COVID Community Partnership Project 2020-2021: Outcomes of Integrating Community Health Workers into COVID-19 Response Efforts

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EXECUTIVE SUMMARY

The COVID Community Partnership (CCP) project aims to address disparities in COVID-19 related health outcomes among under-resourced communities in Utah. The CCP project employs community health workers (CHWs) from diverse communities by partnering with community-based organizations (CBOs) and local health departments (LHDs) to incorporate CHWs into the COVID-19 emergency response.

CHWs are involved in many different activities for the CCP project. Individuals who indicate they need help with basic needs during the contract tracing process are provided with education. CHWs also conduct a comprehensive social determinants of health (SDOH) screening to identify specific areas of need. CHWs then connect individuals to resources for basic needs, assist with adherence to public health protocols, and ultimately reduce the spread of COVID-19 among disproportionately affected groups.

The CCP project was created in 2020 and to date has been operationalized in three phases. In 2020 with Phases 1 and 2, the CCP project partnered with COVID-19 testing sites to increase accessibility in communities experiencing health disparities. Through July 2021 with Phase 3, the project transitioned to focus on supporting equitable vaccine distribution efforts and combating misinformation.

Strategies and Key Findings

1. Partnerships to Reach Diverse Communities (Phases 1-3)

- 16 CBOs and 12 of Utah's LHDs partnered
- 1,055 partnerships formed through CCP

2. Building CHW Capacity (Phases 1-3)

- Total trainings provided to CHWs:
  - (Onboarding [1] + UPHA CHW Sections [23] + Weekly Check-in [129]) = 153 trainings
- Average number Training Attendance of CHWs:
  - UPHA CHW Section: 50
  - Weekly Check-in: 40
- Number of CHWs completing onboarding training: 144

3. Access to Testing and Vaccines (Phase 3)

- Total referrals to testing: 19,875 (Phases 1-3)
- Total referrals to vaccine clinics: 40,704
- Hosted vaccine sites: 277
- Supported vaccine sites: 245
- CHWs onsite at vaccine clinics: 1,065
- Individuals registered by a CHW for a vaccine appointment: 24,615

4. Addressing Needs (Phases 1-3)

- Individuals referred to CCP CHW for follow-up: 17,171
- Number reporting one or more social need: 1,704 (46%)
- Top 3 needs: Housing, food, utilities
- Total referred to resources: 8,436

5. Community Outreach and Education (Phases 1-3)

- Number of outreach activities: 13,512
- Estimated reach of outreach activities: 6,341,030
- Number of languages outreach activities were provided in: 54

INTRODUCTION

The COVID Community Partnership (CCP) project was established in May 2020 by the Utah Department of Health (UDOH) Office of Health Disparities (OHD) in response to the impact the coronavirus pandemic had on Utah's communities that experience health disparities. The CCP project focused on slowing the spread of COVID-19 among under-resourced communities across the state by addressing health disparities. Community health workers (CHWs) were identified as a necessary component in this public health response to mitigate the spread and effects of COVID-19 on communities placed at a higher risk of poor health outcomes.

Since its formation, the CCP project has now completed three phases:

Phase 1: May 2020-August 2020 (see report)
Phase 2: September 2020-December 2020 (see report)
Phase 3: February 2021-July 2021

This report shares the outcomes from Phase 3, as well as a summary of results and outcomes of Phases 1-3.

The CCP project was initially established in May 2020 to support community-based organizations (CBOs) in mobilizing their CHW workforce to provide education, prevention, testing, and access to resources for communities who are underserved and underrepresented. The CCP project's focus on collaborative efforts to address community needs related to COVID-19 helped address the spread of COVID-19 primarily among Utah's racial/ethnic minority communities.

This work has expanded partnerships and created new pathways, particularly with local health department (LHD) CHW workforces, for reaching communities and assessing needs through culturally appropriate methods. Phase 3 continued CCP efforts with a shift in focus from barriers-free COVID-19 testing to improved access to the COVID-19 vaccine.

INTRODUCTION

As COVID-19 spread to Utah in 2020, Utah's racial and ethnic minority communities were recognized as carrying some of the pandemic's heaviest burdens. These disproportionate impacts can been seen in Utah's surveillance data, with higher rates of cases, hospitalizations, and deaths among people from racial and ethnic minority communities. Surveillance data is included in this report to provide context on the experiences of communities hit hardest during this pandemic who were served by this project.

2020 Utah COVID-19 Surveillance Data

In Table 1 below, case counts in 2020 are broken down by people from racial and ethnic groups and demonstrate the disproportionate impact of COVID-19 positive cases among Utah's racial and ethnic minority communities at the start of Phase 3 of the CCP project.

People who identify as Native Hawaiian/Pacific Islander and Hispanic/Latino had the highest case rates per 100,000--almost double the rate of all Utahns (14,679 and 13,489 vs. 8,568 respectively). Furthermore, these communities made up a larger percentage of cases when compared with the percentage of the Utah population. People who identify as Hispanic/Latino comprise 14.6% of Utah's population, but 23.0% of COVID-19 cases in 2020. Utah's Native Hawaiian/Pacific Islander communities comprise 1.6% of Utah's population, but 2.7% of COVID-19 cases in 2020.

Table 1. Utah COVID-19 Case Count Surveillance Data, March 6—December 31, 2020

Race/Ethnicity	% of Total Utah Population	Case count n (%)	Case rate/100,000 population
All Utahns	----	281,731 (-)	8,568
American Indian/Alaska Native	2.2%	4,035 (1.4%)	5,475
Asian	3.7%	5,607 (2.0%)	4,660
Black/African American	2.1%	3,976 (1.4%)	5,715
Hispanic/Latino	14.6%	64,717 (23.0%)	13,489
Native Hawaiian/Pacific Islander	1.6%	7,496 (2.7%)	14,679
White alone, not Hispanic or Latino	75.6%	175,797 (62.4%)	7,050

Data source: Utah COVID-19 Surveillance dashboard.

Note: Race and ethnicity groups follow Census estimates for race alone or in combination in order to provide a broad snapshot of Utah's growing diversity, including the many multiracial and multiethnic individuals who call Utah home. Groups are not mutually exclusive and will not sum to total.

Demographic data: There will be small count differences in data presented by age groups, self-reported sex, and hospitalization status. This is because some cases are not initially reported with all of these data elements and unknowns (7.9% of statewide cases) are excluded from this report. Case data will be updated as LHDs and UDOH complete investigations.

Table 2 displays the rates of COVID-19 hospitalization and case fatality reported for 2020. As of December 31, 2020, a total of 11,766 hospitalizations were recorded in the state of Utah. People who identify as American Indian/Alaska Native and Native Hawaiian/Pacific Islander experienced higher hospitalization rates of 95.2 and 91.0 per 1,000 cases respectively, which is more than double the hospitalization rate of all Utahns (41.8). With regard to the case fatality rate, people who identify as American Indian/Alaska Native had the highest case fatality rate (17.1) followed by people who identify as Asian (8.9).

Table 2. Utah COVID-19 Rates of Hospitalizations and Deaths Surveillance Data, March 6—December 31, 2020

Race/Ethnicity	% of Total Utah Population	Hospitalizations n (%)	Hospitalization rate/1,000 cases	Deaths	Case fatality rate/1,000 cases
All Utahns	----	11,766 (-)	41.8	1,773	6.3
American Indian/Alaska Native	2.2%	384 (3.3%)	95.2	69	17.1
Asian	3.7%	265 (2.3%)	47.3	50	8.9
Black/African American	2.1%	196 (1.7%)	49.3	19	4.8
Hispanic/Latino	14.6%	2,790 (23.7%)	43.1	261	4.0
Native Hawaiian/Pacific Islander	1.6%	682 (5.8%)	91.0	52	6.9
White alone, not Hispanic or Latino	75.6%	7,178 (61.0%)	40.8	1,201	6.8

Data source: Utah COVID-19 Surveillance dashboard.

Note: Race and ethnicity groups follow Census estimates for race alone or in combination in order to provide a broad snapshot of Utah's growing diversity, including the many multiracial and multiethnic individuals who call Utah home. Groups are not mutually exclusive and will not sum to total.

Demographic data: There will be small count differences in data presented by age groups, self-reported sex, and hospitalization status. This is because some cases are not initially reported with all of these data elements and unknowns (2.1% of statewide hospitalizations) are excluded from this report. Case data will be updated as LHDs and UDOH complete investigations.

This data illustrates people from racial and ethnic minority communities may benefit from additional support and resources to reduce the disproportionate impacts of COVID-19. The CCP project was developed through a health equity lens to address factors associated with the social determinants of health (SDOH) that contribute to increased risk of COVID-19 infection and the associated impacts.

CCP PROJECT STRATEGIES

The COVID Community Partnership (CCP) project has six (6) key strategies. Their individual and collective impacts are displayed through data presented throughout the report.

1. Partnerships to Reach Diverse Communities

Through collaboration with 16 contracted CBOs and 12 LHDs, the CCP project implemented program activities through CHW outreach and intervention in under-resourced communities.

2. Building CHW Capacity

The CCP project provided ongoing training, technical assistance, and support to CHWs to increase their capacity to effectively provide education and support to their communities.

3. Access to Testing & Vaccines

In 2020, barriers-free testing site locations were strategically selected to reach Utah's racial and ethnic minority groups and reduce barriers to testing access.
In 2021, CCP project activities focused on supporting equitable COVID-19 vaccine distribution and addressing misinformation.

4. Addressing Social Needs

Social determinants of health (SDOH) screenings were conducted with individuals who expressed a need for assistance. Identification of social needs was crucial to connect community members to needed resources, and lessen the burden of COVID-19.

5. Community Outreach & Education

CBOs and LHDs provided outreach and education about COVID-19 to community members through a variety of formats and settings. Education is an important component to support individuals in their ability to adhere to public health guidance, and ultimately to mitigate the spread of COVID-19 in communities who experience health disparities.

6. Understanding Community Experiences & Health Disparities

The OHD recognizes the importance of learning from CHWs and the communities they serve. Data was collected to understand community experiences and the barriers under-resourced communities face that contribute to health disparities seen among people in Utah's racial and ethnic minority groups.

STRATEGY #1: PARTNERSHIPS

Community-Based Organizations (CBOs) & Local Health Departments (LHDs)

Through Phases 1-3 of the CCP project, the OHD contracted 16 CBOs and 12 of Utah's 13 LHDs to maintain reach to under-resourced communities, particularly racial and ethnic minority groups. With a range of 66 to 69 FTE since May 2020, the CCP project employed 129 CHW positions at one time (90 at CBOs and 39 at LHDs).

CBOs contracted in May 2020:

1. **Alliance Community Services**
2. **Centro Hispano**
3. **Community Building Community**
4. **Comunidades Unidas**
5. **International Rescue Committee**
6. **OCA - Asian Pacific American Advocates**
7. **Project Success**
8. **Somali Community Self-Management Agency**
9. **Urban Indian Center of Salt Lake**
10. **Utah Pacific Islander Health Coalition**

CBOs contracted in September 2020:

11. **Association for Utah Community Health**
12. **Children's Service Society**
13. **Comunidad Materna en Utah**
14. **Latino Behavioral Health**
15. **Utah Health and Human Rights**

CBO contracted May-Dec 2020:

16. **Holy Cross Ministries**

LHDs contracted in September 2020:

1. **Bear River**
2. **Central**
3. **Davis**
4. **Salt Lake**
5. **San Juan**
6. **Summit**
7. **Tooele**
8. **TriCounty**
9. **Utah**
10. **Wasatch**
11. **Weber-Morgan**

LHD contracted Sep-Dec 2020:

12. **Southeast**

CHWs have capacity in 30 different languages.

CBOs and LHDs have reach to more than 60 different cultures.

CBOs and LHDs mobilized partnerships to increase reach to Utah's communities. From Phases 1-3, CCP-contracted organizations reported **615 COVID-related partners**.

Total partnerships in Phases 1-3 (both COVID-related and vaccine-specific): 1,055

In addition to these COVID partnerships, CBOs and LHDs also formed vaccine-specific partnerships to increase reach to underserved and underrepresented communities, particularly racial/ethnic minorities in Utah. In Phase 3, **587 vaccine-specific new partners** were reported.

STRATEGY #2: BUILDING CHW CAPACITY

The CCP project built CHW capacity through initial training and ongoing support from the OHD consisting of: onboarding, training opportunities including bi-monthly Utah Public Health Association (UPHA) CHW section meetings, regular check-in calls, and mental health support. The OHD provided training and resources about COVID-19 throughout the project, and began providing training and resources on the COVID-19 vaccine in Phase 3.

Onboarding

CHWs were offered onboarding in an initial training and to each CHW as they joined the CCP project. Onboarding training included information about COVID-19, public health protocols specific to Utah, and project processes and procedures. In Phase 3, COVID-19 vaccine questions were added. CHWs were asked to complete a pre- and post-test to evaluate knowledge acquisition and training effectiveness.

There were 144 CHWs fully onboarded throughout Phases 1-3. Based on these evaluations, nearly one-third (31.9%) of CHWs improved their knowledge about COVID-19 information due to the onboarding training provided.

Table 3. CCP Onboarding Training, Phases 1-3.

	Total # of CHWs completing both Pre & Post Tests	CHWs meeting minimum score in Post Test (10/13)	*CHWs with increased knowledge (higher score on Post Test than Pre Test)
Phases 1-2	116	99.1% (115/116)	32.8% (38/116)
Phase 3	28	100% (28/28)	28.6% (8/28)
Combined Total	144	99.3% (143/144)	31.9% (46/144)

*83/144 had no change in score, 28/83 scored perfect on both.
NOTE: Out of all the CHWs onboarded, 15 took Pre Test only, seven took Post Test only, and one did not leave an identifier to match with Pre Test.

CHWs were required to attend 23 UPHA CHW section training sessions throughout Phases 1-3. **An average of 50 CHWs attended each training**. These training sections included topics on COVID-19, public health guidance, COVID-19 vaccine training, community resources, self-care, workforce development, and more.

STRATEGY #2: BUILDING CHW CAPACITY

Check-in Calls

Regular check-in calls with training and other activities provided the opportunity to build the capacity of CCP CHWs, provided a space to network with others, and allowed the OHD to learn from the communities CCP CHWs served. Check-in calls were weekly during Phases 1-2, and in Phase 3, check-in calls transitioned to every other week. Three time options were provided for each meeting to accommodate CHWs with different schedules.

In Phase 3, an average of 36 CHWs attended each of the 44 check-in calls.

Throughout Phases 1-3, an average of 42 CHWs attended 129 check-in calls to improve best practices for the project and COVID-19 Response.

Table 4. CCP Check-in Calls, Phases 1-3.

Phase 1-2*	Phase 3	Overall Total
# of Calls Offered		
85	44	129
Average # Attending		
40	36	38
*Only attendance with CHWs at CBOs was averaged.		

Training and topics covered during check-in calls in Phase 3 included: COVID-19 Updates; Vaccine Activities (Vaccine equity roadmap, Central request form, CHW participation on vaccine sites, Vaccine Week "Bring it Home"); Vaccine Updates (Transmission index, Vaccine matrix, Vaccine misinformation); Training (AUCH discretionary funds, COVID Information Line); Resources Introduced (mental health services, eviction moratorium, statewide rental assistance, unemployment assistance, UTA transportation to vaccine clinics; tax assistance, Lyft rides to vaccine clinics, FEMA funeral assistance, WIC increase in produce, emergency broadband benefit internet assistance, American Rescue Act additional insurance options, Health Policy Project).

Mental Health Support

During Phase 2 of the CCP project, the OHD began to provide mental health resources and training to adequately support CHWs in their frontline positions. This mental health support provided through Phase 3 of the project consisted of:

Support Groups: 42
English Support Groups: 22
Spanish Support Groups: 20

Self-Care Sessions: 62
Facilitated in check-in calls.

Mental Health Training: 2
Training included:

- Question Persuade and Refer (QPR)
- How to Support Clients in Getting Mental Healthcare.

STRATEGY #2: BUILDING CHW CAPACITY

Building CHW Skills and Knowledge

CHWs with the CCP project were given ongoing training with a focus on COVID-19 education. The goal was to increase CHWs' overall skills and knowledge. Capacity growth in knowledge and skill areas were monitored throughout Phase 1-3.

In Phase 3, CHWs were asked about their confidence in navigating vaccine resources for their communities.

CHWs were surveyed asking **how confident they felt in appropriately responding to community concerns about the COVID-19 vaccine**. At the beginning of Phase 3 (2/16/2021, 66 respondents) 42.4% of CHWs reported feeling very confident and 57.6% reported feeling somewhat confident, while no CHWs reported feeling not at all confident. At the end of Phase 3 (7/12/2021, 50 respondents), reported **confidence increased**, with 64% of CHWs feeling very confident, 34% somewhat confident, and only 2% not at all confident.

CHWs were also surveyed regarding **how confident they feel referring and connecting individuals to COVID-19 vaccine clinics**. Reported **confidence increased** from the beginning of Phase 3 (3/1/2021, 51 respondents) to the end of Phase 3 (7/12/2021, 50 respondents), from 80.4% to 88% who felt very confident, and no CHWs who felt not at all confident.

At the conclusion of Phase 3, CHWs were asked what **skills and knowledge they gained from participating in this CCP project**.

All CHWs surveyed on 7/26/2021 (39 respondents) reported developing basic knowledge about COVID-19 and Utah-specific updates, as well as developing skills of using information and updates to respond to community needs and educating community members how to keep themselves and those around them safe. CHWs also shared the most valuable skills developed and knowledge gained from participation in this project.

"[The most valuable skill I developed was learning how to] take care of myself, take care [of] others: my family, my friends."

"[The most valuable thing I learned was] the people we're helping were already struggling, and now with COVID are struggling even more."

"To be flexible in accommodating to change and the importance of organized communication."

"Learning about all the amazing community resources and the best ways to connect community members in crisis with resources."

"All the people deserve respect, empathy, health, and help at my community."

STRATEGY #3: ACCESS TO **TESTING**

The CCP project was vital to address health disparities faced by Utah's under-resourced communities during this pandemic by providing access to barriers-free COVID-19 testing. The CCP project's targeted focus on communities with limited access to barriers-free testing created a more expansive reach into racial and ethnic minority groups, when compared with the reach of the state of Utah's overall COVID-19 testing efforts.

Barriers-free testing includes COVID-19 testing with no cost, no symptoms required, and community-based accessibility.

Provision of Barriers-Free Testing in 2020

The CCP project partnered with the University of Utah's Wellness Bus (TWB) and the Utah Department of Health's Mobile Testing Team (MTT) to provide barriers-free testing in Phases 1-2 of the project through safe integration of CHWs into testing sites.

Throughout Phases 1-2 of the project, CCP CHWs attended 140 (93%) of the 150 testing sites.

Reaching Utah's Racial and Ethnic Minority Groups in 2020

Before the CCP project, TWB served seven (7) languages among 696 participants with more than 71% speaking English and 27% speaking Spanish. Throughout Phases 1-2 of the CCP project, TWB served 45 languages among 13,875 participants, with 29% speaking Spanish.

In 2020, CCP project testing at TWB served and reached more racial/ethnic minority communities compared to all testing conducted in Utah statewide, including people who identify as Hispanic/Latino (37.3%), American Indian/Alaska Native (1.3%), Asian (3.0%), Black/African American (2.2%), and Native Hawaiian/Pacific Islander (5.6%).

Referrals to Testing 2020-2021

In Phase 3, the CCP project transitioned away from test site provision but maintained the practice of referral to COVID testing. Throughout Phase 3, CHWs referred 10,068 individuals to testing sites near them.

In Phases 1-3, CCP CHWs made more than **19,875 referrals** to COVID-19 testing sites.

To find more outcomes from the CCP project's testing efforts, see the COVID Community Partnership Project 2020 report.

STRATEGY #3: ACCESS TO **VACCINES**

In Phase 3, the CCP project incorporated activities and strategies to increase community access and capacity to the COVID-19 vaccine among target communities across the state.

Vaccine outreach activities CCP CHWs were involved in included:

1. Host a Vaccine Clinic Site

- CBOs and LHDs hosted vaccine sites at locations accessible to underserved communities.
- There were a total of **277 vaccine clinics hosted** by CCP-contracted organizations.

2. Support a Vaccine Clinic Site

- CBOs and LHDs conducted outreach and provided assistance onsite at vaccine clinics.
- There were a total of **245 vaccine clinics supported** by CCP-contracted organizations.

3. CHWs Assist Onsite at Vaccine Clinics

- CHWs attended vaccine clinics to provide culturally appropriate information, answer questions, and help community members feel comfortable with the vaccination process.
- A total of **1,065 CHWs** assisted vaccine clinics onsite**.**

4. CHWs Register Individuals for a Vaccine Appointment

- Before vaccines became widely accessible, CHWs helped individuals create vaccine appointments when they experienced barriers to technology.
- CHWs **registered 24,615 individuals** for vaccine appointments.

5. CHWs Refer Individuals to Vaccine Clinics

- CHWs referred community members to accessible vaccine site locations.
- CHWs **referred 40,704 individuals** to vaccine clinics.

Vaccine Site Locations Included:

Alliance Community Services, Comunidades Unidas, Centro Hispano, Urban Indian Center of Salt Lake, Mexican Consulate, Redwood Rec Complex, Chinatown Market, LDS Tongan West Stake, LDS Riverside Ward, Calvary Church, Asian Association of Utah, Refugee Education & Training Center, Southern UT PI Coalition, Homebound and Care Facilities, Dee Event Center, Legacy Event Center, Deseret Peak Complex, Wasatch County Events Center, Utah Film Center, Ben Lomond School, Taylor Elementary School, Utah Valley University, Utah Navajo Health System, Mana Academy (West Valley City), Salt Lake County Government Center, Sauniatu Church (Taylorsville), Mobile Clinics.

STRATEGY #4: ADDRESSING SOCIAL NEEDS

Onsite Social Determinants of Health (SDOH) Screening

During Phases 1-2, the CCP project integrated CHWs from CBOs into the barriers-free testing process to conduct onsite social determinants of health (SDOH) pre-test screenings to assess and identify needs within communities.

Between May 2020 and December 2020, CBO CHWs conducted 6,303 pre-test SDOH screenings onsite. Of the individuals screened onsite, **37% (2,328)** consented for a CHW follow-up for assistance with one or more needs.

The primary social needs identified by households at TWB and MTT included assistance with:
Food, housing, employment, prescriptions, and technology.

Follow-Up Social Determinants of Health Screening

CCP-contracted partners implemented unique processes to identify and refer individuals affected by COVID-19 to a CHW for assistance.

Phases 1-2

Community-Based Organizations (CBOs)

Individuals who consented for a follow-up at testing sites were assigned to a CBO CHW for a three-week case period. Individuals were assigned to CBO CHWs based on need, language capacity, cultural norms, and CBO capacity.

Local Health Departments (LHDs)

Within the UDOH, a basic needs question was incorporated into the case investigation process. The question asked individuals being contacted by a contact tracer if they needed assistance from a CHW to connect them to resources for basic needs to help with isolation and quarantine. Individuals who responded "yes" to this question, were referred to an LHD CHW for follow-up.

STRATEGY #4: ADDRESSING SOCIAL NEEDS

Follow-Up Social Determinants of Health Screening

Phase 3

In Phase 3, the CCP project centralized the referral process so CBOs and LHDs both received referrals from the case investigation process. The reason for centralizing the referral process was to deduplicate efforts between CBOs and LHDs, as well as to more evenly distribute the workload between CBOs and LHDs, as the number of cases and referrals increased.

"We have Community Health Workers on staff who may be able to link you to resources for urgent needs to help you isolate or quarantine (such as food, rent, utilities). If you do not have other means for help, they will try their best to find resources but we cannot guarantee resources are available. Is this something you feel that you need at this time?" (Asked in the case investigation process)

During follow-up, CHWs conducted comprehensive post-test SDOH screenings, provided referrals to resources, and educated individuals on isolation, quarantine, and the COVID-19 vaccine.

Number of individuals referred to a CCP CHW for follow-up in Phase 3: **6,518**

CHWs completed 1,680 SDOH screenings in Phase 3. Of households who completed a post-test SDOH screening:

- **1,142 (68%) had social needs**
- 438 (26%) had no needs at the time
- 100 (six percent) of needs were unknown

In Phase 3, CHWs provided COVID-19 vaccine education to **78.5% (897) of individuals** who identified one or more social needs.

Table 5. Most Frequently Reported Top Need by Race/Ethnicity, Phase 3.

Hispanic/Latino	1. Housing (201) 2. Vaccine (107) 3. Food (76)
Non-Hispanic	1. Housing (293) 2. Food (146) 3. Utilities (38)
American Indian/Alaska Native	1. Housing (13) 2. Food (8) 3. Utilities (1)
Asian	1. Housing (16) 2. Food (6) 3. Any Other Need (3)
Black/African American	1. Housing (17) 2. Food (11) 3. Any Other Need (2)
Native Hawaiian/Pacific Islander	1. Housing (18) 2. Food (8) 3. Unknown (2)
White or Caucasian	1. Housing (384) 2. Food (172) 3. Vaccine (107)
White, Non-Hispanic	1. Housing (227) 2. Food (117) 3. Utilities (35)

STRATEGY #4: ADDRESSING SOCIAL NEEDS

Follow-Up Social Determinants of Health Screening

Overall

Total individuals referred to a CCP CHW for follow-up in Phases 1-3: **17,171**

CHWs completed 3,704* SDOH screenings in Phases 1-3. Of households who completed a post-test SDOH screening:

- **1,704 (46%) had social needs**
- 1,151 (31%) had no needs at the time
- 849 (23 %)needs were unknown

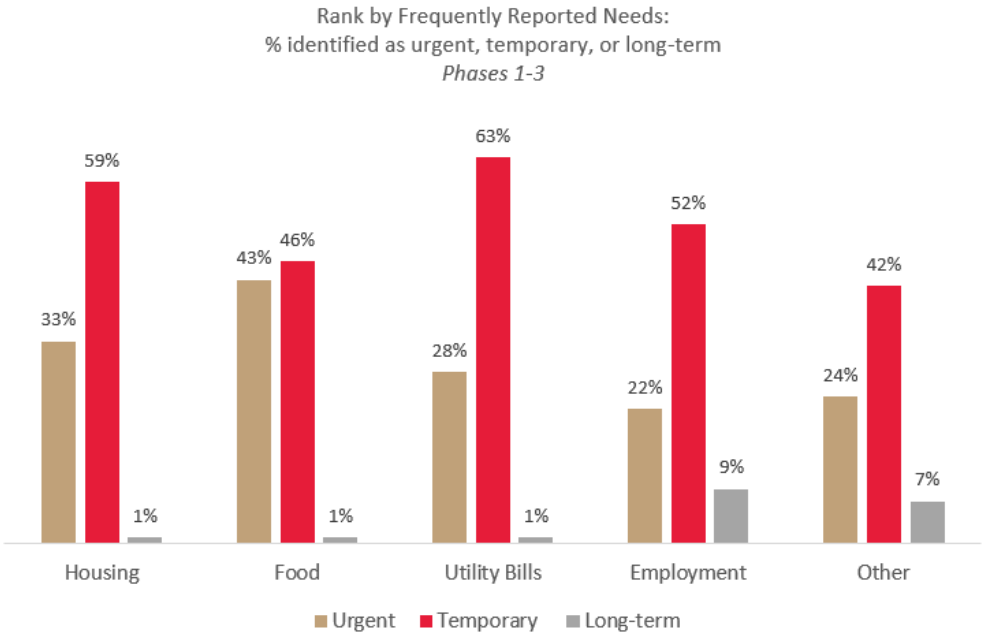
**Does not include LHD data for Phases 1-2*

On average, households reported needing help with at least one (1) social need. However, households reported needing help with anywhere from one (1) to eight (8) social needs.

- 89% reported 1-2 social needs
- 10% had 3-4 social needs
- 1% had 5 or more social needs

Of individuals with social needs in Phases 1-3:

- 31.1% identified the need as urgent
- 52.2% identified the need as temporary
- 4% identified the need as long-term



CHWs provided public health protocol or vaccine education to a total of **1,378 individuals** during follow-up.

STRATEGY #4: ADDRESSING SOCIAL NEEDS

Referring to Resources

CHWs referred individuals to resources to assist with basic needs and help them adhere to quarantine and isolation protocols in order to mitigate the spread of COVID-19 among communities experiencing health disparities.

Wrap-around funding, administered through AUCH, was accessible for CHWs to apply for and assist individuals in isolation and quarantine who were experiencing urgent needs.

Total number of referrals to resources in Phase 3: **1,372**

The social needs with the highest number of referrals in Phase 3 included **housing (648), food (374), and utility bills (202).**

Of referrals made to resources, **55.3% (759)** of individuals were able to successfully connect to and utilize the resource provided.

The top reasons individuals were not successfully connected to resources for Phase 3 include:

1. Person did not respond to follow-up (77)
2. CHW didn't fill out the reason (40)
3. Person decided not to use the resource at this time (14)

For more information and analysis of gaps in resource connection experienced by individuals served by the CCP Project, see OHD's published brief: *Lack of Availability or Accessibility to Resources: Analyzing the Gaps in Resource Connection During COVID-19*

Overall

Throughout Phases 1-3, CHWs made **8,436** referrals to resources.

Housing, food, and utility bills remained the most prevalent needs throughout Phases 1-3 of the CCP project.

STRATEGY #5: OUTREACH & EDUCATION

CCP partners provided outreach and education regarding COVID-19 and the COVID-19 vaccine in order to raise awareness and answer questions from community members.

Total estimated reach through outreach education efforts Phases 1-3:
6,341,030

Vaccine-Specific Outreach Efforts (Phase 3):

- 423 outreach activities
- Estimated reach of 2,554,312
- Vaccine outreach provided in 24 different languages

CBOs and LHDs engaged in more than **13,500 outreach activities** between May 2020 and July 2021.

These outreach activities were delivered in **54 different languages**.

Outreach Activity Highlights:

- Vaccine promotion flyers given at LDS Churches *(Centro Hispano)*
- Mass Whatsapp messages Q & A on the COVID-19 vaccine *(Bear River Health Department)*
- COVID-19 vaccine educational articles in La Bala magazine *(Alliance Community Services)*
- Utah Asian Americans Community Town Hall COVID-19 vaccine discussion *(OCA - Asian Pacific Islander American Advocates)*
- NAACP National Webinar on COVID & the Black Community *(Project Success)*
- KSL News broadcast promoting community vaccine clinics *(Utah County Health Department)*
- Small group education on COVID-19 vaccination at the Latino Health Fair *(Salt Lake County Health Department)*

STRATEGY #6: UNDERSTANDING COMMUNITY EXPERIENCES

Each month throughout Phases 1-3, CBOs and LHDs identified the barriers their communities faced during the COVID-19 pandemic, as well as what their communities were doing to adapt to COVID-19, highlighting the resiliency of Utah's most under-resourced populations. Common themes are grouped below by how frequently these actions were identified in their communities.

Barriers Presented in Communities

Prevalent barriers throughout the pandemic include not being able to access community resources, not understanding or believing public health protocol, concern with rising case counts, and misinformation or concerns with the vaccine.

Spring/Summer 2020 (May-August)

- Language & Cultural Barriers
- Not Understanding or Believing Public Health Protocol
- Paying for Rent, Food & Basic Needs
- Reduced or No Employment

Fall/Winter 2020 (September-December)

- Not Accessing Community Resources
- Not Understanding or Believing Public Health Protocol
- Paying for Rent, Food & Basic Needs
- Holiday Season Group Gatherings

Winter/Spring 2021 (January-April)

- Not Accessing Community Resources
- Isolated & Mental Health Issues
- COVID Vaccine Concerns & Misinformation
- Concern with Rising Case Count

Summer 2021 (May-August)

- Not Accessing Community Resources
- Wanting Pandemic to be Over
- COVID Vaccine Concerns & Misinformation
- Concern with Rising Case Count

Actions Taken to Cope with Pandemic

Prevalent actions throughout the pandemic include wearing face masks, accessing community resources, and willingness to get the COVID-19 vaccine.

Spring/Summer 2020 (May-August)

- Wearing Face Masks
- Social Distancing / Hosting Activities Outdoors
- Support From Community Members
- Staying at Home

Fall/Winter 2020 (September-December)

- Wearing Face Masks
- Accessing Community Resources
- Accessing the Flu Vaccine
- Quarantining / Isolating as Needed

Winter/Spring 2021 (January-April)

- Meeting with Groups Virtually
- Listening to Correct Public Health Protocol
- Willingness to Get COVID Vaccine
- Combining Households for Cost

Summer 2021 (May-August)

- Wearing Face Masks
- Accessing Community Resources
- Willingness to Get COVID Vaccine
- Hosting Activities Outdoors

Experiences Shared with the COVID-19 Vaccine

CCP CHWs from CBOs and LHDs shared their community members' stories throughout Phase 3. Four stories from CHWs in different settings are shared below, depicting community members' experiences accessing the COVID-19 vaccine. These stories showcase the barriers Utah's under-resourced communities face, as well as the positive impact CHWs have on families who need assistance navigating this process.

CBO CHW

"Two elderly refugee women...both needed support in accessing the vaccine. Both had some hesitancies and had misinformation about vaccine deaths and other concerns. Both also did not feel comfortable using the free Lyft service because of the language barriers...we talked specifically about our staff's personal experience with the vaccine. One of the women was still hesitant after initial conversations, but the other agreed to get her vaccine. I accompanied her to the clinic and she got her first dose. She was then able to talk with her friend and help her feel safe with the vaccine. I have accompanied both of these women to their vaccine appointments and both were happy to receive it after these conversations. One main thing was that for these women we provided individual transportation. The barrier wasn't just the ride, it was the language barrier and navigating the clinic that was the compounding issue."

LHD CHW

"A senior citizen in my community was interested in getting his COVID-19 vaccine, but unable to register...due to not having a working computer. Knowing that I worked as a CHW for our county health department, he reached out to me to see if I would be able to help him...I was able to schedule an appointment on his behalf. I worked with the client to get all of the necessary information for registration, scheduled a time for his vaccine and took a printed copy of his appointment confirmation to him so he could present it at the vaccine clinic....He had a friend in the same position as himself and passed my information along to him and I was able to help him also. Several people who have had problems trying to schedule their vaccine appointments have reached out to me for help and I have been able to get them scheduled."

LHD CHW

"Participant had her vaccine at her workplace but she needed to register her parents and and other members of her community for a vaccine clinic. Participant didn't know how to sign up for clinic, and was worried that many members of her community with issue of access to internet and computer, and not being able to read and write. CHW helped connect the participant with vaccine information resources and CRIC staff and volunteers who are partnering with [Bear River Health Department]...Participant [was] able to sign up 4 family members and 2 neighbors to a clinic...and [is] hoping to sign up around 30 people from her community. This is an extraordinary success story of finding a potential Burmese/Karen community leader for a large number of unrepresented refugee community in our jurisdiction."

STRATEGY #6: UNDERSTANDING COMMUNITY EXPERIENCES

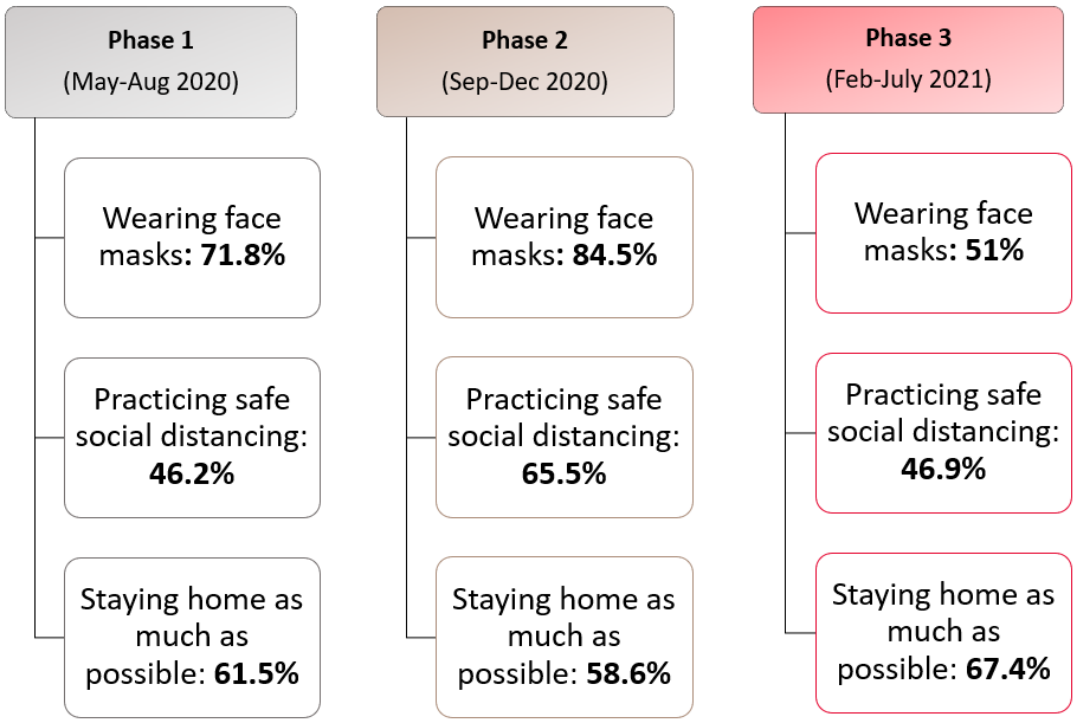
CBO CHW

"El dasafio que enfrente fue el de no saber interpretar los sintomas despues de la aplicxacion de la vacuna a mi sobrino de 19 años. A mi sobrino lo vacunaron contra el COVID-19 un Sabado y para amanecer Domingo el tenia mucho vomito, temperatura, diarrea y dolor de cuerpo. Todos los sintomas los identifique como comunes despues de la vacuna pero el vomito no...El sitio oficial de coronavirus tienen un numero para hablar de sintomas frecuentes de la vacuna...En la linea con la enfermera, ella me dio las instrucciones para tratar los sintomas que estaba presentando mi sobrino. La experiencia fue muy buena porque tambien tuve un interprete con la enfermera y me dejo mas tranquila porque pude entender todo muy bien."

"The challenge I faced was not knowing how to interpret the symptoms after my 19-year-old nephew was vaccinated for COVID-19. My nephew was vaccinated against COVID-19 on a Saturday and by dawn Sunday he had a lot of vomiting, temperature, diarrhea and body aches. I identified all the symptoms as common after the vaccine, but the vomiting was not. The official coronavirus site has a number to talk about common vaccine symptoms... The nurse on the line gave me instructions on how to treat the symptoms my nephew was having. It was a very good experience because I also had an interpreter with the nurse and it put my mind at ease because I was able to understand everything very well."

Community Adherence to Public Health Guidance

During weekly CCP check-in calls throughout Phase 1-3, CHWs were surveyed asking to report their perception of their communities' compliance with Utah's public health guidance. CHWs were surveyed in Phase 1 (5/26/2020, 39 respondents), in Phase 2 (12/14/2020, 58 respondents) and in Phase 3 (6/7/2021, 49 respondents) to monitor change in compliance over the course of the ongoing pandemic. Results showed an overall decrease in compliance with public health guidance in 2021, particularly with wearing face masks and staying home.



UNDERSTANDING COVID-19 HEALTH DISPARITIES

The CCP project was essential to provide necessary support to people from racial and ethnic minority communities in Utah. COVID-19 surveillance data from 2021 demonstrates some improvement in COVID-19 disparities from 2020, but ongoing burden and disproportionate impacts on these under-resourced communities can still be identified. These continued COVID-19 health disparities further highlight the ongoing importance of the CCP project to not only mitigate the spread of COVID-19, but also to address barriers experienced by these communities as this pandemic's effects continue to persist.

2021 COVID-19 Surveillance Data

From January to July 2021, a total of 152,470 COVID-19 cases were reported in Utah, as shown in Table 6. People who identify as Native Hawaiian/Pacific Islander and Hispanic/Latino reported higher case rates per 100,000 when compared with the case rate of the overall Utah population (5,262 and 4,767 respectively as compared to 4,637 per 100,000).

Despite these racial and ethnic COVID-19 health disparities, the case rates per 100,000 did decrease in 2021 from 2020 (see Table 1) among all groups, particularly for people from Native Hawaiian/Pacific Islander communities (14,679 in 2020 to 7,496 in 2021) as well as for people from Hispanic/Latino communities (13,489 in 2020 to 4,767 in 2021 per 100,000).

Table 6. Utah COVID-19 Case Count Surveillance Data, January 1—July 31, 2021

Race/Ethnicity	% of Total Utah Population	Case count n (%)	Case rate/100,000 population
All Utahns	----	152,470 (-)	4,637
American Indian/Alaska Native	2.2%	1,801 (1.2%)	2,444
Asian	3.7%	2,819 (1.8%)	2,343
Black/African American	2.1%	2,050 (1.3%)	2,947
Hispanic/Latino	14.6%	22,872 (15%)	4,767
Native Hawaiian/Pacific Islander	1.6%	2,687 (1.8%)	5,262
White alone, not Hispanic or Latino	75.6%	109,335 (71.7%)	4,384

Data source: Utah COVID-19 Surveillance dashboard.

Note: Race and ethnicity groups follow Census estimates for race alone or in combination in order to provide a broad snapshot of Utah's growing diversity, including the many multiracial and multiethnic individuals who call Utah home. Groups are not mutually exclusive and will not sum to total.

Demographic data: There will be small count differences in data presented by age groups, self-reported sex, and hospitalization status. This is because some cases are not initially reported with all of these data elements and unknowns (7.8% of statewide cases) are excluded from this report. Case data will be updated as LHDs and UDOH complete investigations.

UNDERSTANDING COVID-19 HEALTH DISPARITIES

Table 7 depicts COVID-19 hospitalization and case fatality rates reported from January to July 2021.

From January to July 2021, Utah recorded 7,164 COVID-19 hospitalizations. People who identify as American Indian/Alaska Native and Native Hawaiian/Pacific Islander experienced higher hospitalization rates (88.3 and 86.7 per 1,000 cases respectively) when compared to the overall Utah population (47.0). Compared to 2020 (see Table 2), hospitalization rates per 1,000 cases increased for most racial and ethnic minority groups, particularly for people who identify as Asian (47.3 to 54.6), Black/African American (49.3 to 56.1) and Hispanic/Latino (43.1 to 53.3). Compared to 2020, hospitalization rates per 1,000 cases did decrease in 2021 for people who identify as American Indian/Alaska Native (95.2 to 88.3) and Native Hawaiian/Pacific Islander (91.0 to 86.7).

From January to July 2021, people from Native Hawaiian/Pacific Islander communities had the highest case fatality rate per 1,000 cases (9.3) followed by people from Asian communities (9.2). When compared to case fatality rates per 1,000 cases in 2020 (see Table 2), rates decreased or stayed the same for most racial and ethnic minority groups, particularly for people from American Indian/Alaska Native communities (17.1 to 7.8). However, case fatality rates per 1,000 cases increased in 2021 from 2020 for people from Asian (8.9 to 9.2) and Native Hawaiian/Pacific Islander (6.9 to 9.3) communities.

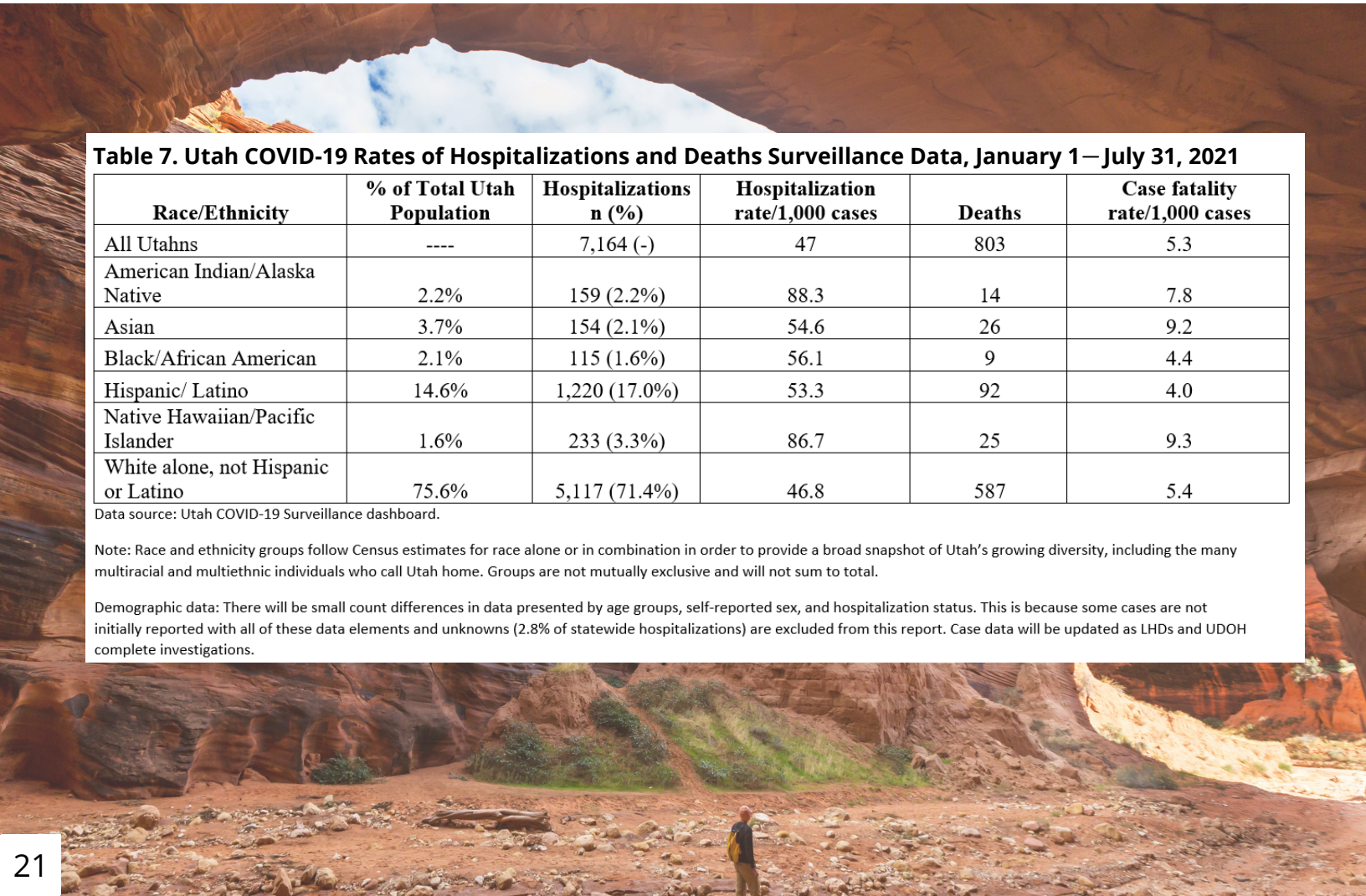


Table 7. Utah COVID-19 Rates of Hospitalizations and Deaths Surveillance Data, January 1—July 31, 2021

Race/Ethnicity	% of Total Utah Population	Hospitalizations n (%)	Hospitalization rate/1,000 cases	Deaths	Case fatality rate/1,000 cases
All Utahns	----	7,164 (-)	47	803	5.3
American Indian/Alaska Native	2.2%	159 (2.2%)	88.3	14	7.8
Asian	3.7%	154 (2.1%)	54.6	26	9.2
Black/African American	2.1%	115 (1.6%)	56.1	9	4.4
Hispanic/ Latino	14.6%	1,220 (17.0%)	53.3	92	4.0
Native Hawaiian/Pacific Islander	1.6%	233 (3.3%)	86.7	25	9.3
White alone, not Hispanic or Latino	75.6%	5,117 (71.4%)	46.8	587	5.4

Data source: Utah COVID-19 Surveillance dashboard.

Note: Race and ethnicity groups follow Census estimates for race alone or in combination in order to provide a broad snapshot of Utah's growing diversity, including the many multiracial and multiethnic individuals who call Utah home. Groups are not mutually exclusive and will not sum to total.

Demographic data: There will be small count differences in data presented by age groups, self-reported sex, and hospitalization status. This is because some cases are not initially reported with all of these data elements and unknowns (2.8% of statewide hospitalizations) are excluded from this report. Case data will be updated as LHDs and UDOH complete investigations.

COVID-19 Vaccine Surveillance Data

Table 8 depicts Utah's vaccination rates of Utahns through July 31, 2021. More than half (51.0%) of Utahns received at least one dose of a COVID-19 vaccine and 45.1% of Utahns were fully vaccinated. People who identify as White have the highest vaccination rate (59.0% received at least one dose), followed by people from Asian communities (50.9%). Only one-third of people from American Indian/Alaska Native, Black/African American and Native Hawaiian/Pacific Islander communities received at least one dose of a COVID-19 vaccine.

Table 8. Utah COVID-19 Vaccine Surveillance Data, as of July 31, 2021

	Utahn's Received at Least One Dose	% Utahn's Received at Least One Dose	Utahn's Fully Vaccinated	% Utahn's Fully Vaccinated
All Utahns	1,681,439	51.0%	1,488,689	45.1%
American Indian /Alaska Native	17,812	32.2%	15,835	28.6%
Asian	49,529	50.9%	45,391	46.7%
Black/ African American	16,950	33.2%	14,688	28.8%
Hispanic/ Latino	175,008	48.5%	150,513	41.7%
Native Hawaiian /Pacific Islander	12,329	32.8%	10,480	27.8%
White alone, not Hispanic or Latino	1,208,381	59.0%	1,087,139	53.1%
Unknown	211,144	---	179,335	---

Data source: Utah COVID-19 Surveillance dashboard.

Note: Race and ethnicity groups follow Census estimates for race alone or in combination in order to provide a broad snapshot of Utah's growing diversity, including the many multiracial and multiethnic individuals who call Utah home. Groups are not mutually exclusive and will not sum to total.

Particularly within some racial and ethnic minority communities, COVID-19 vaccine attitudes and access to vaccination are barriers to getting the vaccine. Promoting vaccination through addressing vaccine hesitancy and access barriers continues to be a necessary statewide public health effort in order to prevent the transmission of COVID-19.

CHWs are trusted members of the community and have been a vital component of addressing these lower vaccination rates among people from racial and ethnic minority communities in Utah. CHWs were mobilized to support Utah's under-resourced populations to access the COVID-19 vaccine. Moving forward, the CCP project will continue to focus on addressing misinformation and mistrust of the COVID-19 vaccine, while also addressing identified access barriers.

For more information on data collected through the CCP project on vaccine attitudes and barriers, refer to the OHD's published brief, *COVID-19 Vaccine Hesitancy or Access Barriers: Understanding Utah's Racial and Ethnic Minority Communities' Attitudes to Inform an Effective Approach*.

CCP PROJECT MOVING FORWARD

The CCP project extended programming past Phase 2 with funding from the Intermountain Foundation in 2021, with this recent conclusion of Phase 3. With new funding from the CDC, the CCP project will extend into a fourth phase of the project from August 2021 to June 2023. The extension of the CCP project is necessary as the COVID-19 pandemic continues to affect Utah's communities. The main goals of the next phase will be to adapt to community needs as they are identified, continue to link underserved populations to COVID-19 vaccines and low-barriers testing, and assist those who need help through quarantine and isolation with needed resources. In Phase 4, the CCP project has partnered with 21 community-based organizations and Utah's 13 local health districts to not only expand geographical reach throughout Utah, but to also increase the CCP project's ability to better serve more types of under-resourced communities experiencing health disparities and who have been disproportionately impacted by COVID-19.

COVID-19 efforts continue to focus on vaccine uptake, and the CCP project will continue to provide ongoing support to CHWs and CCP partners through COVID-19 vaccine training sessions, education and information for communities, and assisting with vaccination clinics throughout the state. As resources are often difficult to access due to technology, language, and geographic barriers, CHWs acting as advocates for their communities as trusted sources of assistance and information continue to be essential. With partnerships from LHDs and AUCH, the project has increased the ability for CHWs to support communities who have fewer options for resources, particularly those in rural areas, and will be vital during the COVID-19 vaccine distribution process.

As COVID-19 continues to affect communities across Utah, the CCP project will continue to support CBOs, LHDs, and other organizations to provide advocacy, support, funding, and assistance to CHWs. This support will help communities withstand the effects of dealing with this pandemic and propel us toward recovery.

APPENDIX

List of Tables

Acronyms Used

UDOH = Utah Department of Health
OHD = Office of Health Disparities
CCP = COVID Community Partnership
CHW = Community Health Worker
CBO = Community-Based Organization
LHD = Local Health Department
AUCH = Association for Utah Health
UPHA = Utah Public Health Association
TWB = The University of Utah Wellness Bus
UPHL = Utah Public Health Laboratory
SDOH = Social Determinants of Health

Commonly Used Terms

Social Determinants of Health: Conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Health Disparities: A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location.