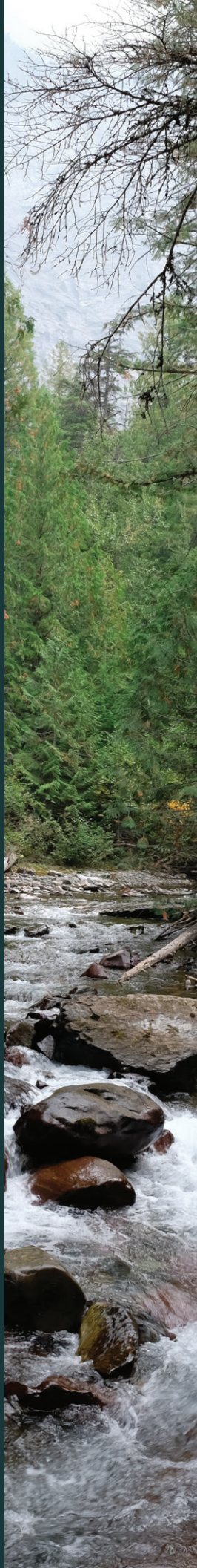
HEALTH EQUITY, SOCIAL DETERMINANTS OF HEALTH, AND MONTANA'S COVID-19 RESPONSE

A Supplement to the Statewide Summary of Local and Tribal Health Department's After-Action Reviews



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Introduction

In 2021, the Montana Public Health Institute (MTPHI) was contracted to support the after-action review (AAR) process related to the COVID-19 response in Montana. Through that effort, MTPHI assisted 28 health departments in their AAR processes, and **published a report outlining findings** from 40 local and tribal public health department AARs in October 2022.

While comprehensive in nature, the AAR process didn't fully address the health equity considerations that COVID-19 brought to the forefront. It is documented that the health impacts of COVID-19 disproportionately burden racial and ethnic minority groups, as well as other groups that have been marginalized. For example, in 2020, the Montana Department of Public Health & Human Services (DPHHS) reported that Montana American Indian residents had mortality rates 11.6 times higher than white residents during the first several months of the COVID-19 pandemic[1]. Today, similar disparities still exist. Data collected and complied by the Centers for Disease Control and Prevention (CDC) show that American Indians, Asians, and African Americans in Montana continue to experience disproportionately high percentages of COVD-19 deaths relative to their percent of the population[2].

This supplemental analysis seeks to add critical information learned on the ground related to health equity to help strengthen future public health emergency response efforts in Montana.

Methodology

In January 2023, MTPHI emailed a survey to lead local health officials at all of Montana's local and tribal health departments requesting information about their health department's strengths and areas of improvement for the COVID-19 response as it related to health equity and/or the social determinants of health (SDOH). Specifically, health departments were asked to reflect on how their department, their agency, and/or their community worked to connect with populations that have been marginalized and are therefore harder to reach – such as American Indians, people experiencing homelessness, individuals with disabilities, individuals who identify as LGBTQ+, recent immigrants, individuals who speak English as a second language, and people of color.
The survey focused on two primary parts of the COVID-19 response: the initial response (before vaccines were available) and the response after vaccines became available.
In addition, the survey asked for further information including how supplemental funding was utilized to support health equity, what resources were provided related to health equity, and what resources would be helpful for the future (a copy of the survey instrument is available in Appendix B).

[1] Covid-19 Associated Death among Montana Residents, Provisional Data March – October 2022; Montana Department of Public Health & Human Services, November, 2020
[2] Health Disparities: Provisional Death Counts for Coronavirus Disease 2019; Centers for Disease Control and Prevention, January 2023

MTPHI received 51 survey responses representing 46 local and tribal health departments (a full list of participants is included in Appendix A).

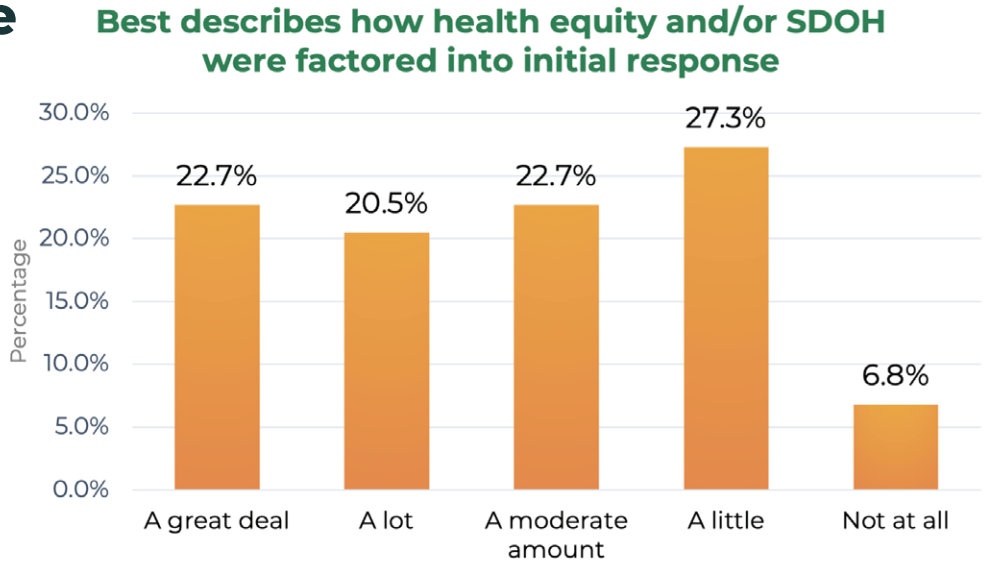
Key Findings from Montana's Response

MTPHI assessed the survey responses to identify trends and themes that emerged among the various communities. Those findings are summarized below.

Initial Response

Strengths

Respondents were asked to provide a qualitative response to their strengths in the initial response related to health equity and/or SDOH. The responses were themed and are summarized below.



- Variety of partnerships & relationships were well-established: Community partners had long-standing relationships that were key to the success of the initial response. While most of these were with response agencies, health departments also indicated strong pre-existing relationships with various agencies that may serve marginalized populations such as Federally Qualified Health Centers, Urban Indian Health Centers, and Senior Centers.
- Services were added to serve needs: Many health departments expanded staffing and volunteers to add services for things like food delivery for patients in quarantine, visits to homebound community members, and linking patients who had tested positive for COVID-19 to non-congregate housing options. In addition, call centers or direct calls to community members were implemented to ensure questions were answered and referrals to additional services were provided.
- Free and accessible testing: Testing was offered to the community for free and health departments worked with a variety of partners to expand accessibility of testing through increased locations and hours.
- Robust, multi-faceted communication strategies: Health departments and their collaborative partners utilized a variety of communication methods throughout the response, including social media, emergency alerts, traditional media, reader boards, and posters to try to reach all members of the community.

Improvement Areas

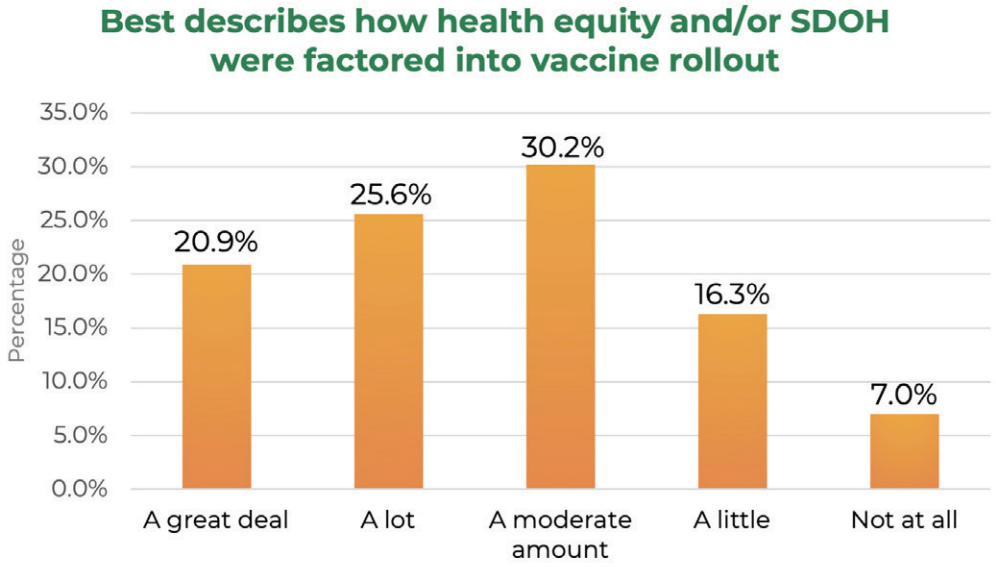
Respondents were asked to provide a qualitative response to how, in the initial response, they think they could have improved efforts to address health equity and/or SDOH. The responses were themed and are summarized below.

- Staff capacity: Despite ramping up staffing and volunteers, health departments still felt they lacked capacity to serve all the needs identified, particularly as it related to health equity and SDOH.
- Coordination with community agencies serving vulnerable and marginalized populations: Emergency coordination and communication with agencies serving vulnerable and marginalized populations was limited across response efforts. Health departments indicated that this lack of coordination and communication stemmed from the lack of pre-existing relationships with individuals or organizations serving these populations.
- Communication with hard-to-reach populations: Inconsistent internet access in rural communities presented numerous complications in disseminating information to the public, as it required multiple messages over numerous platforms (including the postal service) to reach most of the population. This was often time-consuming and impacted by operational demands on staff and technological challenges. In addition, populations that do not utilize technology did not always receive communication.
- Housing for isolation and quarantine: Housing for isolation and quarantine for COVID-19 positive patients, especially in multigenerational households, tourists, and individuals experiencing homelessness, was difficult to solve and there was a lack of hotels and other short-term housing options wanting to collaborate on this issue.
- Pre-planning and education: Emergency plans did not include components related to health equity and/or SDOH. This resulted in lack of conversations on this topic and an unclear understanding of how to incorporate it into the decision-making process.

Vaccine Rollout

Strengths

Respondents were asked to provide a qualitative response to their strengths in the vaccine rollout, when supply was limited, related to health equity and/or SDOH. The responses were themed and are summarized below.



- Collaboration with local partners: Health departments routinely partnered with other health agencies in their communities to ensure the distribution of vaccines in an efficient manner. This included ensuring physician offices, pharmacies, and long-term care facilities all had vaccine available for distribution. Many partners also assisted with staffing for vaccine / mass immunization events.
- Free vaccines and increased accessibility: Vaccines were offered to communities for free and health departments worked to expand accessibility through increased locations and hours. This included the use of mobile clinics, home visits, remote clinics in different parts of the counties, and vaccine clinics at worksites.
- Use of call centers: Health departments utilized formal and informal call centers to make information available to the public and to provide a secondary way for community members to book vaccine appointments.
- Translation services: Health departments worked to translate vaccine information into various languages and routinely offered language translation to those receiving vaccines through services such as the Language Line.

Improvement Areas

Respondents were asked to provide a qualitative response to how, in the vaccine rollout, when supplies were limited, they think they could have improved related to health equity and/or SDOH. The responses were themed and are summarized below.

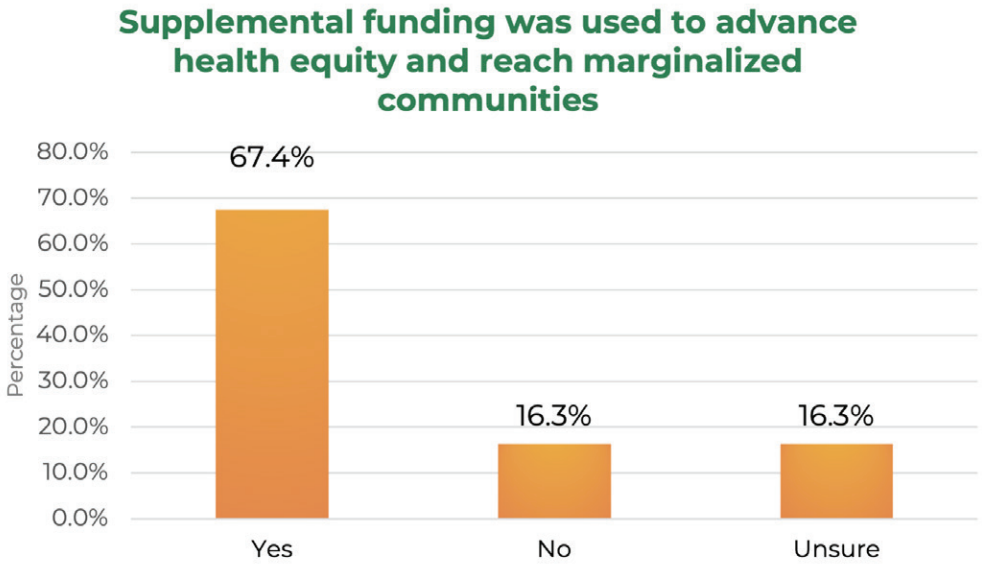
- More accessibility: While health departments indicated they employed a variety of methods to make vaccines available, they also noted that more work to increase accessibility was needed. Specific suggestions included extended clinic hours (e.g., nights and weekends), offering clinics in outlying parts of the county, increased use of mobile vans, and increased use of partners that may have access to marginalized community members.

- Scheduling options: Many health departments used an online platform as the main way to schedule appointments. Although people could also request an appointment via telephone, health departments struggled to keep up with phone calls and noted that those using the online scheduling platform may have had easier access to the appointments.
- Mandated vaccine tiering: The Governor's Directives provided for prioritization of vaccine distribution across Montana and health departments indicated that the statewide priorities did not always align with what they saw as their local community's greatest need.
- Alternative communication and cultural competency: Communication continued to be ongoing concern during vaccine rollout particularly for populations that do not utilize technology. In addition, communication was often aimed at the general population and did not take into consideration specific cultural or linguistic needs.

Additional Funding

Utilization of Funding

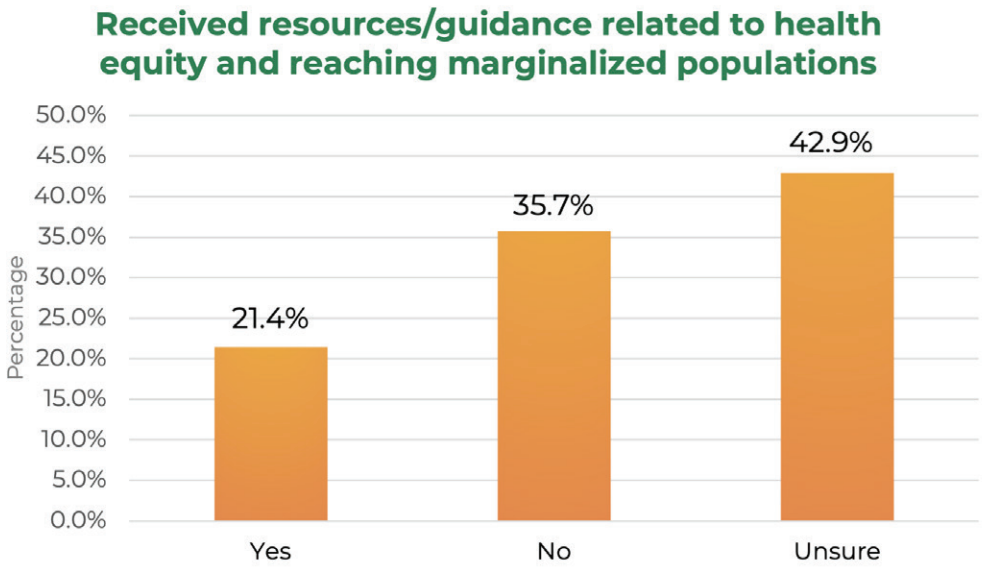
Respondents were asked to provide a qualitative response to how funding was utilized to advance health equity and reach marginalized communities. The responses were themed and are summarized below.



- Staffing: Staffing was increased to assist in the response, which allowed for additional vaccine clinics, expanded services (e.g., home visits), and the opportunity to bring in specific expertise such as staff with experience in communication, communicable disease investigation, or clinic planning/logistics.
- Communication: Communication to the community was increased through advertising and mailings. In addition, funding was utilized to get assistance in translating communication materials and ensuring cultural competence.
- Vaccine clinics: Some health departments used funding to purchase vehicles to allow for mobile clinics and paid for the costs associated with vaccine clinics (e.g., mileage, supplies, event space rental).

Health Equity Resources and Guidance Provided

Respondents were asked to provide a qualitative response to what resources or guidance they received related to health equity and reaching marginalized populations.



This question did not garner many responses but those that did respond mentioned:

- Guidance and technical assistance from DPHHS
- Guidance and technical assistance from one or more Tribal Councils
- Guidance from neighboring counties and joint meetings with other health departments
- Communication support from MTPHI and CDC Foundation

Recommendations

Respondents were asked to provide a qualitative response to what resources or guidance related to health equity would be helpful in the future. The responses were themed and are summarized below.

- **Training:** Training on health equity and SDOH is needed for health department staff, partners, and community stakeholders. Specifically, rural communities may benefit from training on how to recognize and address health inequities and SDOH unique to their community.
- **Specific strategies and technical assistance:** While overall training on health equity was noted, there is also a need for technical assistance and training on how to take the concepts and implement them at the local level. Respondents requested specific strategies on how a health department could work on health equity and SDOH.
- **Guidance on updating plans:** Recognizing that local/tribal emergency response plans steer response efforts, guidance and examples of how to include health equity and SDOH in emergency preparedness plans is needed.
- **Statewide campaigns:** Communication was difficult for health departments with limited capacity, a challenge that is expected to be an ongoing issue of concern. Therefore, there was interest in statewide campaigns and messaging aimed at topics related to health equity that could be utilized by all health departments.

- **Peer learning:** There was interest in additional networking opportunities, specific to health equity and SDOH, for health departments to learn from each other. These networking opportunities would include sharing successes, improvement opportunities, and how funding is being utilized to address health equity.
- **Guidance to cultivate new partnerships:** The lack of relationships with minority or marginalized communities challenged public health response. Health departments should invest resources in building partnerships and collaborating with all types of organizations, especially those serving marginalized populations.

Limitations

This qualitative analysis has several limitations. Each AAR provides only perspective-based data from those that participated in the survey that has not been objectively verified. In addition, this report was intended to collect detailed, descriptive information, rather than to assign exact frequencies to the issues explored or to provide information that could be extrapolated to other populations or issues. As with any qualitative analysis, the personal experiences and knowledge of those compiling the report likely brought inter-rater variation in the summarizing of information. Also, of note, of those that completed the survey, 41 (80.4%) indicated that they were working in public health at the start of the COVID-19 pandemic. This question was asked to gauge the level of information the respondents may have had of the past response efforts. Lastly, not every person completing the survey fully responded to each question.

Conclusion

The Montana public health system experienced major changes and challenges during the COVID-19 response. The recommendations presented in this report provide a starting point for work on health equity and SDOH for Montana's public health system so that every Montanan is afforded the same level of public health programs, services, and protections, and ultimately, so that everyone has a fair and just opportunity to be as healthy as possible.

Appendix A

Health Departments that Completed Survey:

Beaverhead
Big Horn
Blackfeet Reservation
Blaine
Broadwater
Carbon
Cascade
Chouteau
Custer
CSKT
Dawson
Deer Lodge
Fallon
Fergus
Flathead
Fort Peck
Gallatin
Garfield
Glacier
Golden Valley*
Granite
Hill
Jefferson
Judith Basin*
Lake
Lewis & Clark
Lincoln
Madison
Meagher
Mineral
Missoula
Musselshell*
Park
Petroleum*
Pondera
Powder River
Powell
Prairie
Ravalli
Richland
Rock Boy
Roosevelt
Rosebud
Sweet Grass
Toole
Treasure
Valley
Wheatland*
Wibaux
Yellowstone

*Central Montana Health District

Appendix B

Survey Instrument

Health Equity in COVID-19 Response

Background

The Montana Public Health Institute (MTPHI) is conducting this survey as a supplement to the After Action Review process we conducted earlier this year. During that process, the topic of health equity wasn't fully explored, and we feel there are important lessons to be learned to help inform future emergency responses.

This survey will ask you to reflect on how health equity was considered in your response to COVID-19. There are many things that are wrapped up in the term health equity. **For this survey, our hope is that you reflect on, among other things, how you, your department, your agency, and / or your community worked to connect with populations that have been marginalized and are therefore harder to reach – such as Native Americans, people experiencing homelessness, disabled people, recent immigrants, and individuals who speak English as a second language, and people of color.**

This survey should take no more than 10 minutes to complete. Responses are confidential and participation is voluntary.

General Information

As a reminder, results from this survey are confidential. No identifying information will be shared unless we have permission. Collecting your contact information will allow us to reach out if / as needed to ask additional questions about your experiences.

1. What is your name?
2. What is your email address?
3. What county or reservation community do you serve (check all that apply)?
4. Were you working in public health at the start of the COVID-19 pandemic?

   ☐ Yes
   ☐ No

Initial Response

These questions ask about the initial public health response to COVID-19, before vaccines were available.

5. Thinking back to 2020 and your county's / organization's initial response to COVID-19, what best describes the way health equity and / or the social determinants of health factored into your decision making?

    - ☐ A great deal
    - ☐ A lot
    - ☐ A moderate amount
    - ☐ A little
    - ☐ None at all

6. During your initial response, what were your strengths (things you would definitely do again) related to health equity and / or the social determinants of health?

7. Based on what you learned during your initial response, what would you do differently, related to health equity and social determinants of health, to improve future emergency responses?

Vaccine Rollout

These questions ask about the COVID-19 vaccine rollout.

8. Thinking back to 2021 and your county's / organization's COVID-19 vaccine rollout when supply was limited, what best describes the way health equity and / or the social determinants of health factored into your decision making?

    - ☐ A great deal
    - ☐ A lot
    - ☐ A moderate amount
    - ☐ A little
    - ☐ None at all

9. During your COVID-19 vaccine rollout, what were your strengths (things you would definitely do again) related to health equity and / or the social determinants of health?

10. Based on what you learned during your COVID-19 vaccine rollout, what would you do differently, related to health equity and social determinants of health, to improve future emergency responses?

Funding & Resources

11. With the supplemental COVID-19 funding you received, did you use any of it to try and advance health equity and reach marginalized communities?

    - ☐ Yes
    - ☐ Unsure
    - ☐ No

12. How did you use supplemental COVID-19 funding to advance health equity and reach marginalized communities?

13. Did you receive resources or guidance related to health equity and reaching marginalized populations to help you with your response?

    - ☐ Yes
    - ☐ Unsure
    - ☐ No

14. What resources did you receive related to advancing health equity and / or reaching marginalized communities and how did you use them?

15. What additional tools or information would be helpful for you to ensure health equity is considered in future public health emergencies in Montana?

Final Thoughts

16. Thank you for answering our questions. Your input is very important to us. We know the questions we asked may not address some important factors related to health equity and social determinants of health. Please use the space below to tell us what else you would like to share regarding your county's, community's, or Montana's COVID-19 response and the statewide system to support that effort. Please think about resources, technical assistance, and support that could make this effort more effective in the future.