Utah health status update

Key findings

- Approximately 170,000 Utah adults are at risk for serious health problems due to cigarette smoking.

- Healthcare providers are instrumental in promoting quit attempts and linking people to quit resources. The Tobacco Prevention and Control Program's Way to Quit site offers evidence-based tobacco cessation recommendations for providers.

- Even though quitting at a younger age reduces the risk of dying from a smoking-related disease the most, younger Utahns were less likely to receive quit advice or resources from providers compared to older adults.

- Utahns without health insurance and non-White, non-Hispanic Utahns were less likely to receive recommendations for quit medications.

Trends in Utah healthcare provider assistance for quitting cigarette smoking, 2015–2022

Background information

Quitting cigarette smoking greatly reduces the risk for a large number of adverse health effects, including cardiovascular diseases, chronic obstructive pulmonary disease, various forms of cancer, and reproductive health outcomes.[1] Approximately 170,000 Utah adults reported that they smoked cigarettes every day or some days in 2022. A large number of Utahns who currently smoked cigarettes (70%) stated their intention to quit within the next year and 55.3% reported they stopped smoking for one day or longer during the past 12 months because they were trying to quit.[2] However, overcoming nicotine addiction is extremely difficult. For many people who are addicted to nicotine, quitting cigarette smoking involves multiple years and sometimes more than 20 quit attempts (depending on the metrics used) to achieve smoking abstinence that lasts for more than one year.[1]

Healthcare providers can play a key role in supporting smoking cessation by not only encouraging quitting, but also offering brief counseling, prescribing medications, connecting to additional resources such as tobacco quitlines, and offering continued support to prevent relapse. People who smoke cigarettes are 13 times more likely to enroll in treatment (counseling and medications) when they are directly connected to a service such as a quitline through a provider referral, as opposed to being encouraged to call on their own.[3] A combination of counseling and medication during quit attempts has been shown to triple the chances of quitting for good.[4]

Trends

From 2015 to 2020, nearly three-quarters of Utahns who smoked cigarettes and saw a healthcare provider in the past 12 months, reported that a healthcare provider advised them to quit. In 2021, tobacco cessation advice from healthcare providers decreased to 58.3%, possibly due to competing priorities and staffing shortages

during the COVID-19 pandemic. In 2022, healthcare provider advice to quit smoking remained low at 61.6%. The percentage of people who smoked cigarettes and reported that a healthcare provider recommended or discussed medications (such as nicotine gum, patch, nasal spray, inhaler, lozenge, or prescription medication such as Wellbutrin/Zyban/Bupropion) to assist with quitting increased from 36.0% in 2015 to more than half (51.0%) in 2019. Provider recommendations for quit medications started to decline in 2020 and remained low at 38.1% in 2022.

The percentage of people who smoked cigarettes and reported that a healthcare provider discussed or recommended a smoking cessation class or program, a telephone quitline, or one-on-one counseling increased from 24.5% in 2015 to 35.9% in 2018. It declined to an all-time low of 1 in 5 (20.7%) in 2021. In 2022, 22.9% of people who smoked cigarettes reported that their healthcare provider discussed or recommended a quit program with them in the past 12 months (Figure 1).

Percentage of Utah adults who smoked cigarettes and received assistance with quitting from a healthcare provider during the past year, 2015–2022 (age-adjusted)
Figure 1. Smoking cessation advice and recommendations for quit medications and quit programs from healthcare providers decreased in 2020 and 2021.
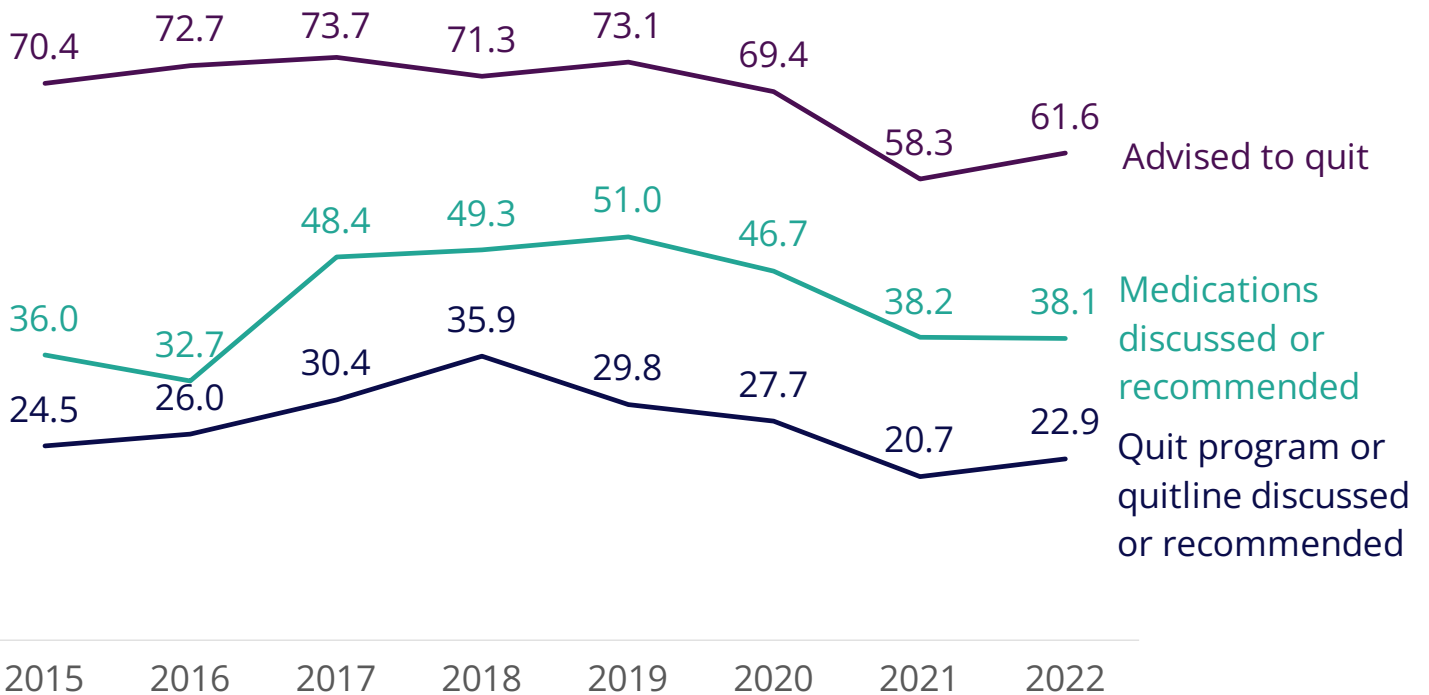
Source: Utah Behavioral Risk Factor Sruveillance System

Disparities
Age is linked to gaps in quit attempts and quit assistance. Among Utahns who smoke cigarettes, younger adults (aged 18–34) are more likely to report a quit attempt in the past year (62.9%) than adults aged 35+ (54.7%).[2] Past-year quit attempts decrease as people age. Although quitting smoking at any age is beneficial, quitting before the age of 35 to 44 years reduces the risk of dying from a smoking-related disease the
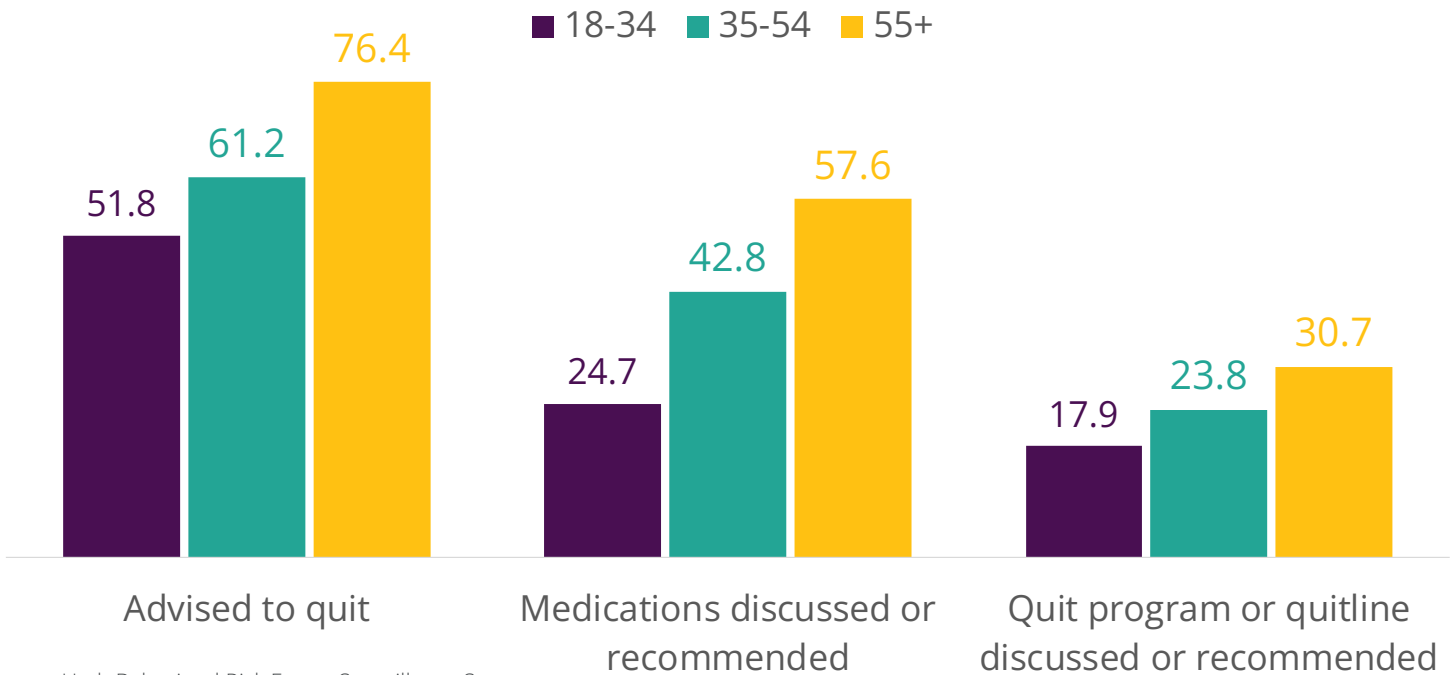
most.[1] Utahns aged 18 to 34 are less likely than older adults to report that they received advice to quit and recommendations for quit medications or quit programs from their healthcare providers (Figure 2).

Percentage of Utah adults who smoked cigarettes and received assistance with quitting from a healthcare provider during the past year by age group, 2020–2022 (combined data)
Figure 2. Utahns aged 18 to 34 are less likely than older adults to report that they received advice to quit, medication recommendations, or referrals to quit programs or quitlines from their healthcare providers.

Legend: 18-34, 35-54, 55+

- Advised to quit: 51.8 (18-34), 61.2 (35-54), 76.4 (55+)
- Medications discussed or recommended: 24.7 (18-34), 42.8 (35-54), 57.6 (55+)
- Quit program or quitline discussed or recommended: 17.9 (18-34), 23.8 (35-54), 30.7 (55+)

Source: Utah Behavioral Risk Factor Surveillance System

Predatory tobacco industry marketing, higher density of tobacco retail outlets, heavier patterns of cigarette smoking, and earlier initiation are linked to greater challenges with quitting. They are also linked to a higher incidence of lung cancer and other tobacco-related diseases among certain population groups defined by educational attainment, poverty status, health insurance status, race/ethnicity, sexual orientation, gender identity, and geography.[1] In some instances, Utah population groups with a higher risk for cigarette smoking were less likely to report receiving quit assistance from their healthcare provider.

Compared to the state average, Utahns who smoked cigarettes and had **no health insurance** and Utahns who smoked cigarettes and identified as **non-White, non-Hispanic** were less likely to receive recommendations for quit medications from their healthcare providers (Figure 3).

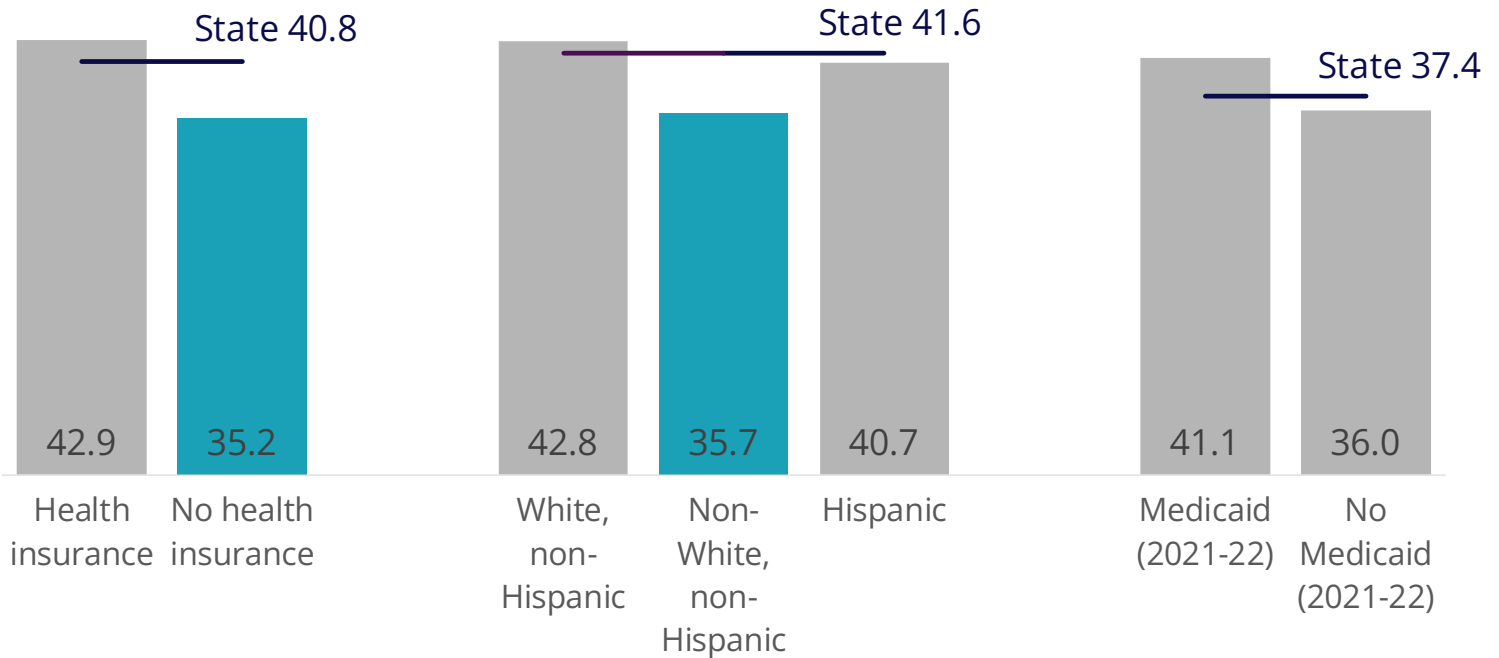In addition, Utahns who smoked cigarettes and identified as **non-White, non-Hispanic** were less likely to report that their healthcare providers discussed or recommended a quit program or quitline (Figure 4). Those who listed **Medicaid** as their health insurance were more likely to report that their healthcare provider discussed or recommended a quit program or quitline than the state average (Figure 4).

Feature article continued

Percentage of Utah adults who smoked cigarettes and received recommendations for quit medications from a healthcare provider during the past year by Medicaid status, race/ethnicity, and insurance status, 2020–2022 (combined data)
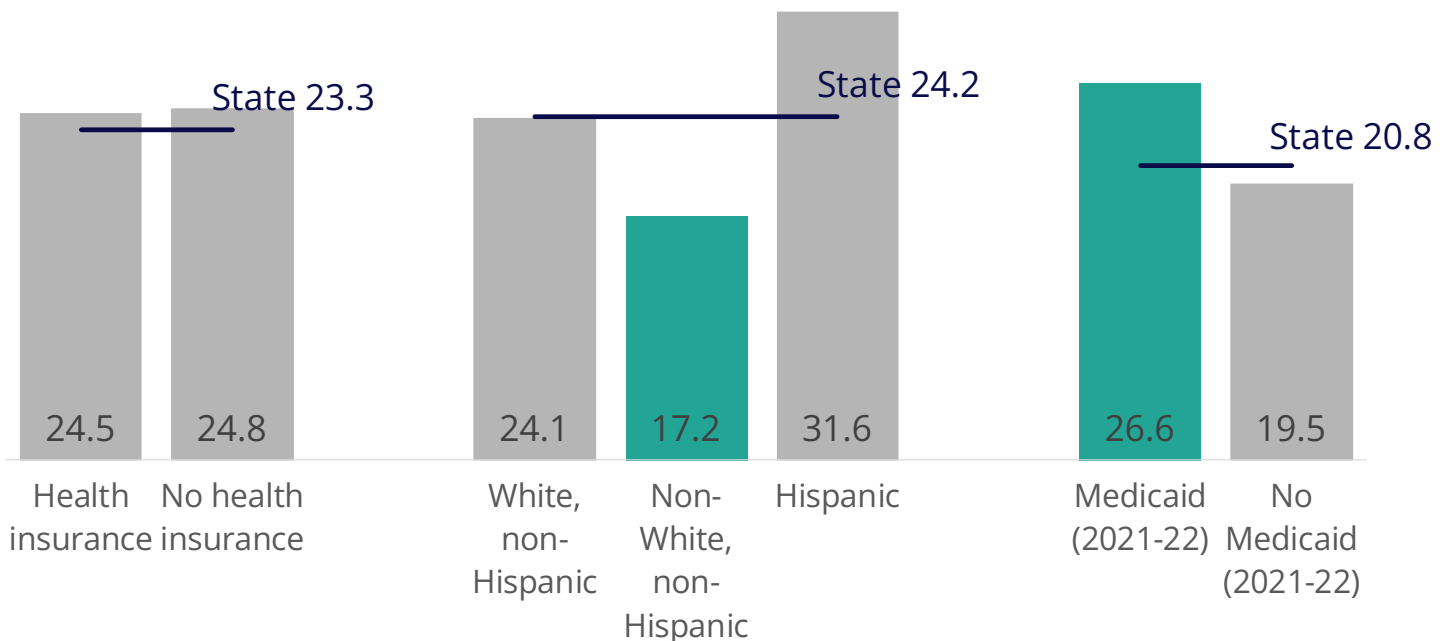
Figure 3. Utahns with no health insurance and those who identified as non-White, non-Hispanic were **statistically significantly less likely** to receive recommendations for quit medications from their healthcare provider compared to the state average.

State 40.8   State 41.6   State 37.4

Health insurance	No health insurance	White, non-Hispanic	Non-White, non-Hispanic	Hispanic	Medicaid (2021-22)	No Medicaid (2021-22)
42.9	35.2	42.8	35.7	40.7	41.1	36.0

Source: Utah Behavioral Risk Factor Surveillance System

Percentage of Utah adults who smoked cigarettes and received a recommendation for a quitline or quit program from a healthcare provider during the past year by Medicaid status, race/ethnicity, and insurance status, 2020–2022 (combined data)

Figure 4. Utahns who identified as non-White, non-Hispanic were **statistically significantly** less likely, and those reporting Medicaid as their health insurance were **statistically significantly** more likely, to report that their healthcare provider recommended a quitline or quit program compared to the state average.

State 23.3   State 24.2   State 20.8

Health insurance	No health insurance	White, non-Hispanic	Non-White, non-Hispanic	Hispanic	Medicaid (2021-22)	No Medicaid (2021-22)
24.5	24.8	24.1	17.2	31.6	26.6	19.5

Source: Utah Behavioral Risk Factor Surveillance System

Resources for healthcare providers

Healthcare providers are instrumental in promoting quit attempts and increasing the chances of successful quitting.[5] The Utah Department of Health and Human Services (DHHS) Tobacco Prevention and Control Program (TPCP) has developed numerous resources to assist healthcare providers with offering quit advice to their patients. These resources can be accessed on the TPCP's Way to Quit site: For Healthcare Providers. The site includes information on patient education, learning modules, referrals, medication and dosage, billing and reimbursements, and cost and coverage.

Additional resources include:
- a handout that describes Ask. Advise. Connect, an evidence-based process for assisting people who use tobacco products with quitting
- a chart that lists the FDA-Approved Medications for Smoking Cessation
- a poster that explains Ask. Advise. Connect - Teen Vaping, a process for youth vape cessation
- a Quitline Fact Sheet for Healthcare Professionals that lists the free phone, online, text, email, and quit medication services available through the Utah Tobacco Quitline (1-800-QUIT-NOW for services in English and 1-855-DEJELO-YA for services in Spanish)

The Utah Behavioral Health Assessment & Master Plan includes specific recommendations for offering tobacco cessation treatment in behavioral health settings ranging from screening, counseling, referrals, and quit medications to the benefits of tobacco-free campus policies.

1. U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.

2. Utah Department of Health and Human Services. Behavioral Risk Factor Surveillance System (BRFSS). Salt Lake City: Utah Department of Health and Human Services, Division of Data, Systems, and Evaluation. Note: quit attempt percentages are listed for combined years 2019–22.

3. Vidrinem J., Shete S., Cao, Y., et al. Ask-AdviseConnect: A New Approach to Smoking Treatment Delivery in Health Care Settings. JAMA Intern Med. 2013; 173(6): 458–464.

4. Kotz D, Brown J, West R. Prospective cohort study of the effectiveness of smoking cessation treatments used in the "real world". Mayo Clin Proc. 2014 Oct;89(10):1360–7.

5. Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: Public Health Service, US Dept of Health and Human Services; 2008.

Spotlights

Utah Department of
Health & Human
Services

2024

J U N E   2 0 2 4

K-12 schools and early childhood education centers HEPA air purifier program

The Utah Department of Health and Human Services (DHHS) implemented a program to improve indoor air quality, funded by CDC to reduce the spread of COVID-19, flu, RSV, and other infectious diseases, in K–12 schools. High quality air filters effectively clean the air in rooms full of people, without inconveniencing them or needing them to do anything. This is especially helpful for busy teachers and children of all ages. DHHS contracted with Utah Physicians for a Healthy Environment (UPHE) to coordinate the program, and Medify and Grainger to supply the product. This effort aligns with the Environmental Protection Agency's strategies to ensure a healthy indoor environment in schools. Air purification positively impacts a wide range of health experiences, from asthma to seasonal respiratory viruses.[1] The program was expanded to include early childhood education centers (ECECs) partway through the project.

This program provided HEPA air purifiers and replacement filters to K–12 schools and ECECs across Utah. From April 2022 to October 2023, the 3 partners contacted schools and ECECs, took orders, and delivered air purifiers and filters. They took 2,111 orders (930 from schools, 1,256 from ECECs) and placed 31,377 purifiers (25,959 in schools and 5,418 in ECECs). Additionally, Weber-Morgan, Murray, and Davis County School Districts distributed air purifiers and filters in their own districts.

Of the 41 school districts in Utah:
- 16 school districts ordered air purifiers and filters for all schools within their district
- 16 school districts ordered air purifiers and filters for some of the schools in their district
- 3 school districts did not participate
- 6 school districts did participate but clear data on level of participation is unavailable
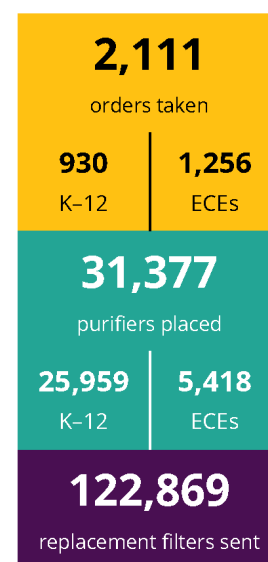
In total, 70% of K–12 schools and 61% of state-licensed early childhood education centers received air purifiers and filters from UPHE.[2] An additional 3 school districts provided purifiers and filters to their own schools, bringing the statewide total of K-12 schools with purifiers to 75%.

The program ended in October 2023 when funding ended but we have continued community and administrative interest. It is important to consider future needs and investments. There are more schools and ECECs that could benefit from better air filtration systems, and the purifiers we placed will need new air filters over time. This project shows how much need there is in the state and presents an opportunity for partners to work in this space.

Air purifiers placed April 2022–October 2023

70%
of K–12 schools

61%
of state-licensed early childhood education centers

2,111
orders taken

| **930** K–12 | **1,256** ECEs |

31,377
purifiers placed

| **25,959** K–12 | **5,418** ECEs |

122,869
replacement filters sent

1. https://www.epa.gov/coronavirus/healthy-indoor-environments-schools-during-covid-19-pandemic-and-beyond#:~:text=If%20possible%2C%20increase%20the%20level,according%20to%20the%20manufacturer's%20instructions.
2. DHHS/UPHE HEPA Portable Air Purifier Program for Utah Schools & Daycares Report 2023

Spotlights

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June 2024

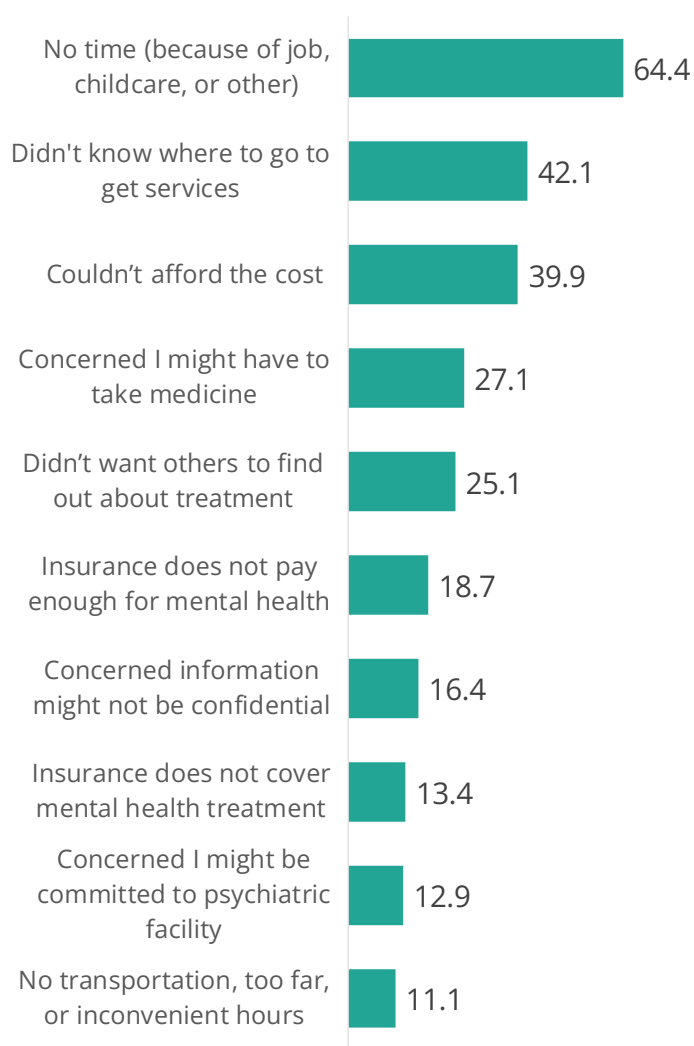## Barriers to postpartum mental health care: Utah, 2022 PRAMS data

Postpartum depression is estimated to affect 1 in 8 Utah women according to Pregnancy Risk Assessment Monitoring System (PRAMS) data. Additionally, 1 in 3 Utah women experience either depression during pregnancy, anxiety during pregnancy, or postpartum depression. Postpartum depression can severely limit a mother's ability to recover from childbirth and bond with their new baby [1]. In rare cases, severe postpartum mental health issues can cause symptoms of psychosis including hallucinations and delusions. While these disorders are treatable, many women face barriers to treatment. The PRAMS Social Determinants of Health supplement aims to identify these barriers.

PRAMS is a population-based survey designed to collect information on maternal experiences and behaviors prior to, during, and immediately following pregnancy among mothers who have recently given birth to a live infant. For 2022 births, a survey supplement titled "Social Determinants of Health" was included with the questionnaire, which included questions about mental health needs and access to services.

Among Utah respondents, 36% reported needing mental health services such as counseling, medications, or support groups to help with feelings of anxiety, depression, grief, or other issues after their new baby was born. Of those respondents, 33% said they were not able to get the services they needed. The most common barrier to services was a lack of time due to childcare, work, or other commitments (64%). Other common barriers included not knowing where to get services (42%), the cost of treatment (40%), concerns about medication (27%), and not wanting others to know they needed treatment (25%). The full list of barriers can be found in the accompanying figure.

The most common barriers to mental health services for postpartum women are issues of accessibility and lack of knowledge. Increasing awareness of the Utah Maternal Mental Health Referral Network (https://maternalmentalhealth.utah.gov/) may help remove these barriers. Families can locate nearby providers, filter by insurance type, and find providers that offer online services. Removing barriers related to stigma and shame by increasing awareness of maternal mental health issues should also be a priority. Additionally, DHHS and the Utah Women and Newborns Quality Collaborative (UWNQC) created a Maternal Mental Health Toolkit for providers with information on how to identify and treat perinatal mood and anxiety disorders. This toolkit can be found at https://mihp.utah.gov/mmhtoolkit.

Percentage of Utah women who were unable to get needed treatment reporting each reason as a barrier to getting treatment for postpartum mental health services, 2022

Barrier	Percentage
No time (because of job, childcare, or other)	64.4
Didn't know where to go to get services	42.1
Couldn't afford the cost	39.9
Concerned I might have to take medicine	27.1
Didn't want others to find out about treatment	25.1
Insurance does not pay enough for mental health	18.7
Concerned information might not be confidential	16.4
Insurance does not cover mental health treatment	13.4
Concerned I might be committed to psychiatric facility	12.9
No transportation, too far, or inconvenient hours	11.1

Source: 2022 Utah Pregnancy Risk Assessment Monitoring System

1. Mughal S, Azhar Y, Siddiqui W. Postpartum Depression. [Updated 2022 Oct 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519070/

Monthly health indicators

Monthly report of notifiable diseases, May 2024	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 *(Campylobacter)*	49	52	259	208	1.2
Hepatitis A (infectious hepatitis)	0	2	2	7	0.3
Hepatitis B, acute infections (serum hepatitis)	1	2	4	7	0.5
Influenza	Weekly updates at https://epi.utah.gov/influenza-reports/				
Meningococcal disease	1	0	1	1	1.3
Pertussis (whooping cough)	5	24	55	84	0.7
Salmonellosis *(Salmonella)*	31	31	162	119	1.4
Shiga toxin-producing *Escherichia coli (E. coli)*	8	18	72	66	1.1
Shigellosis *(Shigella)*	7	6	51	32	1.6
Varicella (chickenpox)	7	9	58	49	1.2
West Nile (human cases)	0	0	0	0	0.0

Quarterly report of notifiable diseases, 1st quarter 2024	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	2,612	2,763	2,612	2,763	0.9
Gonorrhea	472	735	472	735	0.6
HIV/AIDS*	53	32	53	32	1.6
Syphilis	62	47	62	47	1.3
Tuberculosis	12	6	12	6	2.0

Medicaid expenditures (in millions) for the month of May 2024	Current month	Expected/ budgeted for month	Fiscal YTD	Budgeted fiscal YTD	Variance over (under) budget
Mental health services	$ 20.5	$ 18.5	$ 233.4	$ 280.8	$ (47.4)
Inpatient/outpatient hospital services	12.2	18.7	255.5	290.9	(35.4)
Nursing home services	31.9	36.8	311.0	327.8	(16.8)
Pharmacy services	13.2	13.1	127.7	154.0	(26.2)
Physician/osteo services‡	8.3	8.8	84.0	88.1	(4.1)
Medicaid expansion services	32.7	33.6	535.3	592.6	(57.3)
Total Medicaid§	120.6	132.1	1,613.8	1,881.0	(267.2)

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

Monthly health indicators

Utah Department of Health & Human Services

Program enrollment for the month of May 2024	Current month	Previous month	% change‖ from previous month	1 year ago	% change‖ from 1 year ago
Medicaid	235,883	239,535	-1.5%	357,368	-34.0%
CHIP (Children's Health Insurance Plan)	5,593	5,615	-0.4%	3,014	+85.6%

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%	8 (2022)
Drug overdose deaths involving opioids	2022	435	12.8 / 100,000	-5.1%	7 (2022)
Suicide deaths	2022	717	21.1 / 100,000	+9.5%	45 (2022)
Unintentional fall deaths	2022	457	13.4 / 100,000	+10.8%	7 (2022)
Traumatic brain injury deaths	2022	701	20.6 / 100,000	-0.5%	27 (2022)
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%	5 (2022)
All cancer deaths	2022	3,500	102.8 / 100,000	-1.5%	1 (2022)
Stroke deaths	2022	958	28.1 / 100,000	+10.2%	18 (2022)
Births to adolescents (ages 15–17)	2022	257	3.0 / 1,000	-10.8%	6 (2022)
Early prenatal care	2022	33,326	72.8%	-5.5%	n/a
Infant mortality	2022	226	4.9 / 1,000	+5.3%	11 (2021)
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 2022 NIS for children aged 24 months (birth year 2020).