



Utah health status update

Key findings

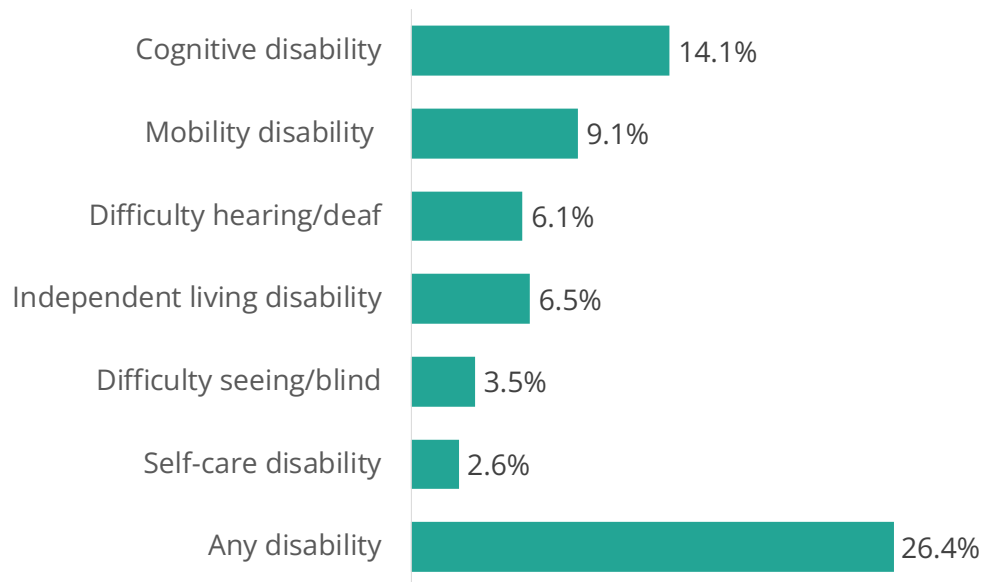
- One in every 4 Utah adults (26.4%) has a disability. This equates to more than 647,000 Utah adults.
- Adults with disabilities are more likely to report food insecurity, activity limitations due to health, and experiencing harm in a relationship.
- Chronic health conditions and poor health outcomes are significantly more common among adults with disabilities.
- People with disabilities report significant barriers to access and receive healthcare.
- The DHHS Disability and Health Program collaborates with the Utah Health Policy Project to offer free help to Utah adults with disabilities to navigate their healthcare needs.

Health disparities and barriers to health among people with disabilities

One in every 4 Utah adults (26.4%) has a disability (figure 1).¹ This equates to more than 647,000 Utah adults. Disability is common and many people with disabilities continue to have unmet needs. Poor social factors (also referred to as social determinants of health) disproportionately affect people with disabilities, and can contribute to poor health outcomes.² These and unmet needs among people with disabilities produce barriers to living a full, healthy life.

Disability prevalence in Utah by functional type, 2022

Figure 1. Cognitive disabilities and mobility limitations are the most common types of disability in Utah.



Source: Behavioral Risk Factor Surveillance System, Utah Department of Health and Human Services

A higher percentage of Utah adults with disabilities report unhealthy behaviors, including physical inactivity and smoking than Utah adults without disabilities (figure 2).³ In addition, adults with disabilities

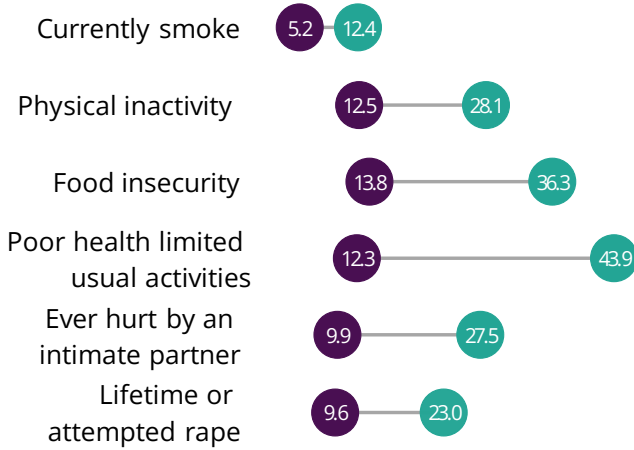




Feature article continued

Percentage of Utahns who report unhealthy behaviors and events by disability status, 2022

Figure 2. A higher percentage of Utah adults with disabilities engage in unhealthy behaviors and report traumatic experiences than adults without disabilities.



Source: Behavioral Risk Factor Surveillance System, Utah Department of Health and Human Services

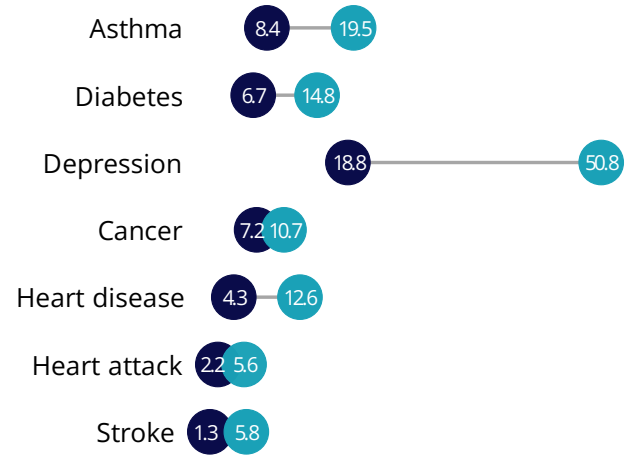
are also more likely to report food insecurity, activity limitations due to health, and experiencing harm in a relationship.

Additionally, chronic health conditions and poor health outcomes are significantly more common among adults with disabilities (figure 3).⁴ For example, people with disabilities are more likely to have asthma, cancer, diabetes, depression, heart disease, and are more likely to experience heart attacks and strokes than people without disabilities.

People with disabilities report significant barriers to access and receive healthcare (figure 4).⁵ Adults with disabilities are less likely to have healthcare coverage and more likely to report cost as a barrier to receiving care. Further, adults with disabilities are more likely to be kept from appointments due to lack of transportation and to experience discrimination while receiving healthcare. These and other barriers affect the access to and use of

Percentage of Utahns who report chronic conditions and poor health outcomes by disability status, 2022

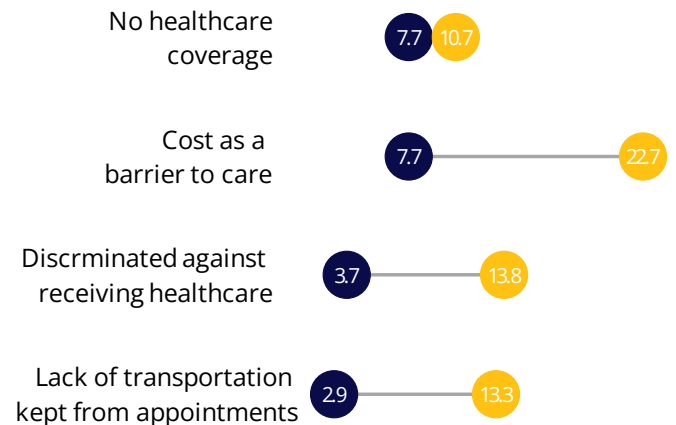
Figure 3. Utah adults with disabilities are significantly more likely to be affected by chronic health conditions and to report poor health outcomes than adults without disabilities.



Source: Behavioral Risk Factor Surveillance System, Utah Department of Health and Human Services

Percentage of Utahns who report barriers to healthcare by disability status, 2022

Figure 4. Utah adults with disabilities are more likely to report barriers to access and use healthcare than adults without disabilities.



Source: Behavioral Risk Factor Surveillance System, Utah Department of Health and Human Services



Feature article continued

preventive healthcare, as well as overall health status and outcomes.

The Disability and Health Program (DHP) is working with statewide partners to continue to identify and address barriers to accessing healthcare services among people with disabilities. DHP is currently collaborating with the Utah Health Policy Project on a project designed to offer free help to Utah adults with disabilities to navigate their healthcare needs. They are specifically working to connect participants to healthcare services and health promotion programs to help improve their health. To participate or if you know someone who has disabilities with unmet healthcare needs, fill out a [Utah Health Policy Project Referral form](#).

1. Utah Department of Health and Human Services. Utah Behavioral Risk Factor Surveillance System (BRFSS) configuration selection. IBIS. <https://ibis.health.utah.gov/ibisph-view/query/selection/brfss/BRFSSSelection.html>

2. Krahn, G. H., Walker, D. K., & Correa-De-Araujo R. (2015). Persons with disabilities as an unrecognized health disparity population. *AJPH*, 105, S198-S206.



An innovative approach to measure health disparities in Utah

Key findings

- Calculating disparity ratios adds value to health disparities analysis. It helps identify where the magnitude of health disparities and health differences are greatest.
- Racial and ethnic minority populations in Utah often bear a disproportionate burden of health disparities.
- Poverty and/or child poverty was 1 of the top 3 disparities for all racial/ethnic minority populations.
- Tuberculosis had the largest disparity ratio of any indicator (10.0 for the Asian/Asian American population and 10.3 for the Black/African American population).

Twenty Years of Health Data for Communities in Utah is a set of reports released by the Utah Department of Health and Human Services (DHHS) Office of Health Equity (OHE) that provide 2 decades of data on health trends and health disparities in communities in Utah, grouped by race and ethnicity. In these reports, OHE uses an innovative methodology to analyze health disparities in Utah, introducing the use of disparity ratios. These reports bring attention to not only the potential and ongoing health disparities among Utah's populations, but also to the magnitude of those disparities. This supports the crucial evidence-based decision-making needed in public health to take action where it is most needed. This aligns with the vision of DHHS for all Utahns to have fair and equitable opportunities to live safe and healthy lives.

Twenty Years of Health Data for Communities in Utah is unique for compiling longitudinal data across 20 years for each of 6 racial and ethnic populations residing in Utah: American Indian/Alaska Native, Asian/Asian American, Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, and White, non-Hispanic. The reports draw on data collected from 1997 to 2020, previously published in 4 editions of the *Utah Health Status by Race and Ethnicity* reports, also published by OHE. *Twenty Years of Health Data for Communities in Utah* analyzes health disparities, disparity ratios, health disparity gaps, and health trends over time for 46 health and public health indicators and compares the health status of each of the six racial and ethnic populations to Utah overall.

One dimension that adds value to health disparity interpretation in the analyses provided in these reports is the prevalence ratio between a population of interest (any of the 6 racial and ethnic populations) and the Utah population overall, referred to as a disparity ratio or difference ratio. A disparity/difference ratio greater than 1.0 indicates the measure for the population of interest is worse than that of Utah overall. A disparity/difference ratio equal to 1.0 indicates the measure for the population of interest is the same as that of Utah overall. A disparity/difference ratio less than 1.0 indicates the measure for the population of interest is better than the Utah population overall. This analysis was used to determine the magnitude of disparities and differences between a population of interest and Utah overall, to better understand where disparities and differences were greatest.



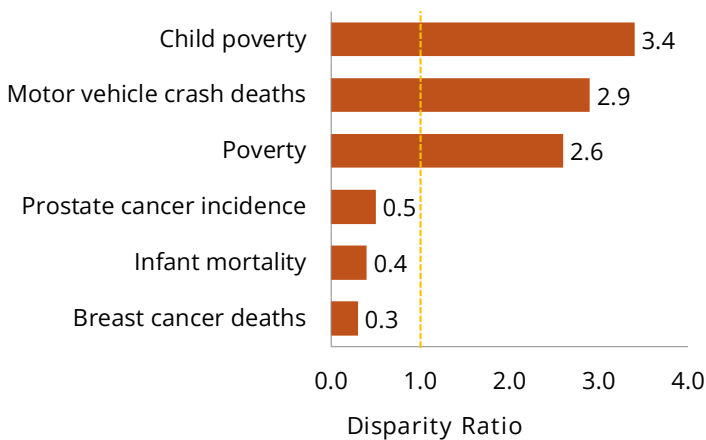


The figures below highlight indicators with the largest and smallest disparity/difference ratios for each of the 6 racial and ethnic populations compared to Utah overall. A dotted line where the disparity/difference ratio is equal to 1 indicates where the health status of the population of interest is equivalent to Utah overall. Indicators that measure higher than, or to the right of this line, indicate areas of health disparities or adverse health differences, where the population of interest is worse off than the Utah population overall. Indicators that measure lower than, or to the left of the dotted line, indicate areas of no health disparities or no adverse health differences, where the population of interest is doing better than Utah overall.

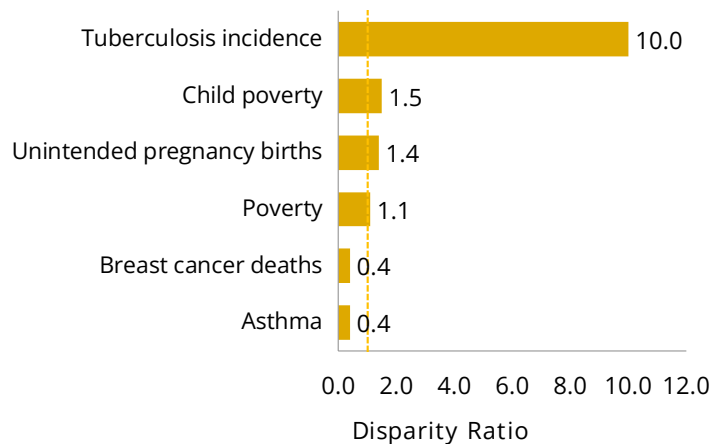
The information in these figures is derived from data reported in 2021 and capture a snapshot in time. Note that the scale of each chart is reflective of the data that is specific to each group, and therefore the scale of each chart is different. In these figures, only those indicators with statistically significant differences are shown.

Indicators with largest and smallest disparity/difference ratios compared to Utah overall

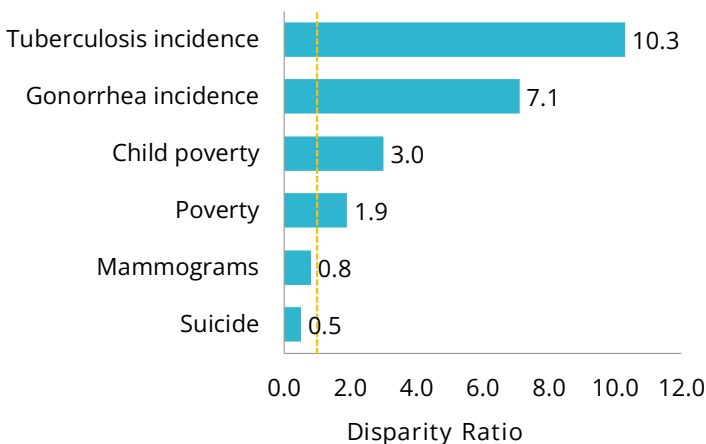
for American Indian/Alaska Native populations in Utah



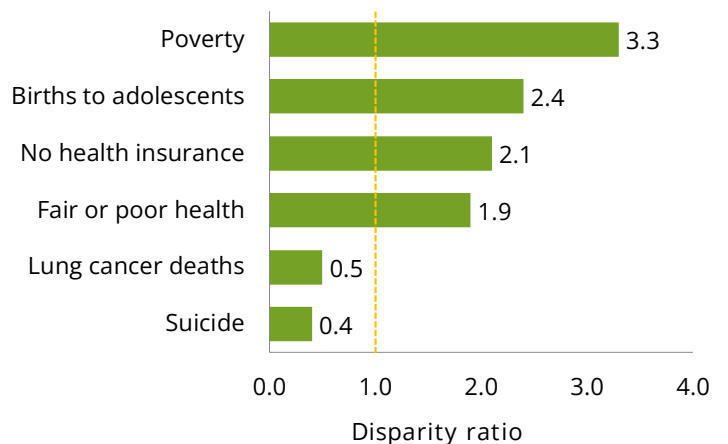
for Asian/Asian American populations in Utah



for Black/African American populations in Utah



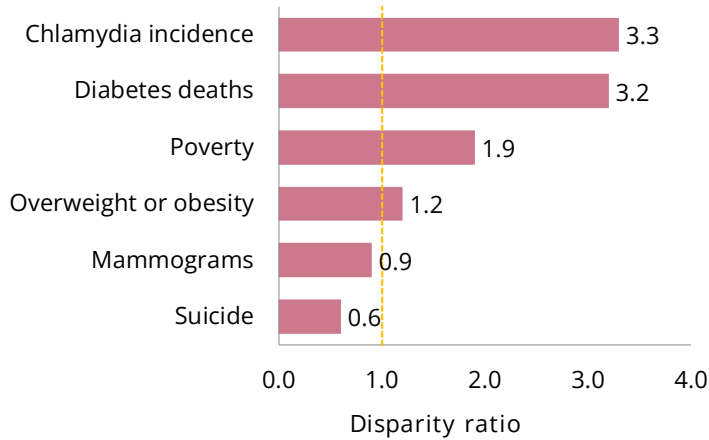
for Hispanic/Latino populations in Utah



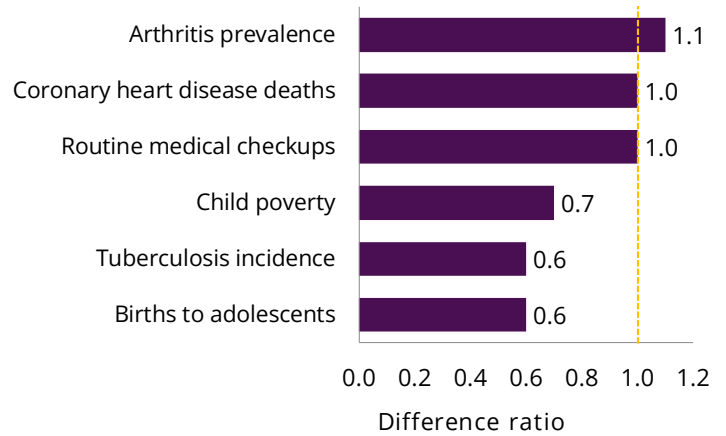


Indicators with largest and smallest disparity/difference ratios compared to Utah overall (continued)

for Native Hawaiian/Pacific Islander populations in Utah



for White, non-Hispanic populations in Utah



Source: Office of Health Equity (2023). Twenty years of health data for communities in Utah. Salt Lake City, UT: Utah Department of Health and Human Services

Disparity/difference ratios help to improve understanding of the many health disparities and potential health disparities identified in *Twenty Years of Health Data for Communities in Utah*. Health disparities are more than differences in health outcomes. Health disparities adversely affect groups of people who have experienced greater obstacles to healthcare based on economic, socio-cultural, environmental, and geographic disadvantage. Racial and ethnic minority populations in Utah often experience poorer health outcomes compared with the Utah population overall.¹

The health disparities described in these reports warrant further investigation, and further study is needed to understand the factors and drivers contributing to these disparities. These reports support DHHS to plan, implement, and evaluate data-informed efforts to close health disparity gaps and improve health outcomes for all people living in Utah.²

The *Twenty Years of Health Data for Communities in Utah* reports and the *Utah Health Status by Race and Ethnicity* reports can be found at the DHHS Office of Health Equity website at healthequity.utah.gov/data-and-reports.

1. Office of Health Disparities (2021). *Utah Health Status by Race and Ethnicity 2021*. Salt Lake City, UT: Utah Department of Health. <https://ibis.health.utah.gov/ibisph-view/query/selection/brfss/BRFSSselection.html>

2. Utah Department of Health and Human Services. (2022). *Performance Measures for the Utah Department of Health and Human Services*.



Utah Walkability Action Institute

Approximately 30% of adult Utahns engage in active transportation which means they walk when they go to/from work, when they run errands, or simply when they move from place to place. Urban planning and public health professions both recognize the health benefits of mobility as it relates to how people move from one place to another in their communities. The Utah Department of Health and Human Services (DHHS), as part of an agreement with the Centers for Disease Control and Prevention (CDC), works closely with Utah's local health departments to support communities as they seek to provide safe and accessible walkable and bikeable routes to everyday destinations. Nationally and in Utah, more people are looking to active transportation for daily errands as well as to get to and from work and school. To address the growing demand, Utah's public health system gives a public health perspective for planning efforts.

Utah DHHS worked with the National Association of Chronic Disease Directors (NACDD) to conduct a hybrid version of their Walkability Action Institute. This course engages representatives from public health, transportation, planning, elected officials, and education agencies to develop action plans to implement policy, system, and environmental changes in their communities. Utah DHHS, Utah Department of Transportation (UDOT), and teams representing Weber/Morgan, Utah County, Salt Lake County, Central Utah, and Summit local health departments and their communities received training and ongoing consultation over the course of a year. Utah piloted a hybrid model of in-person instruction followed by regular virtual interactions that improved the format of the course to include work progress and updates from within the participants' communities.

Cross-sector collaboration is vital to increase population-wide physical activity through encouraging active transportation and community connections. Locations could be greatly enhanced through the creation of walking trails and other improvements in parks, shopping centers, or community centers. After all, the mutual goals are the same: healthy people who can live, work, and play in supportive and safe environments.



Monthly health indicators

Monthly report of notifiable diseases, November 2023	Current month # cases	Current month # expected cases (5-yr average)	# cases YTD	# expected cases YTD (5-yr average)	YTD standard morbidity Ratio (obs/exp)
COVID-19 (SARS-CoV-2)	Weekly updates at https://coronavirus.utah.gov/case-counts/				
Campylobacteriosis (<i>Campylobacter</i>)	56	39	791	525	1.5
Hepatitis A (infectious hepatitis)	0	3	7	59	0.1
Hepatitis B, acute infections (serum hepatitis)	0	1	10	25	0.4
Influenza	Weekly updates at https://epi.utah.gov/influenza-reports/				
Meningococcal disease	1	0	3	2	1.7
Pertussis (whooping cough)	5	16	198	216	0.9
Salmonellosis (<i>Salmonella</i>)	66	26	473	331	1.4
Shiga toxin-producing <i>Escherichia coli</i> (<i>E. coli</i>)	16	14	279	201	1.4
Shigellosis (<i>Shigella</i>)	14	5	169	60	2.8
Varicella (chickenpox)	24	13	127	112	1.1
West Nile (human cases)	2	0	8	26	0.3
Quarterly report of notifiable diseases, 3rd quarter 2023	Current quarter # cases	Current quarter # expected cases (5-yr average)	# cases YTD	# expected cases YTD (5-yr average)	YTD standard morbidity ratio (obs/exp)
Chlamydia	2,842	2,802	8,319	8,185	1.0
Gonorrhea	649	839	1,998	2,305	0.9
HIV/AIDS*	43	43	122	105	1.2
Syphilis	79	50	249	129	1.9
Tuberculosis	9	6	26	17	1.5
Medicaid expenditures (in millions) for the month of July 2023†	Current month	Expected/ budgeted for month	Fiscal YTD	Budgeted fiscal YTD	Variance over (under) budget
Mental health services	\$ 16.2	\$ 16.5	\$ 206.8	\$ 250.5	\$ (43.8)
Inpatient hospital services	30.2	31.4	217.2	318.3	(101.1)
Outpatient hospital services	4.0	4.9	42.9	39.6	3.3
Nursing home services	27.6	37.4	386.3	421.0	(34.7)
Pharmacy services	(6.1)	3.7	172.8	172.6	227.0
Physician/osteo services‡	4.9	4.9	88.1	87.3	767.4
Medicaid expansion services	49.3	58.2	1,158.1	1,132.7	25.4
Total Medicaid§	126.2	157.2	2,272.2	2,422.0	(149.8)

Note: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations.

* Diagnosed HIV infections, regardless of AIDS diagnosis.

† This SFY 2023 report includes supplemental payments to better match the SFY 2023 Medicaid Forecast Budget which costs have not been included in previous years.

‡ Medicaid payments reported under physician/osteo Services do not include enhanced physician payments.

§ The Total Medicaid program costs do not include costs for the PRISM project.



Monthly health indicators

Program enrollment for the month of August 2023	Current month	Previous month	% change from previous month	1 year ago	% change from 1 year ago
Medicaid	433,368	455,458	-4.9%	478,651	-9.5%
CHIP (Children’s Health Insurance Plan)	7,278	7,175	+1.4%	6,473	+12.4%
Commercial insurance payments#	Current data year	Number of members	Total payments	Payments per member per month (PMPM)	% change** from previous year
Medical	2022	12,035,192	\$ 4,057,120,087	\$ 337.10	+3.6%
Pharmacy	2022	11,211,332	1,048,715,815	93.54	+9.5%
Dental	2022	8,688,828	229,619,441	26.43	-7.4%
Annual community health measures	Current data year	Number affected	Percent/rate	% change from previous year	State rank†† (1 is best)
Obesity (adults 18+)	2022	762,300	31.1%	+0.6%	16 (2022)
Child obesity (grade school children)	2018	38,100	10.6%	0.0%	n/a
Cigarette smoking (adults 18+)	2022	164,200	6.7%	-6.9%	1 (2022)
Vaping, current use (adolescents)	2023	19,300	6.0%	-23.1%	n/a
Binge drinking (adults 18+)	2022	313,700	12.8%	+9.4%	1 (2022)
Influenza immunization (adults 65+)	2022	273,700	66.5%	-4.9%	34 (2022)
Health insurance coverage (uninsured)	2021	248,800	7.4%	-14.0%	n/a
Motor vehicle traffic crash injury deaths	2022	310	9.1 / 100,000	-8.0%	12 (2021)
Drug overdose deaths involving opioids	2022	435	12.8 / 100,000	-5.1%	11 (2021)
Suicide deaths	2022	717	21.1 / 100,000	+9.5%	38 (2021)
Unintentional fall deaths	2022	457	13.4 / 100,000	+10.8%	38 (2021)
Traumatic brain injury deaths	2022	701	20.6 / 100,000	-0.5%	24 (2021)
Arthritis prevalence (adults 18+)	2022	551,500	22.5%	+7.7%	17 (2022)
Asthma prevalence (adults 18+)	2022	269,600	11.0%	+13.4%	32 (2022)
Diabetes prevalence (adults 18+)	2022	213,200	8.7%	+8.7%	15 (2022)
High blood pressure (adults 18+)	2021	638,700	26.7%	+3.5%	11 (2021)
Poor mental health (adults 18+)	2022	622,500	25.4%	+0.8%	32 (2022)
Coronary heart disease deaths	2022	1,863	54.7 / 100,000	-2.0%	7 (2021)
All cancer deaths	2022	3,500	102.8 / 100,000	-1.5%	1 (2021)
Stroke deaths	2022	958	28.1 / 100,000	+10.2%	11 (2021)
Births to adolescents (ages 15-17)	2022	257	3.0 / 1,000	-10.8%	11 (2021)
Early prenatal care	2022	33,326	72.8%	-5.5%	n/a
Infant mortality	2022	226	4.9 / 1,000	+5.3%	23 (2020)
Complete immunization by age 2‡‡	2022	36,800	78.3%	+5.0%	4 (2022)

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

Figures subject to revision as new data is processed.

** Percent change is due to changes in membership as well as changes in data suppliers included.

†† State rank in the United States based on age-adjusted rates where applicable.

‡‡ Childhood 7-series (4:3:1:3:3:1:4) data from 2021 NIS is for children aged 24 months (birth year 2019).