

Utah Health Status Update: *Disparities Report*

August 2011

During the 2011 legislative session, the legislature replaced the Utah Department of Health, Center for Multicultural Health (CMH) with the new Office of Health Disparities Reduction (OHD). The new office will continue to address racial and ethnic health disparities, but will expand its mission to address other health disparities, such as disparities by geography.

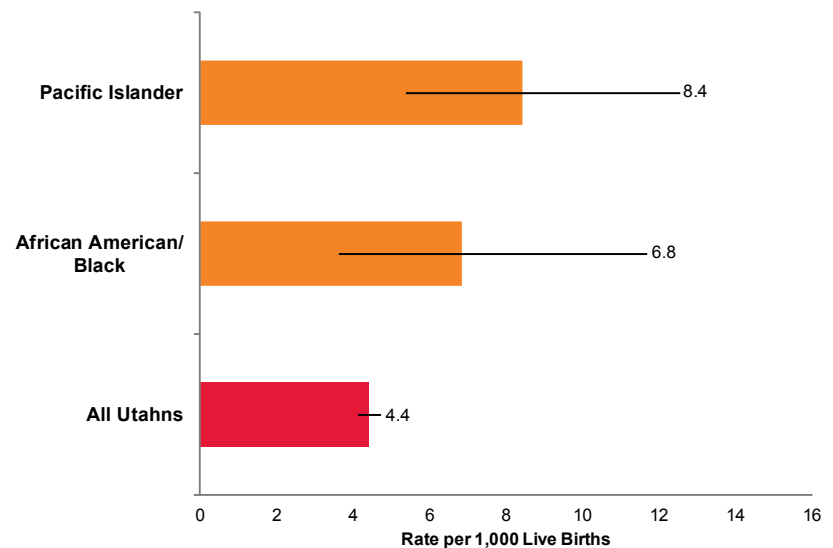
A priority of OHD is to address infant mortality among Pacific Islanders and African Americans/Blacks. In 2005-2008, Utah African Americans/Blacks had an infant mortality rate of 6.8/1,000 live births and Utah Pacific Islanders had an infant mortality rate of 8.4/1,000 live births. During the same time period, the statewide infant mortality rate was 4.4/1,000 live births (Figure 1).¹

Low rates of folic acid consumption and early prenatal care, as well as a high rate of obesity during pregnancy, may contribute to the infant

- **A priority of the Office of Health Disparities Reduction is to address infant mortality among Pacific Islanders and African Americans/Blacks.**
- **Low rates of folic acid consumption and early prenatal care, as well as a high rate of obesity during pregnancy, may contribute to the infant mortality problem among Utah Pacific Islanders.**
- **High infant mortality in Utah's African American/Black population may be related to the high smoking rates during pregnancy and low birth weights seen in this population.²**
- **In 2006-2010, all Utah racial/ethnic minorities, except Asians, had higher age-adjusted adult overweight rates than the statewide rate.⁴**
- **In focus groups, Hispanics/Latinos were concerned about the cost of healthy food, lack of knowledge about nutrition, and the difficulty of physical activity during cold weather.**

Infant Mortality by Race/Ethnicity

Figure 1. Infant mortality per 1,000 live births by race/ethnicity, Utah, 2005-2008 (disparately affected groups only)



Source: Utah Vital Records, Birth-Death Linked Infant Mortality (birth cohort), 2005-2008

mortality problem among Utah Pacific Islanders. High infant mortality in Utah's African American/Black population may be related to the high smoking rates during pregnancy and low birth weights seen in this population.²

During focus groups, Pacific Islanders reported that many people in their community are unaware of the health advantages of taking folic acid, getting prenatal care, attaining a healthy weight prior to pregnancy, or spacing pregnancies at least 18 months apart. African Americans focused more on the problem of unplanned pregnancy. They also pointed out that since most state-sponsored services for pregnant women are only available to women after they become pregnant, these services are too late to prevent problems caused by poor maternal health, lack of folic acid and lack of family planning prior to pregnancy.

Disparities in infant mortality also exist by geography. The small areas with the highest infant mortality rates from 2005-2008 included the area encompassing Sevier, Piute and Wayne Counties; Wasatch County; Box Elder County (excluding Brigham City); Midvale; Downtown Ogden and Kearns.¹

In 2008, 75.3% of Utahns lived in Utah's four most populated counties: Salt Lake, Utah, Davis and Weber counties. With the exception of American Indians, Utah racial/ethnic minorities were even more urban, with 91.3% of Pacific Islanders, 87.1% of Asians, 86.0% of Blacks/African Americans, and 83.6% of Hispanics living in the four most populated counties. Only 43.1% of Utah American Indians lived in these four urban counties.³

While Pacific Islanders and African Americans/Blacks had the highest infant mortality rates of all Utah racial/ethnic groups, the three small areas with the highest infant mortality rates were rural areas where less than 0.5% of the population was of Pacific Islander or African American/Black race.^{1,3}

Another objective of the OHD, is to reduce disparities in overweight body mass index among Utah racial/ethnic minorities. In 2006-2010, all Utah racial/ethnic minorities had higher age-adjusted adult overweight or obese rates than the statewide rate, with the exception of Asians, who had an age-adjusted adult overweight rate of only 39.6% (Figure 2).⁴

During focus groups, community members of all represented races and ethnicities emphasized that the modern lifestyle of convenience food and sedentary activities contributes to obesity in their communities. Minorities also discussed the need to address depression. The relationship between depression and obesity has been confirmed by recent UDOH research.⁵ Pacific Islanders stated that many people of Pacific Island background consider large body sizes to be attractive and that traditional island social traditions of eating large meals continue in Utah with processed foods substituted for the fish, fruits and vegetables typical of island meals. Hispanics/Latinos were more concerned about the cost of healthy food, lack of knowledge about nutrition, and the difficulty of physical activity during cold weather.

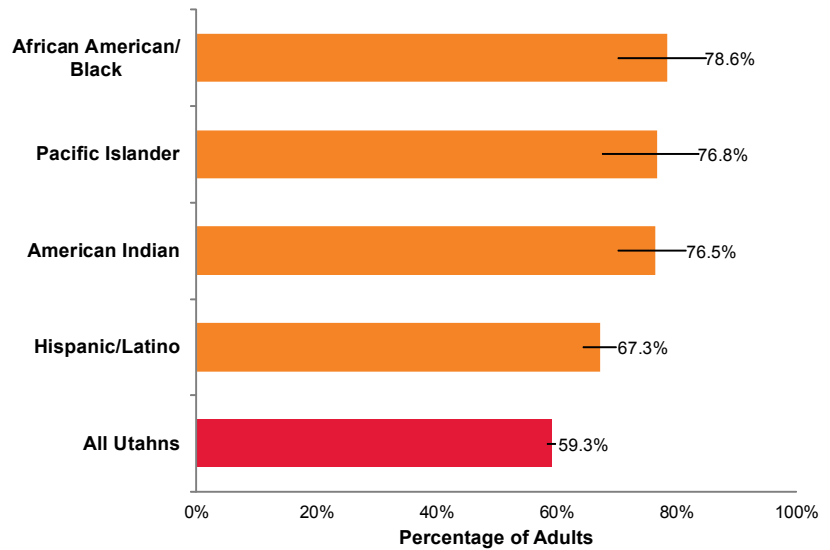
Most of the geographic areas with high overweight rates were located in urban areas (Figure 3).⁴ As OHD expands its mission to address geographic disparities as well as racial/ethnic disparities, it will investigate why certain areas have more health problems than others.

References

1. Utah Vital Records, Birth-Death Linked Infant Mortality, birth cohort, 2005-2008
2. <http://health.utah.gov/disparities/data/healthstatus.pdf>
3. <http://health.utah.gov/disparities/data/2008CountyMinorityEstimates.pdf>
4. Utah Behavioral Risk Factor Surveillance System, 2006-2010
5. <http://health.utah.gov/opha/publications/brfss/Depression/Depression.html>

Overweight or Obese by Race/Ethnicity

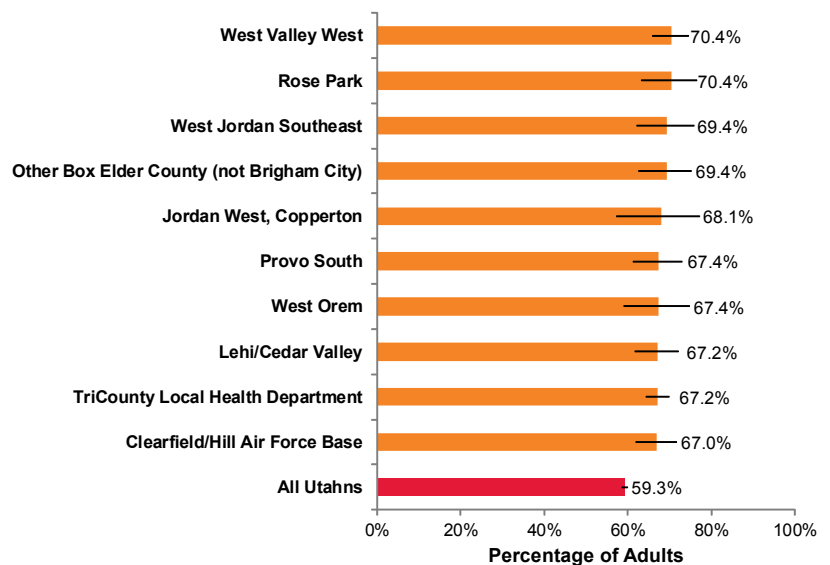
Figure 2. Age-adjusted percentage of adults overweight or obese by race/ethnicity, Utah, 2006-2010 (disparately affected groups only)



Overweight or obese is defined as a Body Mass Index ≥ 25
Source: Utah Behavioral Risk Factor Surveillance System, 2006-2010

Overweight or Obese by Small Area

Figure 3. Age-adjusted percentage of adults overweight or obese by small area, Utah, 2006-2010 (disparately affected groups only)



Overweight or obese is defined as a Body Mass Index ≥ 25
Source: Utah Behavioral Risk Factor Surveillance System, 2006-2010

August 2011 Utah Health Status Update

For additional information about this topic, contact April Young Bennett, MPA, Office of Health Disparities Reduction, Utah Department of Health, Salt Lake City, UT, (801) 703-0127, email: aybennett@utah.gov, or visit <http://health.utah.gov/disparities/>; or the Office of Public Health Assessment, Utah Department of Health, Box 142101, Salt Lake City, UT 84114-2101, (801) 538-9191, email: chdata@utah.gov

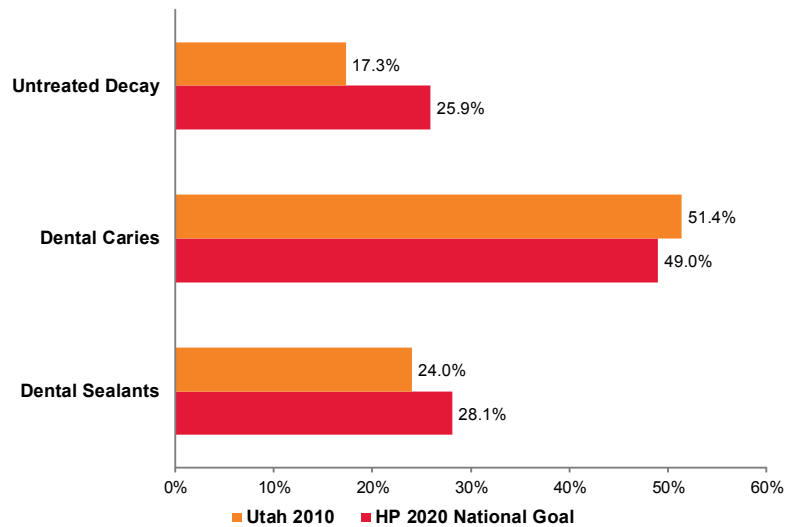
Breaking News, August 2011

Oral Health Status Among Utah Children

Dental decay is the most common chronic disease affecting children in the U.S. In order to assess the oral health status among Utah children, the Oral Health Program (OHP) within the Utah Department of Health conducted a statewide dental survey in the fall of 2010. More than 3,000 children in grades one through three from 25 public elementary schools throughout the state were screened. The survey collected information on caries history, untreated decay, treatment needs, sealant utilization and access to dental care. This report presents the key findings from the survey for children six through nine years of age (n=3,025).

Overall, close to one in five children (17.3%) had untreated caries (active unfilled cavities). More than half of children between six and nine years of age (51.4%) had experienced caries (active tooth decay or fillings in primary or permanent teeth). This rate is slightly higher than the Healthy People 2020 objective of 49% indicating progress is needed to reach the national goal. Dental sealants are very effective in preventing caries, yet 24.0% of Utah children had dental sealants. Tooth decay is a preventable disease. The OHP promotes dental decay prevention methods such as fluorides, sealants, and early childhood caries intervention and water fluoridation.

Oral Health of Utah Children vs. Healthy People 2020 National Goals, Utah, 2010

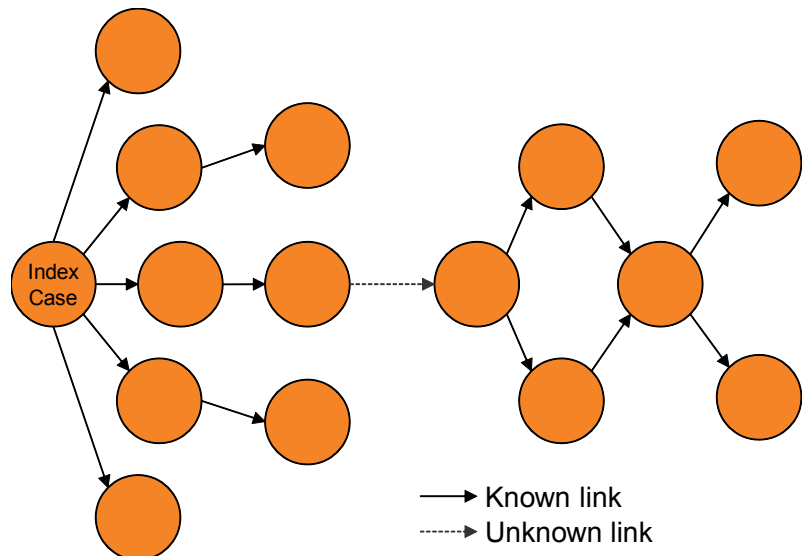


Community Health Indicators Spotlight, August 2011

2011 Measles Outbreak Reinforces Importance of Early Reporting and Vaccination

Measles (Rubeola) is an extremely contagious, acute viral illness that can lead to life-threatening complications and death. Measles is characterized by a two to four day prodromal period (eg. cough, fever) and closely followed by a maculopapular rash that spreads from head to foot. Two doses of Measles, Mumps, and Rubella (MMR) vaccine provide 99.7% effectiveness in preventing measles and are routinely recommended for children. Although measles is no longer endemic in the United States due to vaccination, imported cases have been reappearing. Since April 2011, Utah has had a total of 15 confirmed cases. The index case of this outbreak was unvaccinated and known to have recently traveled to a country with current measles activity. The outbreak began in Salt Lake County, but then at least two generations of cases went undiagnosed prior to the reemergence in Cache and Millard Counties. Airborne transmission occurred through close contact with infectious persons with exposure ranging from five minutes to several days. Two cases had documented receipt of two MMR doses. Major public health actions included excluding individuals without documented immunity from work and school and contact investigations in 11 counties. Measles is an immediately reportable disease in Utah.

2011 Transmission of Measles



Monthly Health Indicators Report

(Data Through June 2011)

Monthly Report of Notifiable Diseases, June 2011	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	40	47	192	166	1.2
Shiga toxin-producing Escherichia coli (E. coli)	7	14	28	33	0.9
Hepatitis A (infectious hepatitis)	0	1	3	5	0.6
Hepatitis B, acute infections (serum hepatitis)	0	2	1	7	0.1
Meningococcal Disease	0	1	7	4	1.9
Pertussis (Whooping Cough)	10	25	224	201	1.1
Salmonellosis (Salmonella)	32	32	150	152	1.0
Shigellosis (Shigella)	6	3	28	17	1.7
Varicella (Chickenpox)	7	12	205	422	0.5
West Nile (Human cases)	0	1	0	1	0.0
Quarterly Report of Notifiable Diseases, 2nd Qtr 2011	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV/AIDS†	6	34	28	122	0.2
Chlamydia	1,687	1,443	3,405	2,946	1.2
Gonorrhea	66	146	119	297	0.4
Tuberculosis	11	9	23	17	1.4
Medicaid Expenditures (in Millions) for the Month of June 2011	Current Month	Expected/Budgeted‡ for Month	Fiscal YTD	Budgeted‡ Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 12.4	\$ 13.1	\$ 151.2	\$ 157.4	\$ (6.2)
Inpatient Hospital	\$ 21.4	\$ 28.8	\$ 318.5	\$ 346.0	\$ (27.5)
Outpatient Hospital	\$ 10.6	\$ 8.9	\$ 100.8	\$ 107.3	\$ (6.5)
Long Term Care	\$ 17.8	\$ 13.5	\$ 155.8	\$ 161.9	\$ (6.2)
Pharmacy§	\$ 16.5	\$ 14.4	\$ 171.4	\$ 173.3	\$ (1.9)
Physician/Osteo Services	\$ 9.0	\$ 8.2	\$ 95.6	\$ 98.7	\$ (3.1)
TOTAL HCF MEDICAID	\$ 189.0	\$ 156.8	\$ 1,780.4	\$ 1,881.5	\$ (101.1)

Program Enrollment for the Month of June 2011	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	244,470	241,455	+1.2%	221,954	+10.1%
PCN (Primary Care Network)	16,780	17,323	-3.1%	14,946	+12.3%
CHIP (Children's Health Ins. Plan)	37,700	37,425	+0.7%	42,068	-10.4%
Health Care System Measures	Annual Visits			Annual Charges	
Number of Events	Rate per 100 Population	% Change¶ From Previous Year	Total Charges in Millions	% Change¶ From Previous Year	
Overall Hospitalizations (2009)	276,924	9.3%	-2.6%	\$ 5,116.1	+8.8%
Non-maternity Hospitalizations (2009)	166,045	5.4%	-0.7%	\$ 4,298.2	+9.5%
Emergency Department Encounters (2009)	684,176	23.3%	-1.1%	\$ 1,081.4	+22.9%
Outpatient Surgery (2008)	299,958	10.4%	-1.0%	\$ 1,277.7	+15.2%
Annual Community Health Measures	Current Data Year	Number Affected	Percent/Rate	% Change¶ From Previous Year	State Rank# (1 is best)
Obesity (Adults 18+)	2010	454,700	23.1%	-4.0%	11 (2010)
Cigarette Smoking (Adults 18+)	2010	180,100	9.1%	-6.9%	1 (2010)
Influenza Immunization (Adults 65+)	2010	175,900	68.2%	-0.8%	23 (2010)
Health Insurance Coverage (Uninsured)	2010	301,900	10.6%	-5.6%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2009	227	8.1 / 100,000	-16.6%	15 (2007)
Poisoning Deaths	2009	543	19.4 / 100,000	+7.0%	49 (2007)
Suicide Deaths	2009	445	15.9 / 100,000	+15.3%	n/a
Diabetes Prevalence (Adults 18+)	2010	128,000	6.5%	+0.2%	15 (2010)
Poor Mental Health (Adults 18+)	2010	296,100	15.0%	+6.8%	17 (2010)
Coronary Heart Disease Deaths	2009	1,469	52.5 / 100,000	-4.4%	1 (2007)
All Cancer Deaths	2009	2,543	90.8 / 100,000	+1.1%	1 (2007)
Stroke Deaths	2009	734	26.2 / 100,000	-2.2%	14 (2007)
Births to Adolescents (Ages 15-17)	2009	992	16.5 / 1,000	-10.6%	19 (2008)
Early Prenatal Care	2009	38,562	71.6%	-9.6%	n/a
Infant Mortality	2009	285	5.3 / 1,000	+11.4%	4 (2007)
Childhood Immunization (4:3:1:3:3:1)	2009	41,500	76.6%	+4.1%	16 (2009)

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ Budget has been revised to include supplemental funding from 2011 General Session.

§ Only includes the gross pharmacy costs. Pharmacy Rebate and Pharmacy Part-D amounts are excluded from this line item.

¶ % Change could be due to random variation.

State rank based on age-adjusted rates.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for influenza virus has ended until the 2011-2012 season.