UTAH DEPARTMENT OF HEALTH

Utah Health Status Update:

Health Disparities by Utah State Legislative District

Special Edition 9 *(August 2019)*

In January 2019, per the request of Utah state legislators, the Utah Department of Health (UDOH) Office of Health Disparities (OHD) released the *Health Disparities by Utah State Legislative District* report. The report was the first of its kind in Utah and uniquely demonstrated not all districts experience health in the same way.

Health disparities are widely misunderstood

A primary role of the report was to clarify that health disparities are more than differences in health outcomes. Although all health disparities are poor health outcomes, not all poor health outcomes are health disparities. A "disparity" implies the difference is avoidable, unfair, and unjust. Health disparities are closely linked to economic, socio-cultural, environmental, and geographic disadvantages.

KEY FINDINGS

- **A "disparity" implies the difference is avoidable, unfair, and unjust. Health disparities are closely linked to economic, socio-cultural, environmental, and geographic disadvantages.**
- **76% of Senate districts and 57% of House districts experienced some type of health disparity.**
- **One in three Senate districts and one in four House districts experienced health disparities in six or more of the 10 indicators.**
- **Health disparities were most prevalent in life expectancy at birth (72% of Senate districts and 52% of House districts).**
- **Almost half (45%) of Senate districts and one-third (28–33%) of House districts experienced health disparities in health care coverage, adults reporting current smoking, and adult obesity.**
- **Approximately one in four Senate and House districts (17–34%) experienced health disparities in drug poisoning deaths, poor or fair general health, suicide, poor mental health, diabetes, and infant mortality.**
- **Data illuminating health disparities can empower elected officials to make informed decisions which improve the health of constituents in their districts, with a particular focus on tailoring efforts for vulnerable and underserved communities.**

Measuring health disparities

The UDOH developed exclusive data resources optimal for identifying and measuring health disparities. The newly revised 99 Utah Small Areas group similar communities providing a geographic picture of health and community within legislative districts. The recently developed Utah Health Improvement Index (HII) measures a combination of economic and social conditions that determine health.

The 99 Utah Small Areas were categorized into five HII groups: very low, low, average, high, and very high. A higher HII indicated a greater need to improve the conditions that determine health. Thus, a health disparity exists if a Utah Small Area with a poor health outcome compared with Utah overall has a high or very high HII.

Health disparities in Utah districts

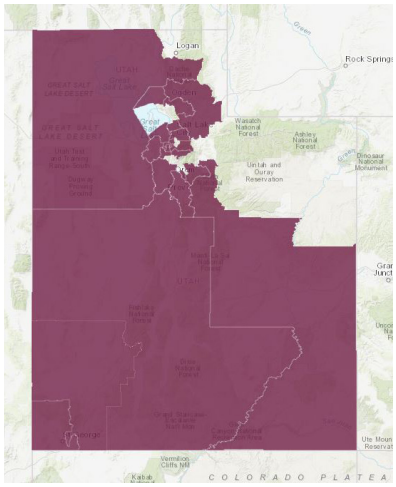
The OHD created individual profiles for the 29 Senate districts and 75 House districts in Utah. Each district profile included information on the Utah Small Areas within that district, the HII group, the percentage of racial/ethnic minorities living in the area, and 10 health indicators linked to the Utah Health Improvement Plan. Most importantly, the profiles highlighted when health disparities existed. Woven together, this information provided a picture of the status of health disparities in each state legislative district and across Utah communities.

The profiles showed 76% of Senate districts and 57% of House districts were experiencing some type of health disparity (Figure 1). This means the

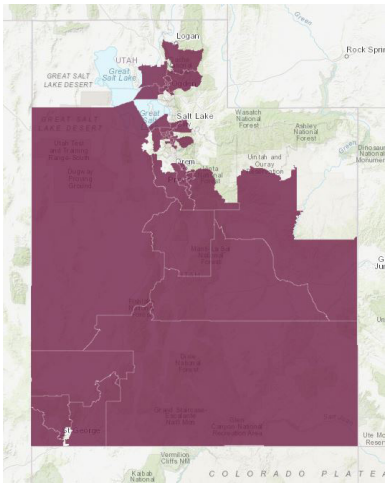
Health Disparities by Legislative District

Figure 1. Most legislative distircts experienced health disparities (76% of Senate districts and 57% of House districts).

Senate Districts



House Districts



district an individual lives in or a neighboring district is likely experiencing a health disparity.

Furthermore, one in three Senate districts and one in four House districts experienced health disparities in six or more of the 10 indicators (Figure 2). This shows that some districts shouldered a high burden of health disparities, which span general health, health care coverage, chronic disease, and mental health.

In Utah districts, health disparities were most prevalent in life expectancy at birth (72% of Senate districts and 52% of House districts). This means in the majority of districts there were constituents whose opportunity to live a long life may be more than six years shorter than Utahns overall.

Almost half (45%) of Senate districts and one-third (28–33%) of House districts experienced health disparities in health care coverage, adults reporting current smoking, and adult obesity. Approximately one in four Senate and House districts (17–34%) experienced health disparities in drug poisoning deaths, poor or fair general health, suicide, poor mental health, diabetes, and infant mortality (Figure 3).

Noticeably, many state legislative districts in Utah experienced gaps in opportunities for their constituents to live long, healthy, quality lives.

Elevating health equity in Utah

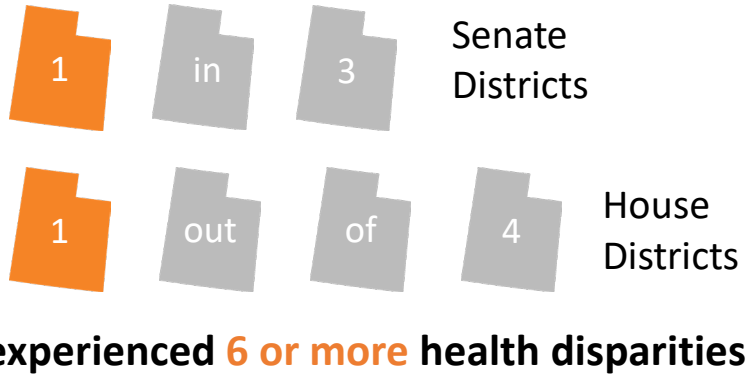
While reporting health status by geographic area such as state, county, ZIP Code, or census block is common, using state legislative districts as the geographic unit of analysis is unique and advantageous to addressing health disparities.

Health disparities are perpetuated by imbalances in the amount of money, power, and resources that people have, all of which is influenced by policy. Data illuminating health disparities can empower elected officials to make informed decisions which improve the health status of constituents in their districts, with a particular focus on tailoring efforts for vulnerable and underserved communities.

These types of community and population-level approaches work toward achieving health equity or helping all Utahns reach their highest health potential. In order for the people of Utah to be among the healthiest state in the country, health disparities must be addressed.

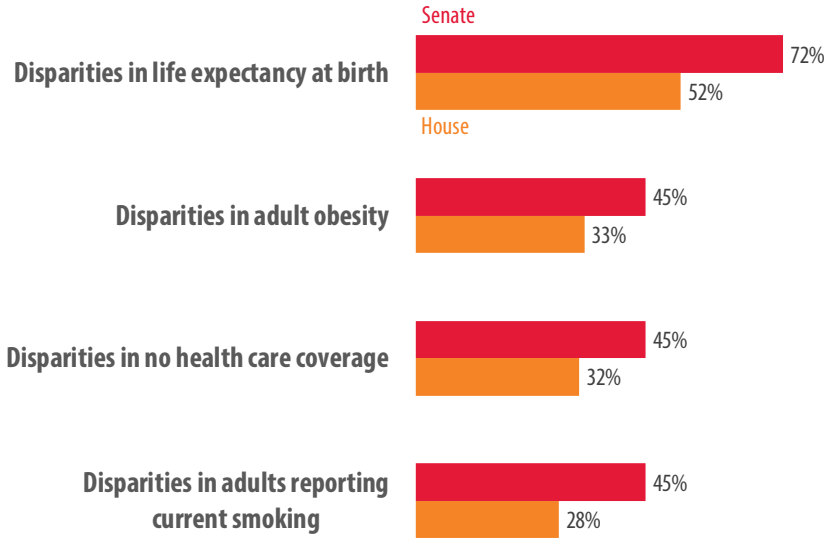
Burden of Disparities Among Districts

Figure 2. Some districts shouldered a high burden of health disparities.



Gaps in Opportunities

Figure 3. Senate and House districts in Utah experienced gaps in opportunities for their constituents to live long, healthy, quality lives.



The full report may be accessed at http://health.utah.gov/disparities/data/ohd/HealthDisparitiesbyUtahStateLegislativeDistrict2019.pdf.

For additional information about this topic, contact Brittney Okada, 385-315-0220, bokada@utah.gov; or the Utah Department of Health Center for Health Data and Informatics, 801-538-9191, chdata@utah.gov.

Community Health Workers Can Help Lower Healthcare Costs

Community health workers (CHWs) are frontline public health workers who serve as a bridge between patients, healthcare providers, and social service providers. They offer a wide variety of services and health information in a linguistically and culturally appropriate manner and are able to extend the reach and quality of healthcare services to improve health outcomes. Their ability to build trust within their communities, understand the needs of their communities, and offer culturally responsive education and support allows them to assist with all barriers to health, including the social determinants of health.

CHWs are gaining attention nationwide for their unique role in healthcare. CHW interventions have been shown to improve outcomes for patients with chronic conditions, enhance disease prevention, reduce 30-day hospital readmissions, improve mental health, promote positive lifestyle behavior change, increase linkages to primary care, decrease hospital costs, and increase patient and provider satisfaction. Addressing these factors ultimately reduces the burden on the healthcare system and healthcare professionals.

Estimated savings from national CHW interventions range from $1.81 to $5.58 for every $1.00 spent. Another study estimated an expected savings of 7.1 percent in the third year of implementing a CHW program within a health system. CHWs can help the state reach its healthcare goals and the Triple Aim (improved health, improved care, and reduced costs); however, they are still underutilized in Utah. Members of the Utah Department of Health CHW Coalition are working to build awareness and infrastructure to support the work of CHWs, as well as conduct a Utah-specific return on investment of CHWs in a variety of settings.

For more information about CHWs, contact Tessa Acker at tacker@utah.gov.

Figure 1. **Benefits of CHWs Integration Into Patient-centered Medical Homes**

Source: Integrating Community Health Workers into a Healthcare System. Massachusetts Association of Community Health Workers. https://machw.org/employers/integrating/

Opioid Epidemic, Medical Cannabis and Medicaid Expansion: Impacts to American Indian/Alaska Native communities in Utah

New funding from the State Opioid Response (SOR) grant, in partnership with the Utah Department of Human Services, provided the Utah Department of Health (UDOH) Office of American Indian/Alaska Native Health Affairs funds to acquire two new positions focused on addressing the opioid epidemic among American Indian/Alaska Native (AI/AN) populations in urban, rural, and frontier Utah. UDOH staff are focusing on several new opioid initiatives, including:

- Collaborating with the Inter Tribal Council of Arizona Tribal Epidemiology Center (TEC) and the Navajo TEC to host the first data sharing summit this fall. National data show that AI/AN have been particularly impacted by the opioid epidemic. Compared with other racial/ethnic groups, AI/AN populations have the largest increase in mortality rates due to drug and opioid-involved overdose mortality rates.[1] However accessing regional, state, or local data is difficult due to issues such as small sample sizes and misclassification of race. The data sharing summit will seek to address some of these gaps. The primary focus will be opioid data; however, other topics may include community issues associated with mental health, substance abuse, and addiction. The goal is to improve data sharing and reporting between tribes, the state, and the TECs.
- Holding trainings and discussion groups with tribal staff and community members. Training will focus on opioid use/abuse and naloxone. The discussions group will be an opportunity for participants to share their experiences, concerns, and identify potential gaps in access and treatment. The data gathered during these discussions will assist in the development of opioid prevention messaging specifically targeting the AI/AN communities throughout Utah.

In addition to the opioid work, staff are facilitating statewide formal Tribal Consultation meetings with the eight Tribal governments located in Utah to address the Utah Medical Cannabis Act and the current Utah Medicaid Waiver for Medicaid Expansion. These important meetings acknowledge tribal sovereignty through the 'government to government' relationship with the tribes. Tribal governments have the opportunity to voice concerns or support and provide feedback. The UDOH and the state have the opportunity to clarify state plans and rule development proposals which directly impact these governments and their communities.

For more information about any of these initiatives, contact Melissa Zito at mzito@utah.gov.

1. MMWR, December 21, 2018. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives—Washington, 1999–2015