-a-public-health-crisis-say-cities-and-counties>

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METHODOLOGY

Leavitt Partners explored the existing literature on racial health disparities and their impact during the COVID-19 pandemic. Key searches were conducted in major journal databases, with terms such as “COVID-19 social determinants of health,” “COVID-19 health disparities,” “COVID-19 racism,” etc. Relevant articles published during 2020 and articles regarding racial and ethnic health disparities during historical pandemics were cataloged by author, title, source, year, racial/ethnic group studied, purpose, variables used, key takeaways, and findings. Leavitt Partners also similarly cataloged relevant news articles, citing the time in which the article was published during the COVID-19 pandemic and the racial or ethnic disparities mentioned, such as COVID-19 infection rates, hospitalization rates, unemployment rates, housing challenges, etc. The literature review identified and cataloged the top 50 resources that highlighted unique learnings.

The research was conducted with the following questions in mind:

- How might race impact the health of ethnically diverse communities in Utah during COVID-19?
- What are the major health disparities faced by racially and ethnically diverse communities around the nation and in Utah?
- How has COVID-19 exacerbated these issues around the nation and in Utah?

The Leavitt Partners team conducted a scan of what other states have done to combat racial disparities that have been exacerbated by the pandemic. This was done through secondary research of the news and media, task force recommendations, government press releases, and other relevant sources. Each intervention was grouped by state and assigned to the appropriate intervention type and stakeholder. This allows for ease of use and the ability to filter as needed. The research was conducted with the following questions in mind.

- What are some promising interventions that could be feasible to implement in Utah to improve conditions during the COVID-19 pandemic with long-term systemic benefits?
- In light of COVID-19, what are some of the short and long-term solutions to reduce health disparities?

In addition to secondary research, the Leavitt Partners team conducted a set of five interviews and one group discussion with key experts in the state recommended by the Multicultural Affairs Committee. Organizations were identified with experience implementing health-related interventions in racially and ethnically diverse populations. The purpose of these interviews and discussions was to identify what types of interventions currently exist or are needed in Utah.

Individuals from the following organizations were included:

- Asian & Pacific Islander American Health Forum
- Comunidades Unidas
- Community Advocate
- Community Health Worker Coordinator, University of Utah
- Department of Public Health, Brigham Young University
- International Rescue Committee in Salt Lake City
- Office of American Indian and Alaskan Native Health Affairs, Utah Department of Health
- Office of Health Disparities, Utah Department of Health
- Project Success Coalition
- Refugee Services Office, Department of Workforce Services
- United Way of Salt Lake
- Voices for Utah Children

