



# Utah Health Status by **Race** *and* **Ethnicity** 2015



UTAH DEPARTMENT OF  
**HEALTH**

Office of Health Disparities



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**HEALTH**

Office of Health Disparities

# Health Status by Race & Ethnicity 2015

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The format of this report is based on previous Health Status by Race and Ethnicity Reports published in 2005 (by the UDOH Center for Health Data) and 2010 (by the UDOH Center for Multicultural Health). For previous editions of the Report, see <http://health.utah.gov/disparities/>. A special thanks to all those who contributed to the IBIS Indicator Reports for their contribution to this report.

Visit IBIS-PH at <http://ibis.health.utah.gov/>.

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## Introduction

*Utah Health Status by Race and Ethnicity 2015* presents information on “health disparities” as they impact racial and ethnic populations in Utah. A “health disparity” exists whenever the health status on a given measure in one or more racial/ethnic populations is found to be different from other groups.

The principal objective of the UDOH Office of Health Disparities (OHD) is to eliminate health disparities that disproportionately impact underserved, underrepresented, and vulnerable populations. This report is intended to serve as a guide for UDOH programs, public health professionals, medical providers, community members, and anyone who is interested in addressing health disparities, to assist in decision-making, planning, and implementation of evidence-based interventions and community-based participatory research.

## The 2015 Report Versus the 2010 Report

This report closely follows the format and content of *Utah Health Status by Race and Ethnicity: 2010*, with a few exceptions. Since 2010, more disaggregated data sources have become available and we are pleased to present additional racial and ethnic data that were not available in 2010 (including routine dental care, down syndrome, adolescent obesity, and e-cigarette usage). A few of the measures that were included in the 2010 report are not reported in 2015 because the disaggregated data by race and ethnicity is either unavailable or unreliable. For example, the Utah Healthcare Access Survey discontinued the collection of data on emergency department point of access to medical care in 2008. As a result, that has been omitted from this report. Other indicators included in 2010 but excluded in 2015 due to unavailable or inadequate data were knowledge of stroke symptoms, knowledge of heart attack symptoms, breastfeeding 2-6 months, and postpartum depression.

## Factors Affecting Health Disparities

In addition to health indicators, demographic information and health care access indicators are included in this report. Demographic factors - such as age and poverty - and health care accessibility factors (such as health insurance coverage and having a primary care provider) are known to affect overall health.<sup>1</sup> Studies suggest that cultural issues, linguistic barriers, geographic location, racism, and other factors also contribute to racial and ethnic disparities.<sup>2</sup> It is not the intention of this report to identify all of the reasons for the disparities described here. However, the OHD seeks to elevate the consciousness of racial and ethnic health disparities in order to stimulate meaningful discourse, enhance existing programming, and facilitate future interventions and collaborations to address these disparities.

## Report Format

On each page, the text element, “*Why is it important?*” includes a short paragraph that describes the public health relevance of the measure. “*How are we doing?*” describes the state’s overall results and notable racial or ethnic disparities. This section may also include information about how Utah compares to the U.S., data trends, and more specific details about data results. “*How can we improve?*” offers a short health message that may be a health guideline, prevention advice, and/or referral to a support resources.

UDOH acknowledges and appreciates that federal, tribal, and local governments; private, non-profit, and community-based organizations; and individuals are also working to address these health problems. The scope and resources appropriated to this project would not be adequate to catalog all of these important efforts; this report focuses on the UDOH.

# INTRODUCTION

**Report Format (cont.)** For each health indicator, a bar graph depicts the calculated measure for all Utahns and for selected racial and ethnic populations. Because these graphs often compare groups with different age distributions, age-adjusted rates are listed whenever appropriate.

Each bar in this graph includes a narrow line that depicts the 95% confidence interval for that bar (or 90% if indicated). For each indicator, a data table contains information used to compute rates, such as age-adjusted values, sample populations, or 95% confidence intervals for the crude and age-adjusted rates. Where applicable, the righthand column of each table contains arrows indicating whenever a rate was significantly higher (upward arrow) or lower (downward arrow) than the statewide rate. A statistically significant difference was defined as, “The age-adjusted state rate does not fall within with the age-adjusted 95% confidence interval of the rate for the racial/ethnic population.” This is consistent with the standard used in the 2005 and 2010 Health Status by Race and Ethnicity reports.

## **Race and Ethnicity Categories**

Significant diversity exists within each of the race and ethnicity categories used in this report and it is acknowledged that the use of such broad categories will, at times, obfuscate health disparities among smaller subgroups. Whenever possible, five race categories were used (along with Hispanic origin or ethnicity), in accordance with the federal Office of Management and Budget categories utilized by the US Census Bureau.<sup>3</sup> Abbreviations for race and ethnicity are as follows: *Am. Indian* (American Indian), *AK Native* (Alaska Native), *African Am.* (African American), *N. Hawaiian* (Native Hawaiian), *Pac. Islander* (Pacific Islander). Data from American Indian/Alaska Native populations are included in this report, with acknowledgment that self-identified American Indians/Alaska Natives may or may not be registered members of federally recognized tribal jurisdictions.

Some data have “unknown” race information included in calculations and will not sum to totals.

## Data Notes

The report utilizes various data sources, all of which have different strengths and weaknesses. For example, the Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey that does not include data from individuals who do not have a telephone or who were unable to respond to the survey in a non-English language.

The reader should also be cautious when comparing this report to the 2005 and 2010 editions in order to identify long-term trends or shifts in health status. Not all data sources are consistent across the 15-year span covered by the series of Health Status by Race and Ethnicity reports.

When data are disaggregated by race, data is often compiled from a series of years in order to obtain reliable estimates. Even then, some samples may not be high enough to yield statistically significant differences. These kinds of data insufficiencies are noted throughout this report with asterisks and footnotes.

Mortality rates are age-adjusted using three age groups (0-44, 45-64, 65+). Cancer incidence rates are age-adjusted using ten age groups (0-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85+).

The information presented in this report are derived from a variety of data sources and were requested directly from data stewards and program specialists at UDOH and other agencies. All data, tables, and graphs were verified for accuracy by the Office of Public Health Assessment. Public health datasets utilized to compile this report include birth certificates, death certificates, communicable disease surveillance, the Utah Cancer Registry, Utah Birth Defect Registry, and health surveys.

## Health Surveys

This report contains data derived from health surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS).

Utah Behavioral Risk Factor Surveillance System (BRFSS) datasets are age-adjusted to the U.S. 2000 standard population based on 3 age groups: 18-34, 35-49, and 50+ (unless otherwise noted).

The Utah Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, population-based, risk factor surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before, during, and after pregnancy, as well as the child's early infancy experience.

The sample for PRAMS is all mothers who are Utah residents who delivered a live-born infant within the state, including infants who die after delivery. Stillbirths, fetal deaths, and induced abortions are excluded from the PRAMS sample.

A stratified random sampling approach is used in selecting women to participate, to allow separate estimates of population subgroups and comparisons across these subgroups. Once a full year of data is collected, it is then weighted by the CDC to represent the birth population for that year and adjusted for sampling probabilities, non-response, and non-coverage.

For this report, the "Average Annual # of Women with Live Birth" category represents the proportion of women who answered specific survey questions during 2009-2011. The "Estimated Annual #" category represents an estimate of the number of women who reported the event. These numbers are weighted to represent the birth population for the year.

# METHODOLOGY

## **Census Bureau**

Demographic information and population counts derived from US Census Bureau (primarily from the American Community Survey or ACS) are noted throughout the report. The US Census Bureau annually releases unbridged population estimates for five-year age groups and race at the county level.

The estimates for years 2010 through 2013 on IBIS-Q for counties by race and ethnicity are the Vintage 2013 state and county resident population estimates by age, sex, race and Hispanic origin from the U.S. Census Bureau based on the 2010 census counts. They were released on June 26, 2014. They were included in IBIS-Q on September 14, 2013.

For more information go to: <http://www.census.gov/popest/methodology/2013-natstcopr-meth.pdf/>.

The estimates for years 2000-2009 are intercensal estimates of the resident population at the county level as of July 1, 2000-July 1, 2009. They are based on the 2000 and 2010 censuses. They were produced by modifying the 2000-2009 postcensal estimates to account for differences between the postcensal estimates for April 1, 2010 and 2010 Census counts. They were released by the U.S. Census in October 2012 and were included in IBIS-Q on November 30, 2012.

For more information go to: [http://www.census.gov/popest/methodology/2000-2010\\_Intercensal\\_Estimates\\_Methodology.pdf](http://www.census.gov/popest/methodology/2000-2010_Intercensal_Estimates_Methodology.pdf)



# Demographic Context



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# DEMOGRAPHIC CONTEXT

## Proportion of the Utah Population

### Why is it Important?

Our health system has developed based on the needs and perspectives of White-American Utahns. Utahns of other backgrounds often experience barriers to receiving adequate, affordable health care. Because of this and other social factors (e.g., proportion of workers in “blue collar” jobs without health benefits, lack of trust in the health care system, greater burden of poverty among many racial and ethnic groups), the health status of non-White ethnic groups is often poorer than that of All Utahns. Reducing race/ethnicity-based health disparities is an overarching goal of the U.S. Public Health Service’s Healthy People 2010 and 2020 initiatives.

### How are we doing?

Utah’s Black/African American, Asian, Native Hawaiian/Pacific Islander, and Hispanic/Latino populations are the fastest growing groups in the state. Since 2000, Utah’s non-Hispanic White population has decreased from 85% to 79.5%.<sup>4</sup> Roughly one out of every five Utahns belong to an ethnic or racial minority group other than White.

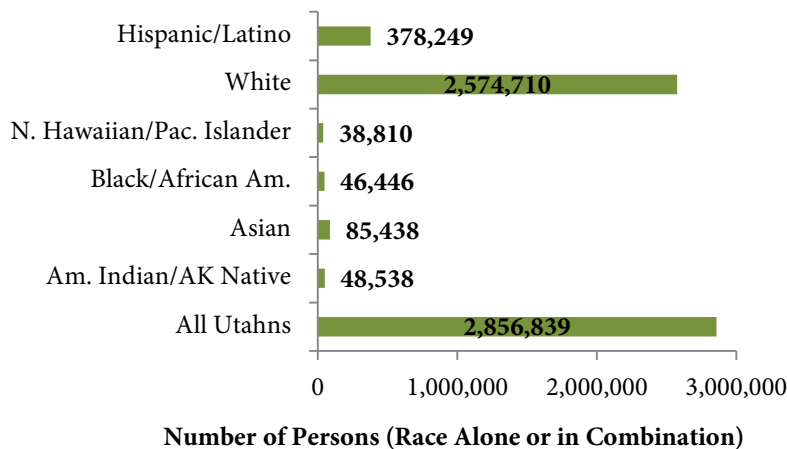
### How can we improve?

Utah should be a state that can provide adequate, accessible health care for all residents, regardless of race/ethnicity. The OHD encourages and assists health sector professionals to provide culturally and linguistically appropriate services and provides resources to help minorities achieve optimal health, such as the online Multilingual Library, Interpretation and Translation Toolkits, training videos, and CLAS (Culturally and Linguistically Appropriate Services) resources. These, and other reports and resources, are available at [www.health.utah.gov/disparities/](http://www.health.utah.gov/disparities/).

Race/Ethnicity	%	Average Annual Population	90% CI (Lower)	90% CI (Upper)
All Utahns		2,856,839	N/A	N/A
Am. Indian/ AK Native	1.7	48,538	47,073	50,003
Asian	3.0	85,438	84,553	86,323
Black/African Am.	1.6	46,446	44,906	47,986
N. Hawaiian/ Pac. Islander	1.4	38,810	37,584	40,036
White	90.1	2,574,710	2,568,426	2,580,994
Hispanic/Latino	13.2	378,249	N/A	N/A

US Census, ACS 2011-2013 3-Year Estimates, Table S0201.  
Groups are not mutually exclusive and will not sum to total.

### Utah Population, 2011-2013



The total Utah population estimates shown on this page are Census estimates for Race Alone or in Combination, in order to provide a broad snapshot of Utah’s growing diversity, including the many multiracial and multiethnic individuals who call Utah home. These estimates will be different than those found elsewhere in this report that are based on Census estimates of persons who identify as one race alone and not in combination.

Population estimates are for Race Alone or in Combination and are not mutually exclusive. Hispanic may be of any race.

# DEMOGRAPHIC CONTEXT

## Age Distribution

### Why is it important?

People's age, sex, culture, and living and working conditions affect their health in ways that must be considered in planning for the public health of the population. Having a large percentage of the population made up of young children emphasizes the importance of making available key preventive health measures (e.g. immunizations) and age-appropriate screenings to identify developmental delays at a time when treatment is most effective.

### How are we doing?

The proportion of young people, especially among Utah's ethnic minority communities, continues to grow. The proportion of aging and elderly people (55 – 75+ years) is highest among Whites.

The proportions of children (<5 to 17 years) among American Indians/Alaska Natives, Black/African Americans, Native Hawaiians/Pacific Islanders, and Hispanics/Latinos are higher than those for all Utahns.

### How can we improve?

It is especially important that services targeted to children and young people be culturally and linguistically appropriate because of the diversity of younger people in Utah. As these young people age, the statewide population continues to become more diverse. The OHD encourages and assists health sector professionals to provide culturally responsive services and resources to help minorities achieve optimal health, such as the online Multilingual Library, language assistance toolkits, training videos, and Culturally and Linguistically Appropriate Services) resources.

These, and other reports and resources, are available at [www.health.utah.gov/disparities/](http://www.health.utah.gov/disparities/).

Race/Ethnicity*	Median Age	90% CI (Lower)	90% CI (Upper)
All Utahns	29.6	29.5	29.7
Am. Indian/ AK Native	27.1	26.2	28
Asian	32.5	31.8	33.2
Black/African Am.	23.4	22.4	24.4
N. Hawaiian/ Pac. Islander	24.0	23.3	24.7
White	30.4	30.3	30.5
Hispanic/Latino	23.6	23.4	23.8

American Community Survey 2009-2013.

\*Race Alone. Hispanic may be of any race.

Race/Ethnicity*	<5 Years (%)	5-17 Yrs (%)	18-24 Yrs (%)	25-34 Yrs (%)	35-44 Yrs (%)	45-54 Yrs (%)	55-64 Yrs (%)	65-74 Yrs (%)	75+ Yrs (%)
All Utahns	9.2	22.0	11.5	15.7	12.4	10.9	9.0	5.2	4.1
Am. Indian/ AK Native	8.7	23.8	13.8	15.8	13.7	11.5	7.7	3.2	1.8
Asian	6.5	15.7	12.9	19.1	16.5	12.5	9.3	4.2	3.2
Black/African Am.	10.4	29.1	13.2	15.6	11.7	10.0	5.9	2.5	1.6
N. Hawaiian/ Pac. Islander	11.1	26.9	14.4	18.4	11.2	8.6	5.6	2.5	1.2
White	8.9	21.5	11.2	15.6	12.3	11.1	9.4	5.6	4.4
Hispanic/Latino	12.3	27.4	12.7	16.7	14.1	8.7	4.8	2.1	1.1

American Community Survey 2009-2013.

\*Race Alone (not two or more races). Hispanic may be of any race.

# DEMOGRAPHIC CONTEXT

## Life Expectancy at Birth

### Why is it important?

Life expectancy is a metric often used to gauge the overall health of a community. Life expectancy measures health status across all age groups. Shifts in life expectancy can be used to describe mortality trends. Being able to predict how populations will age has critical implications for the planning and provision of health services. Small increases in life expectancy translate into large increases in population. As life expectancy rises, so does prevalences of chronic disease because chronic health issues are more common among older persons.

### How are we doing?

In Utah, as in many other parts of the developed world, people are living longer than before. Life expectancy at birth for Utah males increased from 72.4 years in 1980 to 77.9 years in 2013, and for females from 78.6 to 81.7 years. In comparison, life expectancy at birth in the U.S. rose from 70.0 to 76.4 years for males, and from 77.4 to 81.2 years for females.

### How can we improve?

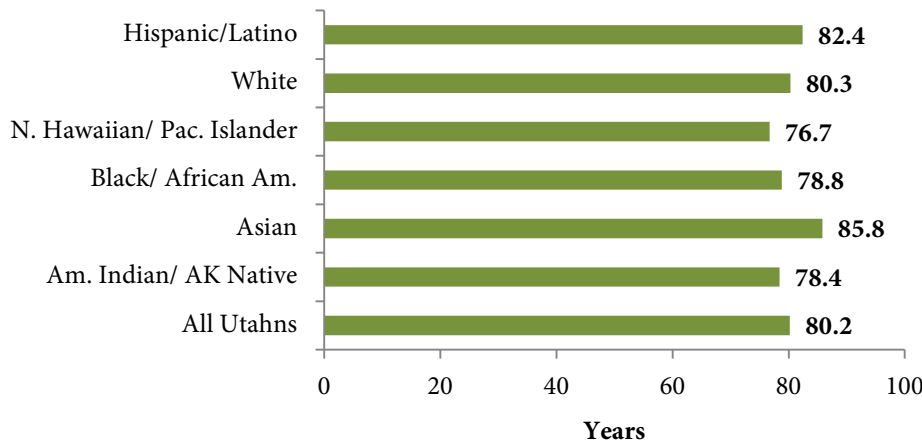
Life expectancy measurements can be impacted by many factors ranging from genetics and risk-taking behaviors to one's environmental exposures and socio-economic status.<sup>5</sup> Some ways to improve life expectancy include promoting maternal and infant health while reducing communicable diseases and accidental deaths. The Utah Department of Human Services, Division of Aging & Adult Services assists people who are 60 or older with resources and programs to encourage fitness, adequate nutrition, and independence.

UT Life Expectancy at Birth, 2009-2013

Race/Ethnicity	Life Expectancy (Years)
All Utahns	80.2
Am. Indian/ AK Native	78.4
Asian	85.8
Black/African Am.	78.8
N. Hawaiian/ Pac. Islander	76.7
White	80.3
Hispanic/Latino	82.4

*Utah Death Certificate Database, Office of Vital Records & Statistics, UDOH. Population Estimates by Age, Sex, Race & Hispanic Origin for Counties in Utah, US Census, IBIS version 2013.*

### Utah Life Expectancy, 2009-2013



*The method developed by C.L. Chiang was used to compute life expectancy.*

# DEMOGRAPHIC CONTEXT

## Poverty

### Why is it important?

Poverty takes into account both income and family size, and has both immediate and long-lasting effects on health. Income provides an assessment of the financial resources available to individual persons or families for basic necessities (e.g., food, clothing, and health care) to maintain or improve their well-being. Persons living in poverty are worse off than persons in more affluent households for many of the indicators tracked by the Utah Department of Health.

### How are we doing?

The percentage of Utahns living in poverty increased from 10.0% in 2006-2008 to 12.6% in 2013. All of Utah's racial/ethnic minority groups have a higher rate of poverty than Whites, with Blacks/African Americans and American Indians/Alaska Natives having the highest poverty rates in 2013.

### How can we improve?

Poverty is a complex issue with multifactorial causes and direct impacts on individual and community health. Providing individuals and families with a liveable wage, employment opportunities, and affordable housing are crucial to promoting public health. Some of the programs intended to serve financially disadvantaged people in Utah include Medicaid, CHIP, and the Primary Care Network (PCN), sliding-scale medical and dental services offered by federally qualified community health centers, and other programs like food stamps and Temporary Assistance for Needy Families (TANF). For more information on services or eligibility, dial 2-1-1 from any phone in Utah, or visit [www.uw.org/211/](http://www.uw.org/211/).

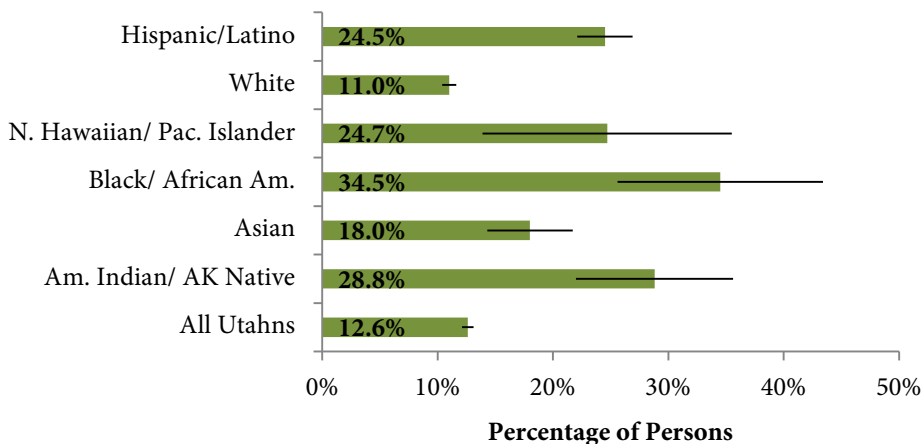
Percentage of Utahns Living in Poverty, 2013

Race/Ethnicity*	%	90% CI (Lower)	90% CI (Upper)	Sig*
All Utahns	12.6	12.1	13.1	
Am. Indian/ AK Native	28.8	22.0	35.6	↑
Asian	18.0	14.3	21.7	↑
Black/African Am.	34.5	25.6	43.4	↑
N. Hawaiian/ Pac. Islander	24.7	13.9	35.5	↑
White	11.0	10.4	11.6	↓
Hispanic/Latino	24.5	22.1	26.9	↑

US Census Bureau, American Community Survey 2013.

\*Race Alone (not two or more races). Hispanic may be any race.

Utahns Living in Poverty, 2013



# DEMOGRAPHIC CONTEXT

## Child Poverty

### Why is it important?

Poverty takes into account both income and family size, and has both immediate and long-lasting effects on health. Poverty in the early years of a child's life, more than at any other time, has especially harmful effects on continuing healthy development and well-being, including developmental delays and infant mortality. Well-being in later childhood, such as teen pregnancy, substance abuse, and educational attainment, is also influenced by early childhood poverty.<sup>6</sup>

### How are we doing?

From 2009-2013, 14.72% of Utah children – more than 127,000 children – were living in poverty in Utah. The racial/ethnic group with the lowest child poverty rate was Whites (12.2%), while American Indian/Alaska Native children were the most likely to live in poverty (35.3%).

### How can we improve?

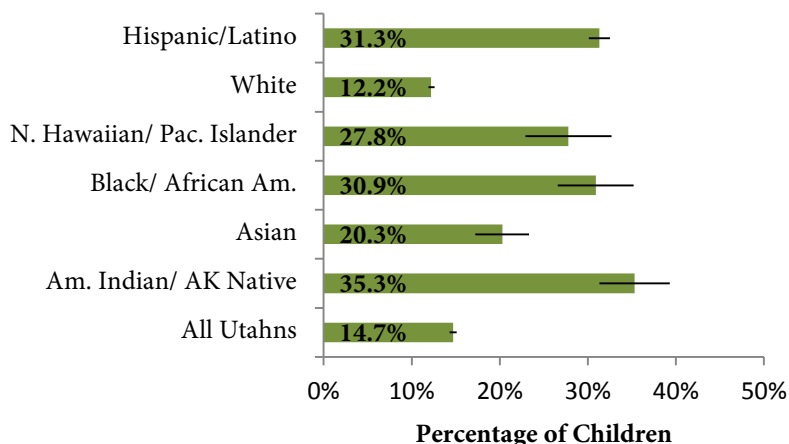
Child poverty is a complex issue with multifactorial causes and direct impacts on individual and community health. Providing individuals and families with a liveable wage, employment opportunities, and affordable housing are crucial to promoting public health. Several programs exist to assist financially disadvantaged families with health care/insurance, food stamps, child care, and more. For more information on services or eligibility, dial 2-1-1 from any phone in Utah, or visit [www.uw.org/211/](http://www.uw.org/211/).

**Utah Children (17 and Under) in Poverty, 2009-2013**

Race/Ethnicity*	Average Annual <17 Population	# in Poverty	% in Poverty (90% CI)	Sig*
All Utahns <17 y	867,558	127,326	14.7% (14.3-15.1%)	
Am. Indian/ AK Native	10,297	3,637	35.3% (31.3-39.3%)	↑
Asian	12,922	2,617	20.3% (17.2-23.3%)	↑
Black/African Am.	12,303	3,799	30.9% (26.6-35.2%)	↑
N. Hawaiian/ Pac. Islander	9,935	2,762	27.8% (22.9-32.7%)	↑
White	755,518	92,498	12.2% (11.9-12.6%)	↓
Hispanic/Latino	146,544	45,862	31.3% (30.1-32.5%)	↑

US Census Bureau, 2009-2013 American Community Survey 5-Year Estimates.  
\*Race Alone (not two or more races). Hispanic may be any race.

**Utah Children in Poverty, 2009-2013**



# Health Care Services and Systems



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# HEALTH CARE SERVICES & SYSTEMS

## No Health Insurance

### Why is it important?

Most people need medical care at some time in their lives. Medical care is often quite expensive and is becoming more expensive. Health insurance covers all or some costs of care and protects people from very high expenses. Persons with health insurance are more likely than persons without health insurance to have a regular source of primary health care and to have routine preventive care. Persons without coverage have often delay seeking needed care and find services difficult to afford.<sup>7</sup>

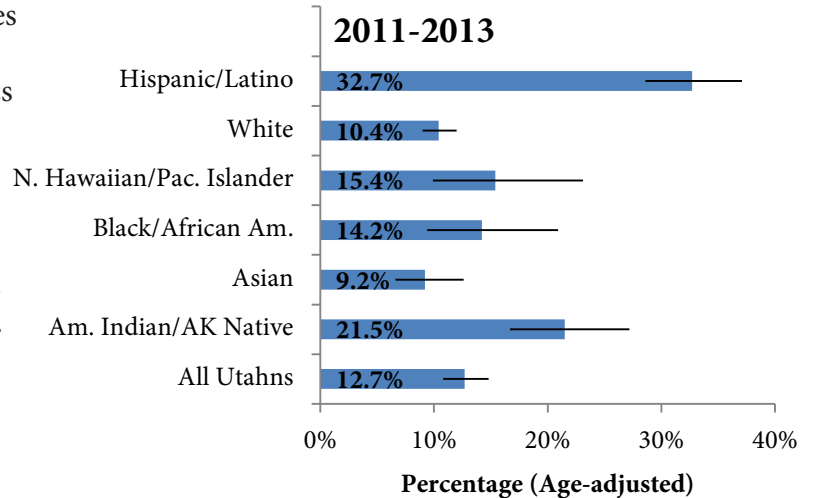
### How are we doing?

From 2011-2013, 12.7% of Utahns reported having no health insurance coverage (age-adjusted rate). American Indian/Alaska Native (21.8%) and Hispanic/Latino populations (32.7%) had the highest age-adjusted rates of no health insurance coverage in the state.

### How can we improve?

Through state and federal legislation that increases access to health insurance, Utah can directly reduce the number of uninsured. Safety net clinics and other programs may help those who cannot afford health insurance. The health insurance marketplace set up by the Affordable Care Act has allowed 128,220 Utahns to sign up for health insurance. Eligibility and enrollment information is available through [www.healthcare.gov](http://www.healthcare.gov) or 2-1-1.

### Utahns Without Health Insurance



### Percentage of Utahns Without Health Insurance, 2011-2013

Race/Ethnicity	Sample Size	Average Annual Population	# of Uninsured	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utahns	25,613	2,856,842	362,819	12.7 % (10.2 -15.8 %)	12.7 % (10.8 -14.8 %)	n/a
Am. Indian/AK Native	245	42,355	9,233	21.8 % (17.4 -26.8 %)	21.5 % (16.7 -27.2 %)	↑
Asian	282	63,594	6,550	10.3 % (7.4 -14.1 %)	9.2 % (6.6 -12.6 %)	↓
Black/African Am.	198	36,650	4,398	12.0 % (8.1 -17.4 %)	14.2 % (9.4 -20.9 %)	
N. Hawaiian/Pac. Islander	137	27,428	4,553	16.6 % (10.4 -25.5 %)	15.4 % (9.9 -23.1 %)	
White	23,310	2,623,003	275,415	10.5 % (8.5 -12.9 %)	10.4 % (9.0 -12.0 %)	↓
Hispanic/Latino	2,148	378,251	123,688	32.7 % (28.0 -37.8 %)	32.7 % (28.6 -37.1 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013 (age-adjusted using four age groups: 0-17, 18-34, 35-49, 50+).

\*Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.



# HEALTH CARE SERVICES & SYSTEMS

## Cost as a Barrier to Health Care

### Why is it important?

Access to health care is still a problem for many Utahns. Individuals who cannot obtain needed health care tend to have higher rates of death and disability from chronic disease.<sup>8</sup> Cost is the most commonly reported barrier to getting needed health care.

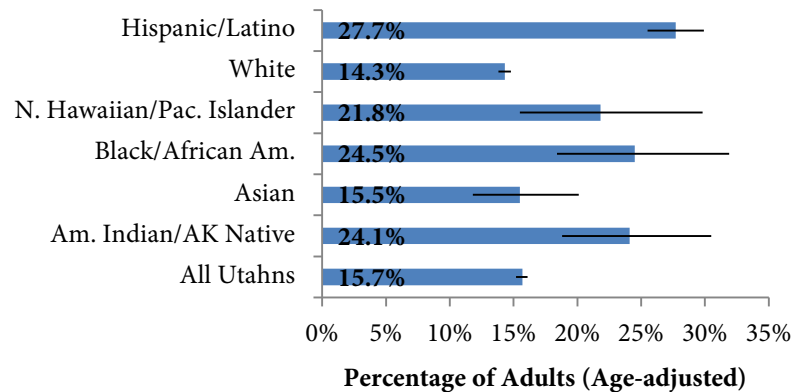
### How are we doing?

From 2011 to 2013, 15.7% of Utahns reported that they were unable to get needed medical, dental, or mental health care in the past year (age-adjusted rate). The percentage of American Indians/Alaska Natives (24.1%), Blacks/ African Americans (24.5%), and Hispanics/Latinos (27.7%) who were unable to get health care due to cost was significantly higher than other racial/ethnic groups in the state.

### How can we improve?

The Affordable Care Act contains provisions, such as subsidies to pay for health insurance premiums, intended to alleviate the consumer burden of health care. The UDOH Bureau of Primary Care offers medical care for the underserved through the Health Clinics of Utah and other Safety Net partners, such as community health centers. Resources for medical and financial assistance can be accessed through the 2-1-1 hotline and website ([www.uw.org/211](http://www.uw.org/211)).

**Utah Adults Unable to Access Care  
2011-2013**



**Percentage of Adults Unable to Access Health Care in the Past Year Due to Cost, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Unable to Access Care	Crude Rate	Age-Adjusted Rate	Sig. *
All Utah Adults 18+	37,749	1,968,094	310,959	15.8 % (15.3 -16.3 %)	15.7 % (15.2 -16.2 %)	n/a
Am. Indian/AK Native	373	21,909	5,105	23.3 % (18.2 -29.4 %)	24.1 % (18.8 -30.5 %)	↑
Asian	416	46,949	7,887	16.8 % (12.9 -21.6 %)	15.5 % (11.8 -20.1 %)	
Black/African Am.	212	19,717	4,831	24.5 % (18.2 -32.1 %)	24.5 % (18.4 -31.9 %)	↑
N. Hawaiian/ Pac. Islander	172	16,524	3,916	23.7 % (16.9 -32.3 %)	21.8 % (15.5 -29.8 %)	
White	34,753	1,753,928	252,566	14.4 % (13.9 -14.9 %)	14.3 % (13.8 -14.8 %)	↓
Hispanic/Latino	2,477	228,844	64,076	28.0 % (25.9 -30.2 %)	27.7 % (25.5 -29.9 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates from 2011-2013 American Community Survey 3-Year Estimates.

\*Arrows indicate whether the rate was higher or lower than for All Utahns.

# HEALTH CARE SERVICES & SYSTEMS

## No Primary Care Provider

### Why is it important?

Primary care providers (PCPs) manage patients' medical care effectively and efficiently because they know their medical history and social background. Persons with a usual place of care are more likely to have routine medical visits and health screenings that may prevent disability and early death.

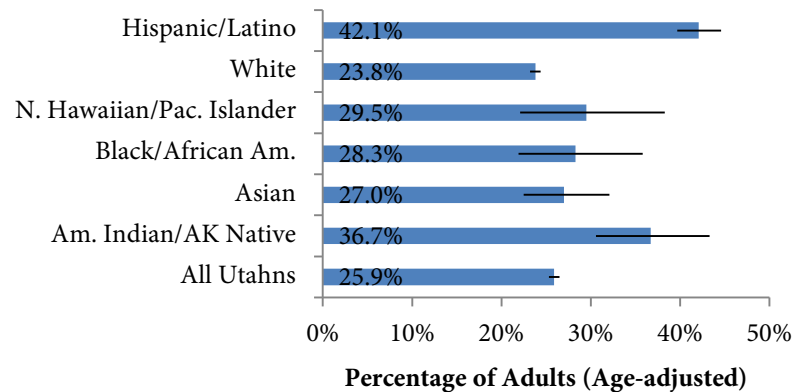
### How are we doing?

From 2009 to 2010, 25.1% of Utahns reported having no personal doctor or health care provider (age-adjusted rate). From 2011 to 2013, the overall age-adjusted rate – 25.9% - did not significantly improve. However, American Indian/Alaska Native (36.7%), and Hispanic/Latino (42.1%) populations continue to be more likely to report that they do not have a primary care provider than Whites (23.8%).

### How can we improve?

The UDOH Bureau of Primary Care offers medical care for the underserved through the Health Clinics of Utah and other Safety Net partners, such as federally qualified health centers. Assistance with finding a primary care provider can be accessed by calling 2-1-1 or visiting [www.uw.org/211/](http://www.uw.org/211/).

### Utah Adults Without a Health Provider 2011-2013



### Percentage of Utah Adults With No Personal Health Care Provider, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Without Provider	Crude Rate (95% CI)	Age-Adjusted Rate (95% CI)	Sig. *
All Utah Adults 18+	37,664	1,968,094	537,290	27.3 % (26.7 -28.0 %)	25.9 % (25.3 -26.5 %)	n/a
Am. Indian/AK Native	370	21,909	8,413	38.4 % (32.2 -45.0 %)	36.7 % (30.6 -43.3 %)	↑
Asian	413	46,949	15,775	33.6 % (28.2 -39.5 %)	27.0 % (22.5 -32.1 %)	
Black/African Am.	212	19,717	5,935	30.1 % (23.2 -38.1 %)	28.3 % (21.9 -35.8 %)	
N. Hawaiian/ Pac. Islander	170	16,524	5,998	36.3 % (28.2 -45.3 %)	29.5 % (22.1 -38.3 %)	
White	34,680	1,753,928	434,974	24.8 % (24.2 -25.5 %)	23.8 % (23.2 -24.4 %)	↓
Hispanic/Latino	2,482	228,844	107,786	47.1 % (44.6 -49.6 %)	42.1 % (39.7 -44.6 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates from 2011-2013 American Community Survey 3-Year Estimates.

\*Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.

## Routine Medical Checkup

### Why is it important?

Clinical preventive services are important for maintaining good health. Early detection and treatment of disease improve the chances of full recovery. Physician counseling can influence health behaviors and prevent disease entirely in many cases. It is especially important for persons in poor health to have a primary provider who understands their medical history and can give appropriate care that fits their medical needs and social context.

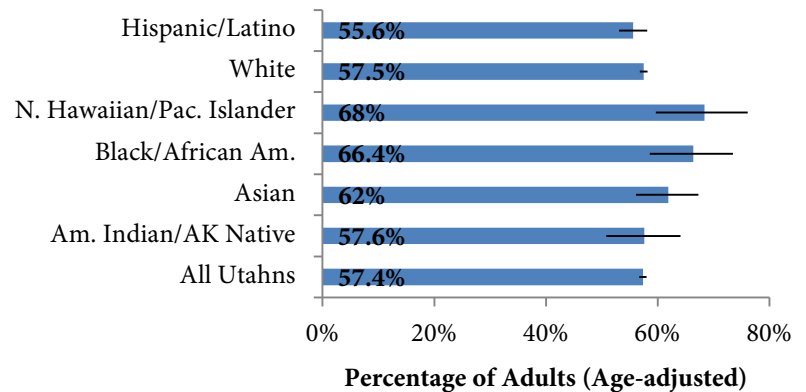
### How are we doing?

From 2011 to 2013, 57.4% of Utahns reported having a routine medical checkup within the past 12 months (age-adjusted rate). Blacks/African Americans (66.4%) and Native Hawaiians/Pacific Islanders (68.4%) had a significantly higher age-adjusted rate of having a checkup than all Utahns (57.4%).

### How can we improve?

Everyone should visit a health care provider regularly, even if they are healthy, to take advantage of preventive services (like immunizations and screenings) that may detect health issues before they become more serious. Well-child visits for children are also important for evaluating developmental milestones and establishing healthy habits. The UDOH Bureau of Primary Care offers routine medical services for the underserved through the Health Clinics of Utah and other Safety Net partners. Resources for medical and financial assistance can be obtained by calling 2-1-1 or visiting [www.uw.org/211/](http://www.uw.org/211/).

### Utah Adults With a Routine Medical Checkup, 2011-2013



### Percentage of Utah Adults Who Had a Medical Checkup in the Previous Year, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# with Routine Checkup	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah Adults, 18+	36,924	1,968,094	1,113,941	56.6 % (55.9 -57.3 %)	57.4 % (56.7 -58.0 %)	n/a
Am. Indian/AK Native	366	21,909	12,422	56.7 % (50.1 -63.1 %)	57.6 % (50.8 -64.1 %)	
Asian	400	46,949	26,573	56.6 % (50.5 -62.4 %)	61.9 % (56.1 -67.3 %)	
Black/ African Am.	209	19,717	12,639	64.1 % (55.8 -71.6 %)	66.4 % (58.6 -73.5 %)	↑
N. Hawaiian/Pac. Islander	164	16,524	9,947	60.2 % (50.9 -68.9 %)	68.4 % (59.7 -76.1 %)	↑
White	34,003	1,753,928	1,001,493	57.1 % (56.4 -57.8 %)	57.5 % (56.8 -58.2 %)	
Hispanic/Latino	2,439	228,844	119,914	52.4 % (49.9 -54.9 %)	55.6 % (53.1 -58.1 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates from 2011-2013 American Community Survey 3-Year Estimates.

\*Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.

# HEALTH CARE SERVICES & SYSTEMS

## Routine Dental Checkup

### Why is it important?

Regular dental visits are important in the prevention, early detection, and treatment of oral and craniofacial diseases and conditions for all ages. Adults need regular professional care to avoid tooth loss, the need for complex restorative treatment, and even systemic health problems. Even people without teeth need to be monitored regularly for oral health which may be affected by systemic conditions, medications, prosthetic devices, and exposure to tobacco. Infrequent use of dental services has been associated with poor oral health among adults.

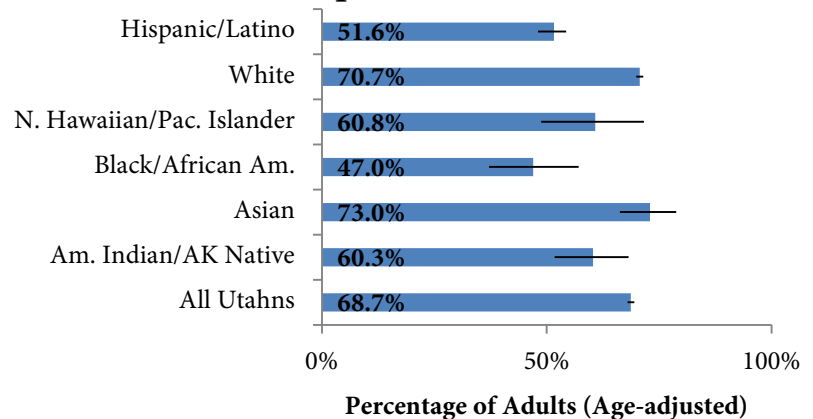
### How are we doing?

In 2010 and 2012, 68.7% (age-adjusted) of all Utahns had a routine dental checkup within the past 12 months. American Indians/Alaska Natives (60.3%), Blacks/African Americans (47.0%), and Hispanics/Latinos (51.6%) were significantly less likely to have routine dental care than other Utahns. Significant racial/ethnic disparities in dental care also exist nationally.<sup>9</sup>

### How can we improve?

Everyone should visit an oral health provider regularly to take advantage of preventive services (like cleanings and fluoride varnishing) that may detect dental issues before they become more serious. The UDOH Bureau of Primary Care offers routine dental services for the underserved through the Family Dental Plan. Other resources for dental care can be obtained by calling 2-1-1 or visiting [www.uw.org/211/](http://www.uw.org/211/).

### Utah Adults With a Routine Dental Checkup, 2010, 2012



### Percentage of Utah Adults Who Had a Dental Checkup in the Past Year - 2010, 2012

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# with Dental Care	Crude Rate (95% CI)	Age-Adjusted Rate (95% CI)	Sig. *
All Utahns	24,383	1,935,446	1,325,781	68.5% (67.7-69.3%)	68.7% (68.0-69.5%)	n/a
Am. Indian/AK Native	213	22,703	13,395	59.0% (50.2- 67.2%)	60.3% (51.8- 68.2%)	↓
Asian	279	44,593	31,260	70.1% (63.0- 76.4%)	73.0% (66.3- 78.8%)	
Black/ African Am.	122	18,954	10,576	55.8% (45.0-66.1%)	47.0% (37.2- 57.1%)	↓
N. Hawaiian/Pac. Islander	98	16,253	9,427	58.0% (46.1-69.1%)	60.8% (48.8- 71.6%)	
White	22,341	1,732,619	1,221,496	70.5% (69.6- 71.3%)	70.7% (69.9- 71.5%)	↑
Hispanic/Latino	1,630	223,136	115,584	51.8% (48.7- 54.9%)	51.6% (49.2- 55.4%)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates averaged from 2010 and 2012 ACS 1-Year Estimates.

\*Arrows indicate whether age-adjusted rate was higher or lower than for All Utahns.

## First Trimester Prenatal Care

### Why is it important?

Women who receive early and consistent prenatal care enhance their likelihood of giving birth to a healthy child. Health care providers recommend that prenatal care begin in the first trimester of pregnancy.

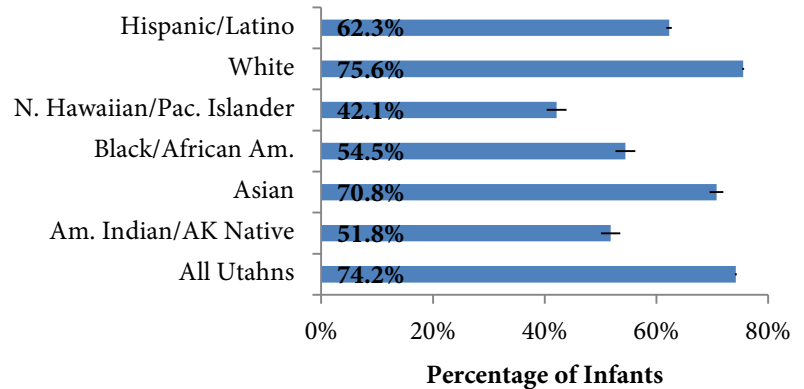
### How are we doing?

From 2009-2013 the overall rate of first trimester prenatal care was slightly lower, at 74.2%. However, significant disparities exist among other Utah racial/ethnic groups, especially Native Hawaiians/Pacific Islanders (42.1%), American Indians/Alaska Natives (51.8%), and Blacks/African Americans (54.5%).

### How can we improve?

The Baby Your Baby program ([www.babyyourbaby.org](http://www.babyyourbaby.org)) encourages expectant mothers to see their health care provider before the 13<sup>th</sup> week of pregnancy and to go back for at least 13 visits before birth. Going to your health care provider early can help identify specific risks for pregnancy complications including preterm delivery, gestational diabetes, and infant mortality.<sup>10</sup> Working with communities to promote culturally and linguistically appropriate outreach and educational approaches has been shown to be a best practice among Native Hawaiians/Pacific Islanders that may be helpful with American Indians/Alaska Natives and Blacks/African Americans.<sup>11</sup>

**Utah Infants Who Received 1st Trimester Prenatal Care, 2009-2013**



**Percentage of Utah Infants Who Received 1<sup>st</sup> Trimester Prenatal Care, 2009-2013**

Race/Ethnicity	# with Prenatal Care	Total # of Live Births	% with Prenatal Care (95% CI)	Sig. *
All Utah infants	192,639	259,509	74.2% (74.1-74.4%)	n/a
Am. Indian/AK Native	1,677	3,235	51.8% (50.1-53.6%)	↓
Asian	3,699	5,227	70.8% (69.5-72.0%)	↓
Black/ African Am.	1,642	3,014	54.5% (52.7-56.3%)	↓
N. Hawaiian/Pac. Islander	1,249	2,965	42.1% (40.4-43.9%)	↓
White	181,868	240,700	75.6% (75.4-75.7%)	↑
Hispanic/Latino	24,738	39,723	62.3% (61.8-62.8%)	↓

Utah Birth Certificate Database, Office of Vital Records and Statistics, UDOH

\*Arrows indicate whether the rate was higher or lower than for all Utahns.

# HEALTH CARE SERVICES & SYSTEMS

## Colon Cancer Screening (Age 50 Years+)

### Why is it important?

Not counting skin cancers, colorectal cancer is the third most common cancer found in men and women in this country. According to American Cancer Society Surveillance Research, it is estimated that there will be 132,700 new cases of colorectal cancer in the U.S. during 2015.<sup>12</sup> Thanks to colorectal screening, polyps can be found and removed before they turn into cancer. Colorectal cancer can also be found earlier when it is easier to cure.

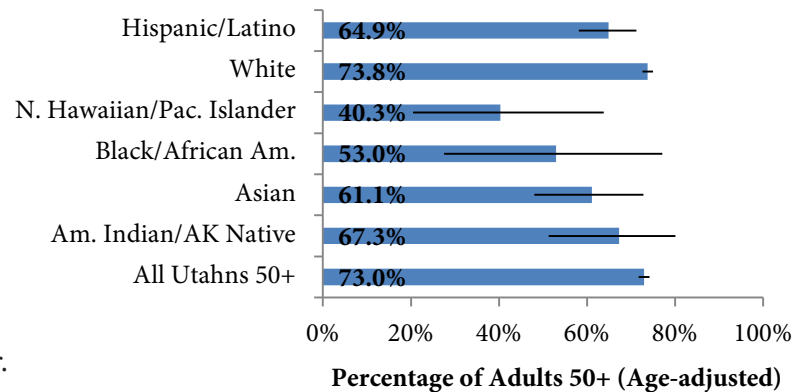
### How are we doing?

From 2012 to 2013, 73.0% of Utah adults age 50 years and older had received a sigmoidoscopy or colonoscopy screening within the last five years (age-adjusted rate). Asians (61.1%), Native Hawaiians/Pacific Islanders (40.3%), and Hispanics/Latinos (64.9%) continue to have significantly lower rates of colon cancer screening than other Utahns.

### How can we improve?

The American Cancer Society recommends that routine screening for colorectal cancer begin at age 50 for adults at average risk. Routine screening can include annual fecal tests (gFOBT, FIT), stool DNA testing every three years, imaging tests every five years (flexible sigmoidoscopy, barium enema, CT colonography), and/or colonoscopy every 10 years.<sup>13</sup> Persons at high risk may need to begin screening at a younger age and individuals should discuss risk factors and screening options with their health care provider.

### Utahns Age 50+ Who Had Colon Cancer Screening, 2012-2013



### Percentage of Utahns Age 50+ Who Had Colon Cancer Screening in the Past Five Years, 2012-2013

Race/Ethnicity	Sample Size	Average Annual 50+ Population	# with Screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults, 50 Years+	9,107	698,618	503,005	72.0 % (70.7 -73.3 %)	73.0 % (71.7 -74.2 %)	n/a
Am. Indian/AK Native	71	7,358	4,775	64.9 % (49.8 -77.6 %)	67.3 % (51.3 -80.1 %)	
Asian	56	14,052	7,026	50.0 % (34.1 -65.8 %)	61.1 % (48.0 -72.8 %)	↓
Black/ African Am.**	25	5,426	2,881	53.1 % (27.1 -77.4 %)	53.0 % (27.5 -77.1 %)	
N. Hawaiian/Pac. Islander**	20	3,935	1,846	46.9 % (22.1 -73.2 %)	40.3 % (20.5 -63.8 %)	↓
White	8,672	662,985	483,979	73.0 % (71.7 -74.3 %)	73.8 % (72.6 -75.0 %)	
Hispanic/Latino	339	47,515	28,319	59.6 % (52.2 -66.6 %)	64.9 % (58.1 -71.2 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013 (age-adjusted using two age groups: 50-64, 65+).

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

## Pap Testing

### Why is it important?

Cervical cancer is one of the most curable cancers if detected early through routine screening. Nearly all cases of cervical cancer are caused by infection with high-risk types of the human papilloma virus (HPV). As these viruses are transmitted through sexual contact, any woman who is sexually active is at risk for developing cervical cancer. Other risk factors include having sexual relations at an early age, having multiple sex partners or partners with many other partners, and cigarette smoking.

### How are we doing?

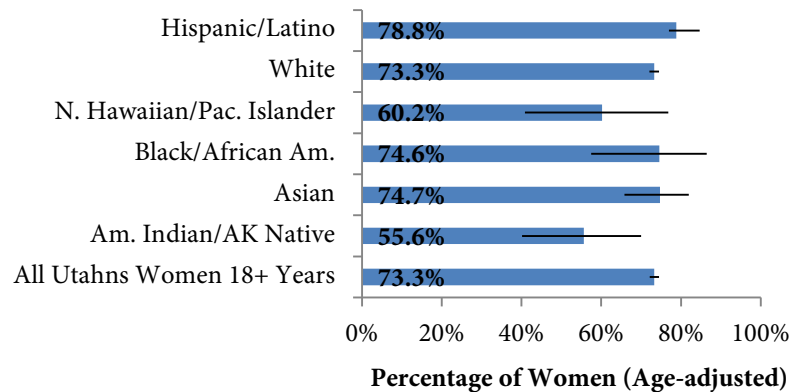
In 2010 and 2012, 73.3% of Utah women (age 18 years and older) had received a Pap test in the past three years (age-adjusted rate). American Indian/Alaska Native women have the lowest rate (55.6%) of cervical cancer screening by Pap test in Utah, followed by Native Hawaiians/Pacific Islanders (60.2%).

### How can we improve?

The American Cancer Society recommends that cervical screening begin about three years after a woman begins having intercourse but no later than 21 years of age. Cervical screening should be performed every year with conventional Pap tests or every two years with liquid-based Pap tests. Beginning at age 30, women who have had three normal test results in a row may undergo screening every two to three years. Females ages 9-26 can also receive the HPV vaccine, which protects against cervical cancer. The UDOH Utah Cancer Control Program offers cervical cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

### Women with Pap Test in Past 3 Years

2010,2012



### Percentage of Women 18+ Who Had Pap Testing in the Past Three Years - 2010, 2012

Race/Ethnicity	Sample Size	Average Annual 18+ Women Population	# with Pap Test	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah women, 18 Years+	9,588	972,476	703,100	72.3 % (71.0 -73.6 %)	73.3 % (72.2 -74.5 %)	n/a
Am. Indian/AK Native	88	11,577	5,939	51.3 % (37.4 -65.1 %)	55.6 % (40.1 -70.0 %)	↓
Asian	146	23,611	16,976	71.9 % (62.0 -80.1 %)	74.7 % (65.8 -81.9 %)	
Black/ African Am.	52	7,793	6,016	77.2 % (61.4 -87.8 %)	74.6 % (57.4 -86.4 %)	
N. Hawaiian/Pac. Islander	43	7,690	4,637	60.3 % (40.4 -77.2 %)	60.2 % (40.8 -76.8 %)	
White	8,737	872,661	631,806	72.4 % (71.0 -73.8 %)	73.3 % (72.1 -74.5 %)	
Hispanic/Latino	757	107,922	83,963	77.8 % (73.5 -81.5 %)	78.8 % (74.7 -82.4 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates averaged from 2010 and 2012 American Community Survey 1-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for All Utahns.

# HEALTH CARE SERVICES & SYSTEMS

## Mammogram

### Why is it important?

Breast cancer is the most commonly occurring cancer in U.S. women (excluding basal and squamous cell skin cancers) and the leading cause of female cancer death in Utah. Deaths from breast cancer can be substantially reduced if the tumor is discovered at an early stage. Mammography is currently the best method for detecting cancer early. Clinical trials have demonstrated that routine screening with mammography can reduce breast cancer deaths by 20% to 30% in women aged 50 to 69 years, and by about 17% in women aged 40 to 49 years.

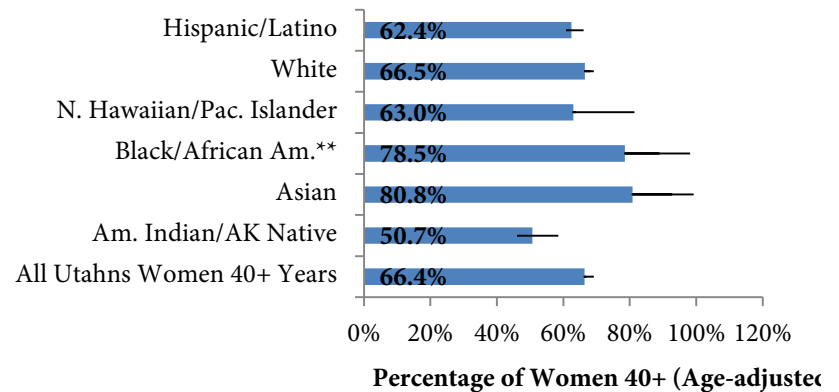
### How are we doing?

During 2010 to 2013, 66.4% of Utah women age 40 and over reported having a mammogram during the last two years (age-adjusted rate). Asian women had a significantly higher rate of mammography (80.8%) than all Utahns, while American Indian/Alaska Native women had a significantly lower rate (50.7%).

### How can we improve?

The American Cancer Society recommends that women aged 40 or older have an annual mammogram.<sup>14</sup> Women who are at higher than average risk of breast cancer should seek expert medical advice about whether they should begin screening before age 40 and the frequency of that screening. The UDOH Utah Cancer Control Program offers breast cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

### Women 40+ Who Had a Mammogram in the Past 2 Years, 2011-2013



### Percentage of Women Age 40+ Who Had a Mammogram in the Past Two Years, 2010-2013

Race/Ethnicity	Sample Size	Average Annual 40+ Women Population	# with Screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah women, 40 Years+	13,065	508,670	342,335	67.3 % (66.2 -68.4 %)	66.4 % (65.2 -67.5 %)	n/a
Am. Indian/AK Native	110	6,274	3,187	50.8 % (38.5 -63.0 %)	50.7 % (38.1 -63.1 %)	↓
Asian	102	12,405	9,552	77.0 % (66.7 -84.9 %)	80.8 % (72.1 -87.2 %)	↑
Black/ African Am.**	40	3,704	3,022	81.6 % (65.9 -91.0 %)	78.5 % (65.0 -87.8 %)	
N. Hawaiian/Pac. Islander	24	3,144	1,770	56.3 % (32.5 -77.5 %)	63.0 % (41.1 -80.6 %)	
White	12,312	478,901	323,258	67.5 % (66.4 -68.6 %)	66.5 % (65.3 -67.6 %)	
Hispanic/Latino	643	43,317	26,813	61.9 % (56.4 -67.1 %)	62.4 % (56.8 -67.7 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013 (age-adjusted using three age groups: 40-49, 50-64, 65+).

\*Arrows indicate where age-adjusted rate was higher or lower than for All Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.



## Prostate Cancer Screening

### Why is it important?

Prostate cancer is the most commonly occurring form of cancer (excluding skin cancer) among men and is the second leading cause of cancer death for men in Utah and the U.S. All men over 40 should visit their doctor for a routine health visit which may include a discussion on prostate health.

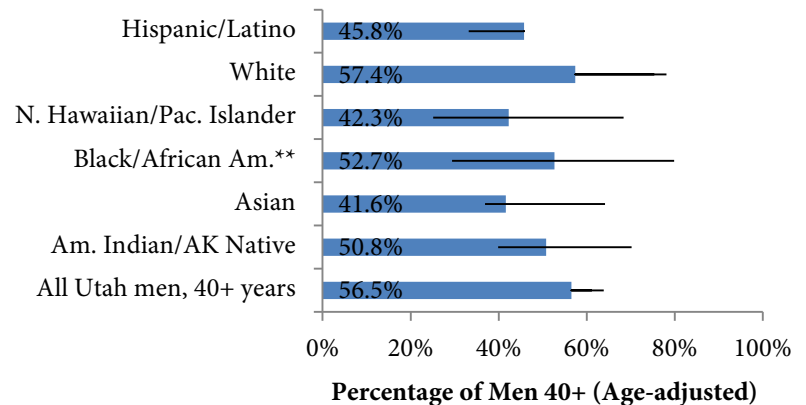
### How are we doing?

For 2010 and 2012, 54.0% of all Utah men age 40 and over had received a PSA test (age-adjusted rate). Hispanic/Latino men had a significantly lower rate (45.8%). Asian men had the lowest rate of PSA testing, at 41.6%.

### How can we improve?

The American Cancer Society recommends that health care professionals discuss the potential benefits and limitations of prostate cancer screening starting when male patients are 50. The recommended screening is for prostate specific antigen (PSA), with the option of digital rectal examination. African American men and those with one first degree relative with prostate cancer should be screened starting at age 45. The UDOH Utah Cancer Control Program offers prostate cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

**Males Age 40+ Who Have Had PSA Test  
2010,2012**



### Percentage of Males Age 40+ Who Have Ever Had a PSA Test - 2010, 2012

Race/Ethnicity	Sample Size	Average Annual 40+ Male Population	# with Screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah men, 40 Years+	6,579	478,377	270,283	56.5 % (55.0 -58.1 %)	56.5 % (55.1 -57.8 %)	n/a
Am. Indian/AK Native	56	5,726	2,829	49.4 % (33.9 -65.0 %)	50.8 % (35.6 -65.9 %)	
Asian	48	9,532	2,984	31.3 % (19.0 -47.0 %)	41.6 % (28.6 -55.9 %)	↓
Black/ African Am.**	19	5,275	2,938	55.7 % (29.9 -78.7 %)	52.7 % (26.8 -77.3 %)	
N. Hawaiian/Pac. Islander	21	3,258	1,310	40.2 % (20.6 -63.6 %)	42.3 % (22.1 -65.4 %)	
White	6,105	450,670	264,994	58.8 % (57.2 -60.3 %)	57.4 % (56.0 -58.7 %)	
Hispanic/Latino	336	42,843	15,423	36.0 % (30.0 -42.6 %)	45.8 % (39.6 -52.1 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013 (age-adjusted using three age groups: 40-49, 50-64, 65+).

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

## Blood Cholesterol Screening

### Why is it important?

High blood cholesterol is a leading risk factor in the development of atherosclerosis and coronary heart disease (CHD). The risks associated with high blood cholesterol can be reduced by screening and early treatment, which includes medication and lifestyle changes. Lifestyle changes could include eating a diet low in saturated fat and cholesterol, engaging in moderate to vigorous exercise on a regular basis, and reducing excess weight. Because high blood cholesterol does not produce obvious symptoms, experts recommend that all adults aged 20 years and older have their cholesterol levels checked at least once every 5 years to help them take action to prevent or lower their risk of cardiovascular disease.

### How are we doing?

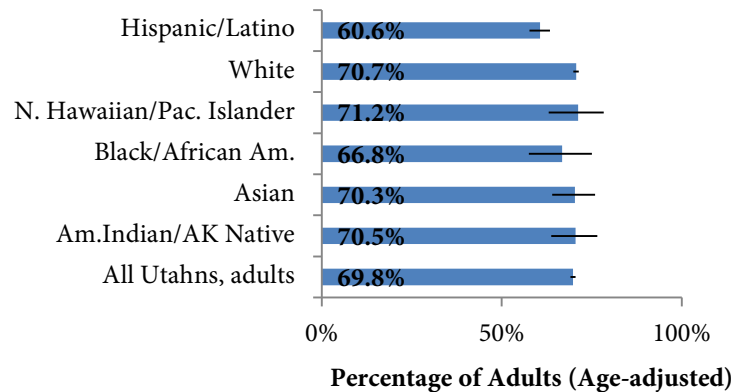
During 2011 to 2013, over two-thirds of Utah adults age 18 and over had their cholesterol checked in the past five years (age-adjusted rate). Hispanics/Latinos had significantly lower age-adjusted rates (60.6%) of cholesterol screening.

### How can we improve?

The American Heart Association recommends that HDL (high density lipoprotein) and total cholesterol be used by health care providers and public outreach personnel for screening and diagnostic purposes. The UDOH Health Clinics of Utah offer cholesterol screenings as well as clinical follow-up, if needed.

### Cholesterol Check within Past Five Years

2011-2013



### Percentage of Adults Who Had a Cholesterol Screening in the Past Five Years - 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# with Screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults, 18 Years +	30,053	1,968,094	1,342,240	68.2 % (67.4 -69.0 %)	69.8 % (69.1 -70.5 %)	n/a
Am. Indian/AK Native	304	21,909	14,526	66.3 % (58.8 -73.1 %)	70.5 % (63.7 -76.5 %)	
Asian	302	46,949	29,484	62.8 % (55.3 -69.8 %)	70.3 % (64.0 -75.9 %)	
Black/ African Am.	169	19,717	12,717	64.5 % (54.5 -73.4 %)	66.8 % (57.5 -75.0 %)	
N. Hawaiian/Pac. Islander	134	16,524	9,617	58.2 % (47.2 -68.4 %)	71.2 % (63.0 -78.3 %)	
White	27,721	1,753,928	1,222,488	69.7 % (68.8 -70.5 %)	70.7 % (69.9 -71.4 %)	↑
Hispanic/Latino	1,989	228,844	127,008	55.5 % (52.5 -58.5 %)	60.6 % (57.7 -63.4 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates from 2011-2013 American Community Survey 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

## Influenza Immunization

### Why is it important?

Influenza, or flu, is an acute viral infection involving the respiratory tract that can occur in epidemics or pandemics. Influenza can cause a person, especially older persons, to be more susceptible to bacterial pneumonia.

### How are we doing?

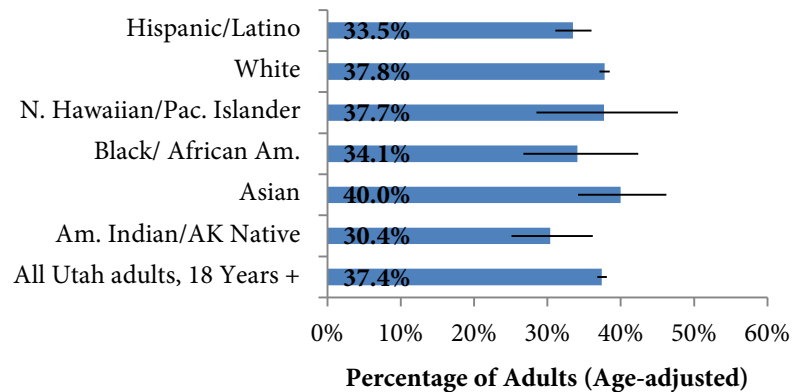
From 2011 to 2013, 37.4% of Utah adults age 18 and over reported receiving a flu shot within the past year (age-adjusted rate). American Indians/Alaska Natives (30.4%) and Hispanics/Latinos (33.5%) had significantly lower rates of flu vaccination than all Utahns.

### How can we improve?

It is recommended that everyone over six months of age be vaccinated prior to the height of the “flu season” (usually during the fall and winter months) by injection or nasal spray. Flu vaccination should be a priority for high-risk persons - including young children, pregnant women, people over age 50, health care workers, and people who live with infants under six months old. Information on flu vaccination can be obtained from the UDOH Immunization Program ([www.immunize-utah.org](http://www.immunize-utah.org)).

### Adults with Flu Shot in the Past Year

2011-2013



### Percentage of Adults Who Had a Flu Shot in the Past Year, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# with Flu Shot	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults, 18 Years +	35,884	1,968,094	724,259	36.8 % (36.1 -37.4 %)	37.4 % (36.8 -38.1 %)	n/a
Am. Indian/AK Native	349	21,909	6,419	29.3 % (23.9 -35.4 %)	30.4 % (25.1 -36.2 %)	↓
Asian	368	46,949	17,089	36.4 % (30.8 -42.5 %)	40.0 % (34.2 -46.2 %)	
Black/ African Am.	192	19,717	6,191	31.4 % (24.1 -39.7 %)	34.1 % (26.7 -42.4 %)	
N. Hawaiian/Pac. Islander	162	16,524	5,552	33.6 % (25.3 -43.0 %)	37.7 % (28.5 -47.8 %)	
White	33,128	1,753,928	655,969	37.4 % (36.8 -38.1 %)	37.8 % (37.1 -38.5 %)	
Hispanic/Latino	2,310	228,844	71,170	31.1 % (28.8 -33.5 %)	33.5 % (31.1 -36.0 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates from 2011-2013 American Community Survey 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# HEALTH CARE SERVICES & SYSTEMS

## Pneumonia Immunization

### Why is it important?

Pneumonia is the most common form of pneumococcal disease - a serious infection of the lungs, blood, or outer lining of the brain. Each year it kills more people in the United States than all other vaccine preventable diseases combined. The clinical results of pneumonia and influenza are often indistinguishable and are grouped together as the 9th leading cause of death in Utah.<sup>15</sup>

### How are we doing?

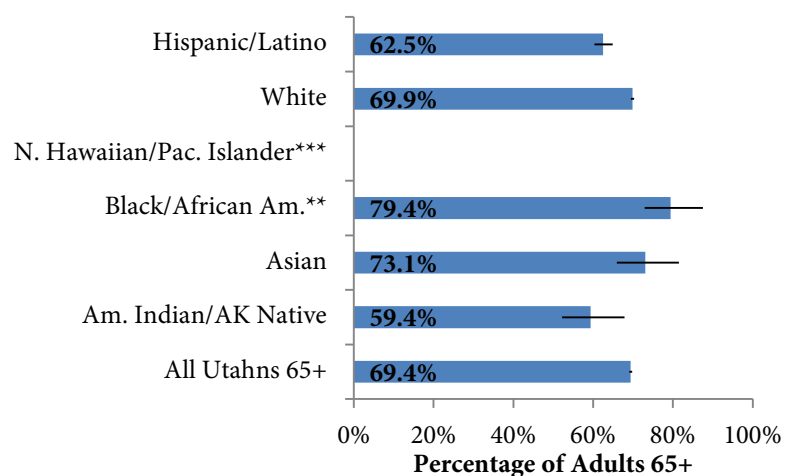
The overall rate of pneumonia vaccination among all Utahns from 2009-2013 was 69.4%. Hispanics/Latinos (62.5%) had a significantly lower rate of pneumonia vaccination than all Utahns.

### How can we improve?

Studies show that pneumococcal vaccines are effective in protecting against pneumonia and invasive pneumococcal disease.<sup>16</sup> The vaccine is recommended for all adults age 65 years and older, people with chronic illnesses, and people with compromised immune systems.

Information on pneumonia vaccination and booster shots can be obtained from the UDOH Immunization Program ([www.immunize-utah.org](http://www.immunize-utah.org)).

Utahns Age 65+ with Pneumonia Vaccine  
2009-2013



Percentage of Adults (Age 65+) with Pneumonia Vaccine, 2009-2013

Race/Ethnicity	Sample Size	Average Annual 65+ Population	# with Vaccine	Crude Rate (95% CI)	Sig. *
All Utah adults, 65 Years +	13,872	261,704	181,623	69.4 % (68.5 -70.4 %)	n/a
Am. Indian/AK Native	81	1,852	1,100	59.4 % (43.8 -73.4 %)	
Asian	55	4,307	3,148	73.1 % (56.9 -84.9 %)	
Black/ African Am.**	26	1,197	950	79.4 % (59.3 -91.0 %)	
N. Hawaiian/Pac. Islander***	14	989	***	***	
White	13,298	252,163	176,262	69.9 % (68.9 -70.9 %)	
Hispanic/Latino	380	12,112	7,570	62.5 % (55.9 -68.7 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census, IBIS Version 2013.

\*Arrows indicate where rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

\*\*\*Estimate has been suppressed because standard error is greater than 50% or undetermined.

# Risk Factors for Illness or Injury



UTAH DEPARTMENT OF  
**HEALTH**

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Office of Health Disparities

# RISK FACTORS FOR ILLNESS OR INJURY

## Overweight or Obese

### Why is it important?

Being overweight increases the risk of many chronic diseases, including heart disease, stroke, hypertension, type 2 diabetes, osteoarthritis, and some cancers. Obesity is the second leading cause of preventable death in the US.<sup>17</sup>

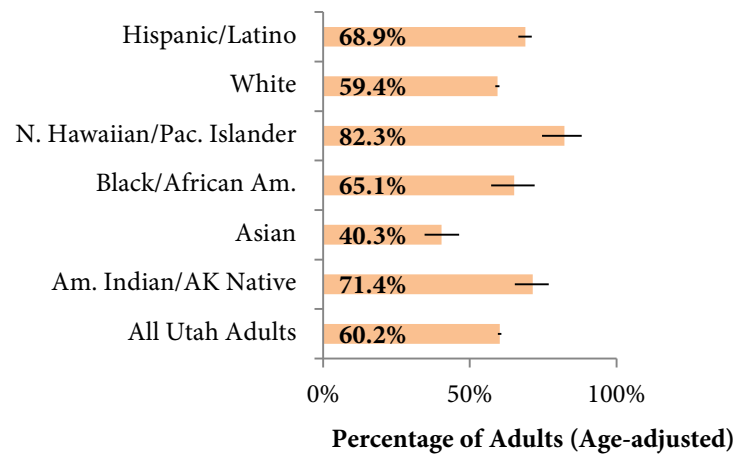
### How are we doing?

Between 2011 and 2013, almost two-thirds (60.2%) of all adults were overweight or obese (age-adjusted rate). Native Hawaiians/Pacific Islanders (82.3%), American Indians/Alaska Natives (71.4%), and Hispanics/Latinos (68.9%) had the highest overweight or obesity rates in Utah; Asians had the lowest rate (40.3%).

### How can we improve?

Health agencies interested in addressing overweight and obesity in American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Hispanic/Latino populations can work with communities to develop or expand culturally responsive interventions and educational campaigns. UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

**Overweight or Obese Utahns, 2011-2013**



**Percentage of Overweight or Obese Adults, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Obese or Overweight	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults, 18+	35,628	1,968,094	1,153,303	58.6 % (57.9 -59.3 %)	60.2 % (59.5 -60.8 %)	n/a
Am. Indian/AK Native	349	21,909	15,073	68.8 % (62.2 -74.8 %)	71.4 % (65.3 -76.8 %)	↑
Asian	390	46,949	17,136	36.5 % (30.9 -42.5 %)	40.3 % (34.6 -46.3 %)	↓
Black/ African Am.	196	19,717	12,441	63.1 % (54.6 -70.9 %)	65.1 % (57.3 -72.1 %)	
N. Hawaiian/Pac. Islander	158	16,524	12,905	78.1 % (69.0 -85.0 %)	82.3 % (74.6 -88.1 %)	↑
White	32,962	1,753,928	1,019,032	58.1 % (57.4 -58.9 %)	59.4 % (58.7 -60.1 %)	↓
Hispanic/Latino	2,205	228,844	148,749	65.0 % (62.4 -67.5 %)	68.9 % (66.5 -71.1 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates from US Census Bureau 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# RISK FACTORS FOR ILLNESS OR INJURY

## Adolescent Obesity

### Why is it important?

Being overweight increases the risk of many chronic diseases, including heart disease, stroke, hypertension, type 2 diabetes, osteoarthritis, and some cancers. Obesity is the second leading cause of preventable death in the US.<sup>17</sup>

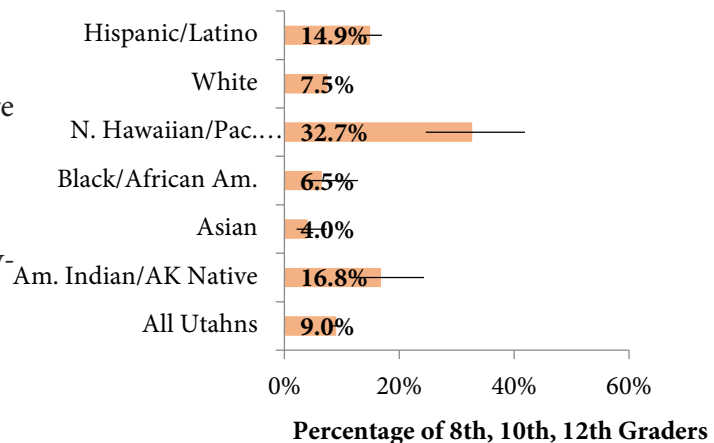
### How are we doing?

In 2013, the obesity rate among adolescents in grades 8, 10, and 12 was 9.0%. The highest obesity rates in this age group were found among Native Hawaiian/Pacific Islander, Hispanic/Latino, and American Indian/Alaska Native students.

### How can we improve?

Policy changes can have significant impact on adolescent obesity by promoting healthy school lunches and increasing school-based physical activity and community-based recreation opportunities. UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

Adolescent Obesity, 2013



Percentage of Obese Adolescents in Grades 8, 10, 12 (2013)

Race/Ethnicity	Sample Size	Crude Rate (95% CI)	Sig. *
All Utah 8th, 10th, 12th Graders	12,457	9.0% (8.4-9.7%)	n/a
Am. Indian/AK Native	195	16.8% (11.3-24.3%)	↑
Asian**	198	4.0% (2.1-7.4%)	↓
Black/ African Am.**	171	6.5% (3.2-12.8%)	
N. Hawaiian/Pac. Islander	181	32.7% (24.6-41.9%)	↑
White	9,639	7.5% (6.9-8.2%)	↓
Hispanic/Latino	1,848	14.9% (13.0-17.0%)	↑

Utah Prevention Needs Assessment, 2013. Population estimates from US Census: Children Characteristics, ACS 2013.

\*Arrows indicate where crude rate was higher or lower than for All Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

# RISK FACTORS FOR ILLNESS OR INJURY

## No Physical Activity

### Why is it important?

Physical activity has been shown to reduce the risk of some cancers, type 2 diabetes, stroke, and heart disease. Regular activity also improves general physical and mental health and may help to relieve pain and improve disorders such as depression and anxiety. Physical inactivity is a leading cause of premature death and also results in greater occurrence of illness.

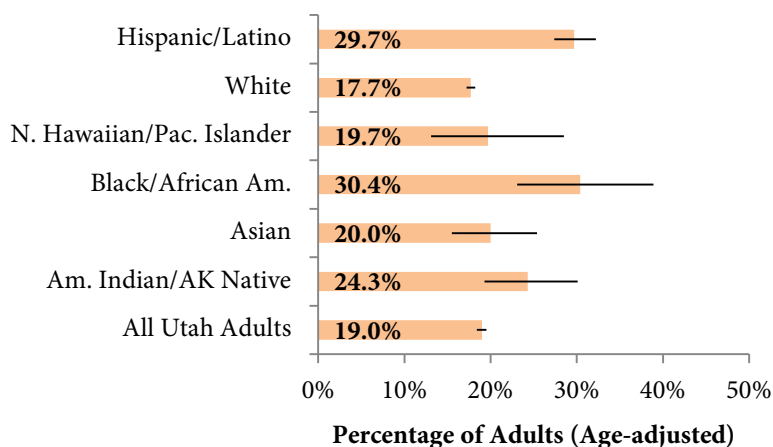
### How are we doing?

From 2011 to 2013, 19.0% of Utah adults reported they were physically inactive (age-adjusted rate). American Indians/Alaska Natives (24.3%), Blacks/African Americans (30.4%), and Hispanics/Latinos (29.7%) had a significantly higher rate of no physical activity than other Utah populations.

### How can we improve?

Policy changes can have significant impact on physical activity by ensuring safe, accessible spaces for exercise and year-round recreation opportunities. UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### No Physical Activity, Utah 2011-2013



### Percentage of Adults With No Physical Activity in the Past Month, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Without Activity	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah Adults 18+	36,503	1,968,094	368,034	18.7 % (18.1 -19.2 %)	19.0 % (18.4 -19.5 %)	n/a
Am. Indian/AK Native	359	21,909	5,149	23.5 % (18.5 -29.4 %)	24.3 % (19.3 -30.1 %)	↑
Asian	387	46,949	9,249	19.7 % (15.3 -24.8 %)	20.0 % (15.5 -25.4 %)	
Black/ African Am.	198	19,717	5,836	29.6 % (22.5 -37.9 %)	30.4 % (23.1 -38.9 %)	↑
N. Hawaiian/Pac. Islander	167	16,524	2,941	17.8 % (12.3 -25.0 %)	19.7 % (13.1 -28.5 %)	
White	33,662	1,753,928	306,937	17.5 % (17.0 -18.0 %)	17.7 % (17.2 -18.2 %)	↓
Hispanic/Latino	2,357	228,844	65,221	28.5 % (26.2 -30.9 %)	29.7 % (27.4 -32.2 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.



# RISK FACTORS FOR ILLNESS OR INJURY

## High Cholesterol

### Why is it important?

High blood cholesterol is a leading risk factor in the development of atherosclerosis and coronary heart disease. The risks associated with high blood cholesterol can be reduced by screening and early treatment, which includes medication and lifestyle changes. Lifestyle changes could include eating a diet low in saturated fat and cholesterol, engaging in moderate to vigorous exercise on a regular basis, and reducing excess weight.

### How are we doing?

In 2011 to 2013, 24.7% of Utah adults reported that they had been told by a doctor that their cholesterol was high (age-adjusted rate). Hispanics/Latinos (21.4%) had a significantly lower age-adjusted rate of high cholesterol than all Utahns.

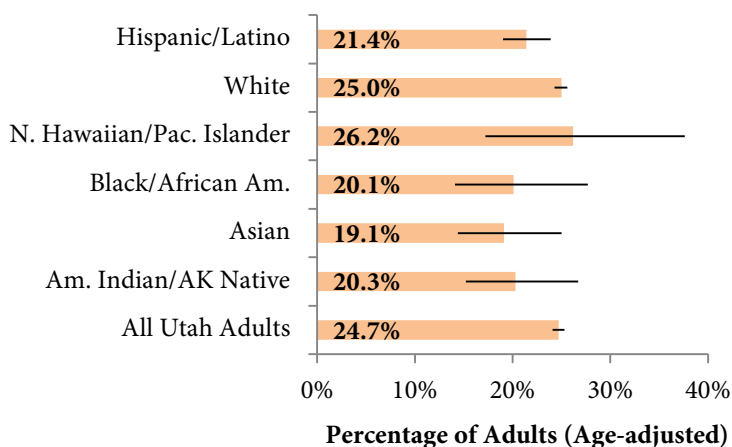
### How can we improve?

Because high blood cholesterol does not produce obvious symptoms, experts recommend adults have their cholesterol checked at least once every 5 years to help them take action to prevent or lower their risk of cardiovascular disease.

UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages.

More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### High Cholesterol, Utah 2011-2013



### Percentage of Adults With High Cholesterol, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# With High Chol.	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah Adults 18+	31,398	1,968,094	460,534	23.4 % (22.8 -24.0 %)	24.7 % (24.1 -25.3 %)	n/a
Am. Indian/AK Native	316	21,909	3,966	18.1 % (13.3 -24.2 %)	20.3 % (15.2 -26.7 %)	
Asian	325	46,949	7,042	15.0 % (11.1 -19.9 %)	19.1 % (14.4 -25.0 %)	
Black/ African Am.	178	19,717	3,549	18.0 % (12.5 -25.2 %)	20.1 % (14.1 -27.7 %)	
N. Hawaiian/Pac. Islander	139	16,524	2,760	16.7 % (10.1 -26.3 %)	26.2 % (17.2 -37.6 %)	
White	28,944	1,753,928	426,205	24.3 % (23.6 -24.9 %)	25.0 % (24.3 -25.6 %)	
Hispanic/Latino	2,080	228,844	38,675	16.9 % (14.9 -19.1 %)	21.4 % (19.0 -23.9 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# RISK FACTORS FOR ILLNESS OR INJURY

## High Blood Pressure

### Why is it important?

High blood pressure (hypertension) is an important risk factor for heart disease and stroke. It is preventable, and in most cases it can be treated with medication and lifestyle changes, such as diet, exercise, and tobacco cessation. Treatment works best when high blood pressure is identified early.

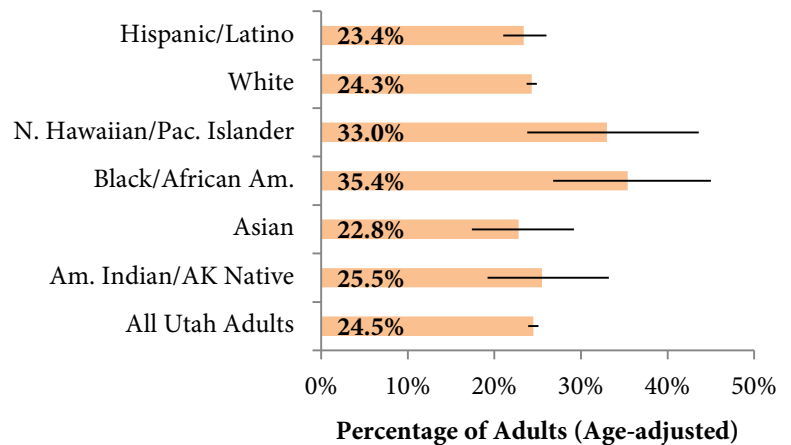
### How are we doing?

In 2011 to 2013, 24.5% of Utah adults reported that they had been told by a doctor that their blood pressure was high (age-adjusted rate). Blacks/African Americans (35.4%) had a statistically significantly higher rate of high blood pressure than all Utahns.

### How can we improve?

Because high blood pressure often does not produce symptoms, regular screening is recommended. UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICCC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

**High Blood Pressure, Utah 2011-2013**



**Percentage of Adults with High Blood Pressure, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# with High BP	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	31,096	1,968,094	468,406	23.8 % (23.2 -24.5 %)	24.5 % (23.9 -25.1 %)	n/a
Am. Indian/AK Native	313	21,909	5,127	23.4 % (17.5 -30.6 %)	25.5 % (19.2 -33.2 %)	
Asian	316	46,949	8,075	17.2 % (12.8 -22.8 %)	22.8 % (17.4 -29.2 %)	
Black/ African Am.	174	19,717	6,566	33.3 % (25.1 -42.7 %)	35.4 % (26.8 -45.0 %)	↑
N. Hawaiian/Pac. Islander	138	16,524	3,569	21.6 % (14.3 -31.2 %)	33.0 % (23.8 -43.6 %)	
White	28,693	1,753,928	424,451	24.2 % (23.5 -24.8 %)	24.3 % (23.7 -24.9 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates from US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# RISK FACTORS FOR ILLNESS OR INJURY

## Cigarette Smoking

### Why is it important?

Tobacco use - including secondhand smoke - remains the leading preventable cause of death and disease in the United States. In Utah, smoking claims more than 1,150 lives each year. It causes or worsens nearly every chronic condition and contributes to Utah's primary causes of death including heart disease, respiratory disease, and cancer. Smoking increases the risk for cancer of the lungs, larynx, esophagus, mouth, and bladder and contributes to cancer of the cervix, pancreas, and kidneys.

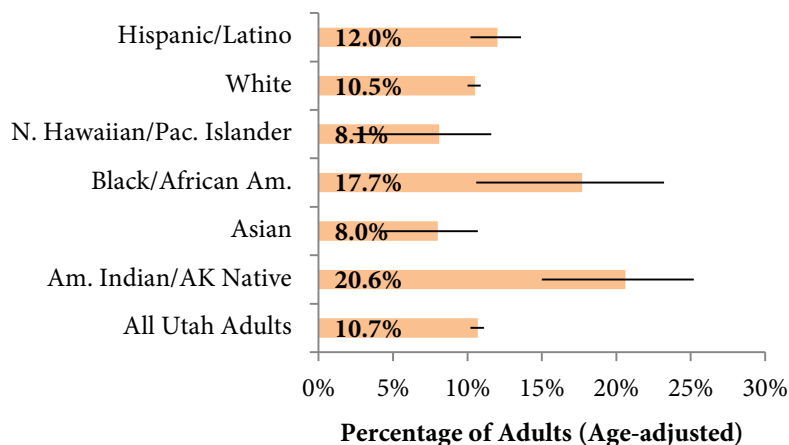
### How are we doing?

From 2011 to 2013, 10.7% of Utah adults reported smoking (age-adjusted rate). Utah's smoking rate is the lowest in the nation, however, over 202,000 Utah adults still smoke. From 2011-2013, American Indian/Alaska Native (20.6%) and Black/African American (17.7%) communities had higher rates of adult smoking than other populations in Utah.

### How can we improve?

The UDOH Tobacco Prevention and Control Program funds statewide and local tobacco-use cessation services like the Utah Tobacco Quit Line in English (1-800-QUIT-NOW, 1-800-784-8669) and Spanish (1-877-629-1585), web-based cessation services ([www.utahquitnet.com](http://www.utahquitnet.com)), school-based programs and youth advocacy groups, and community-based outreach for racial and ethnic minority groups that are disproportionately impacted by tobacco use.

### Current Cigarette Smoking, 2011-2013



### Percentage of Adults Who Are Currently Smoking, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Current Smokers	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,277	1,968,094	214,522	10.9 % (10.5 -11.4 %)	10.7 % (10.3 -11.2 %)	n/a
Am. Indian/AK Native	366	21,909	4,754	21.7 % (16.7 -27.7 %)	20.6 % (16.0 -26.2 %)	↑
Asian	402	46,949	4,648	9.9 % (6.7 -14.3 %)	8.0 % (5.3 -11.9 %)	
Black/ African Am.	207	19,717	3,411	17.3 % (12.0 -24.3 %)	17.7 % (12.2 -24.8 %)	↑
N. Hawaiian/Pac. Islander	171	16,524	1,388	8.4 % (5.0 -13.8 %)	8.1 % (4.6 -13.9 %)	
White	34,350	1,753,928	185,916	10.6 % (10.2 -11.1 %)	10.5 % (10.1 -11.0 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates from US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# RISK FACTORS FOR ILLNESS OR INJURY

## Exposure to Secondhand Smoke

### Why is it important?

The 2006 Surgeon General Report “The Health Consequences Involuntary Exposure to Tobacco Smoke” concludes that there is no safe level of secondhand smoke exposure. Children exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

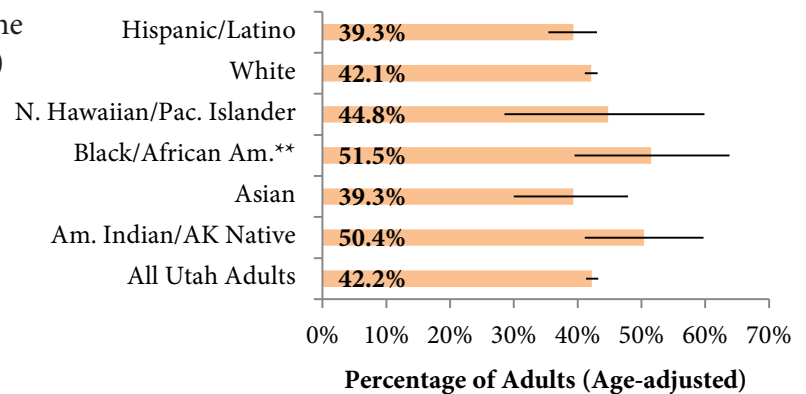
### How are we doing?

From 2011 to 2013, 42.2% (age-adjusted rate) of adult Utahns reported being exposed to secondhand smoke within the last 30 days. No disparities were observed between races/ethnicities.

### How can we improve?

The UDOH Tobacco Prevention and Control Program funds statewide and local tobacco-use cessation services like the Utah Tobacco Quit Line in English (1-800-QUIT-NOW, 1-800-784-8669) and Spanish (1-877-629-1585), web-based cessation services ([www.utahquitnet.com](http://www.utahquitnet.com)), school-based programs and youth advocacy groups, and community-based outreach for racial and ethnic minority groups that are disproportionately impacted by tobacco use.

### Adults Exposed to Secondhand Smoke 2011-2013



### Percentage of Adults Exposed to Secondhand Smoke in the Past 30 Days, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Exposed	Crude Rate (85% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	17,827	1,968,094	846,280	43.0 % (42.0 -44.0 %)	42.2 % (41.2 -43.1 %)	n/a
Am. Indian/AK Native	180	21,909	11,020	50.3 % (40.7 -59.9 %)	50.4 % (41.1 -59.7 %)	
Asian	164	46,949	21,362	45.5 % (35.8 -55.6 %)	39.3 % (30.7 -48.6 %)	
Black/ African Am.	102	19,717	10,943	55.5 % (42.9 -67.4 %)	51.5 % (39.2 -63.5 %)	
N. Hawaiian/Pac. Islander	69	16,524	8,510	51.5 % (37.3 -65.4 %)	44.8 % (29.7 -61.1 %)	
White	16,459	1,753,928	747,173	42.6 % (41.5 -43.6 %)	42.1 % (41.1 -43.1 %)	
Hispanic/Latino	1,184	228,844	95,657	41.8 % (38.1 -45.6 %)	39.3 % (35.6 -43.2 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates from US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns

# RISK FACTORS FOR ILLNESS OR INJURY

## E-Cigarette Use By Youth

### Why is it important?

Electronic cigarettes are battery-powered devices that turn liquids into an aerosol. They are marketed under a variety of different names, but are most commonly referred to as electronic cigarettes, e-cigarettes, vape pens, e-hookahs, or hookah pens. The liquids frequently contain nicotine and flavors. The US Food and Drug Administration has cautioned consumers that e-cigarettes have not been fully studied and may pose potential risks.<sup>18</sup>

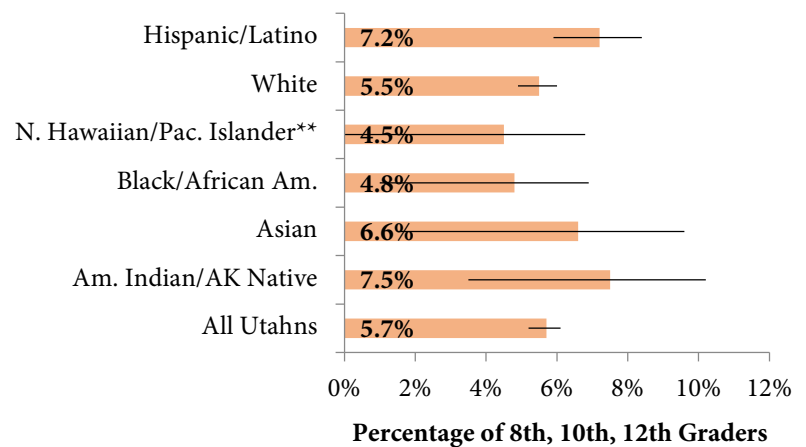
### How are we doing?

Since 2011, Utah has seen a sharp increase in e-cigarette experimentation and use among youth. In 2013, Hispanic/Latino youth had significantly higher usage of e-cigarette youth than others.

### How can we improve?

Given the uncertain public health impact of e-cigarettes and the potential for increasing nicotine addiction among young people, monitoring the use of e-cigarette products and enforcing and strengthening policies that regulate youth access should be public health priorities in Utah. The UDOH Tobacco Prevention and Control Program provides assistance through a variety of mediums. More information available at [www.tobaccofreeutah.org/](http://www.tobaccofreeutah.org/).

**Youth E-Cigarette Use, 2013**



**Percentage of 8th, 10th and 12th Graders Who Reported Using E-Cigarettes, 2012- 2013**

Race/Ethnicity	Sample Size	Crude Rate (95% CI)	Sig. *
All Utah 8th, 10th, 12th Graders	16,261	5.7 % (5.3 -6.2 %)	n/a
Am. Indian/AK Native	275	7.5 % (4.8 -11.5 %)	
Asian	306	6.6 % (3.6 -11.7 %)	
Black/ African Am.	252	4.8 % (2.7 -8.6 %)	
N. Hawaiian/Pac. Islander**	262	4.5 % (2.2 -9.0 %)	
White	12,337	5.5 % (5.0 -6.1 %)	
Hispanic/Latino	2,582	7.2 % (6.0 -8.5 %)	↑

Utah Prevention Needs Assessment Survey 2013, UDOH.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

# RISK FACTORS FOR ILLNESS OR INJURY

## Chronic Drinking

### Why is it important?

Chronic drinking is an indicator of potentially serious alcohol abuse and is related to driving under the influence of alcohol. Alcohol abuse is strongly associated with injuries and violence, chronic liver disease, fetal alcohol syndrome, and risk of other acute and chronic health conditions. Chronic drinking among women of childbearing age is a problem because of the risk for prenatal alcohol exposure. Birth defects associated with prenatal alcohol exposure can occur during the first 6 to 8 weeks of pregnancy before a woman knows she is pregnant.

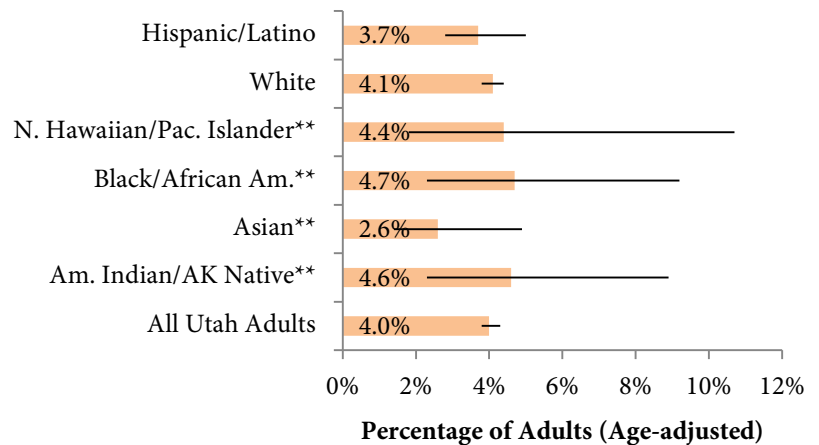
### How are we doing?

From 2011 to 2013, 4.0% of Utah adults reported chronic drinking within the past 30 days (age-adjusted rate). There were no differences in self-reported chronic drinking by race or ethnicity.

### How can we improve?

Signs of a chronic drinking problem include difficulties or changes in relationships, school performance, and social interactions. The Utah Department of Human Services, Division of Substance Abuse and Mental Health provides assistance for Utahns seeking help with chronic drinking and other substance or behavioral issues. More information available at [www.dsamh.utah.gov/](http://www.dsamh.utah.gov/).

**Chronic Drinking, 2011-2013**



**Percentage of Adults Who Reported Chronic Drinking in the Past 30 Days, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Chronic Drinking	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	36,326	1,968,094	80,692	4.1 % (3.8 -4.3 %)	4.0 % (3.8 -4.3 %)	n/a
Am. Indian/AK Native**	353	21,909	1,139	5.2 % (2.7 -9.8 %)	4.6 % (2.3 -8.9 %)	
Asian**	379	46,949	1,690	3.6 % (1.8 -6.8 %)	2.6 % (1.4 -4.9 %)	
Black/ African Am.**	201	19,717	986	5.0 % (2.5 -10.0 %)	4.7 % (2.3 -9.2 %)	
N. Hawaiian/Pac. Islander**	167	16,524	744	4.5 % (1.9 -10.2 %)	4.4 % (1.8 -10.7 %)	
White	33,547	1,753,928	71,911	4.1 % (3.8 -4.4 %)	4.1 % (3.8 -4.4 %)	
Hispanic/Latino	2,319	228,844	8,696	3.8 % (2.9 -5.0 %)	3.7 % (2.8 -5.0 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

# RISK FACTORS FOR ILLNESS OR INJURY

## Binge Drinking

### Why is it important?

Binge drinking is a national problem, especially among males and young adults, that is an indicator of potentially serious alcohol abuse. Alcohol abuse is strongly associated with injuries and violence, chronic liver disease, fetal alcohol syndrome, and risk of other acute and chronic health conditions. Binge drinking among women of childbearing age is a problem because of the risk for prenatal alcohol exposure. Birth defects associated with prenatal alcohol exposure can occur before a woman knows she is pregnant.

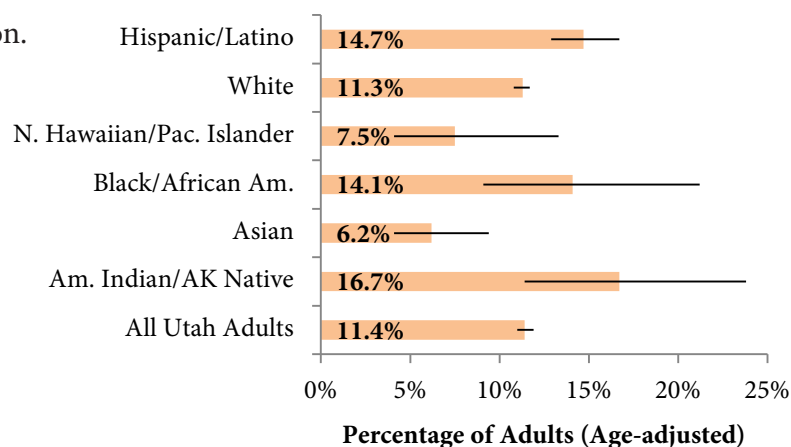
### How are we doing?

From 2011 to 2013, 11.4% of Utah adults reported binge drinking within the past 30 days (age-adjusted rate). Asians had a significantly lower rate (6.2%) and Hispanics/Latinos had a significantly higher rate (14.7%).

### How can we improve?

Individuals can choose not to binge drink and help others not to do it by drinking in moderation. The US Dietary Guidelines on alcohol recommend no more than one drink per day for women and no more than two drinks per day for men. The Utah Department of Human Services, Division of Substance Abuse and Mental Health provides assistance for Utahns seeking help with binge drinking and other substance or behavioral issues. More information available at [www.dsamh.utah.gov/](http://www.dsamh.utah.gov/).

### Binge Drinking, 2011-2013



### Percentage of Adults Who Reported Binge Drinking in the Past 30 Days, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Binge Drinking	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	36,374	1,968,094	232,235	11.8 % (11.3 -12.3 %)	11.4 % (11.0 -11.9 %)	n/a
Am. Indian/AK Native	348	21,909	3,768	17.2 % (12.3 -23.6 %)	16.7 % (11.4 -23.8 %)	
Asian	380	46,949	3,521	7.5 % (4.8 -11.4 %)	6.2 % (4.1 -9.4 %)	↓
Black/ African Am.	198	19,717	2,780	14.1 % (9.2 -20.9 %)	14.1 % (9.1 -21.2 %)	
N. Hawaiian/Pac. Islander	167	16,524	1,685	10.2 % (6.0 -16.9 %)	7.5 % (4.1 -13.3 %)	
White	33,599	1,753,928	201,702	11.5 % (11.0 -12.0 %)	11.3 % (10.8 -11.7 %)	
Hispanic/Latino	2,324	228,844	37,073	16.2 % (14.3 -18.3 %)	14.7 % (12.9 -16.7 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# RISK FACTORS FOR ILLNESS OR INJURY

## Driving Under the Influence (DUI)

### Why is it important?

Drunk drivers were responsible for 42 deaths in Utah in 2014, an increase of 19 deaths from 2013.<sup>19</sup> In 2014, there were 222 fatal vehicle crashes involving 356 motorists. Of the drivers who were tested for alcohol and/or drugs, 17.7% tested positive for alcohol consumption.<sup>19</sup>

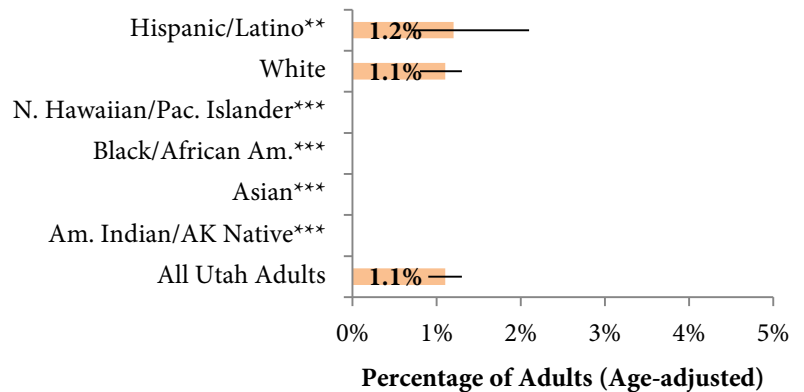
### How are we doing?

In 2010 and 2012, 1.1% of Utah adults reported that they drove a car after drinking alcohol in the past month. There were no significant differences in self-reported driving under the influence by race or ethnicity.

### How can we improve?

It is illegal to drive with a blood alcohol concentration of 0.08 or higher. This means that a person may not drink more than two or three drinks prior to driving, depending on your size and gender. Before partaking in festivities involving alcohol, designate a person to provide a safe and sober ride home who will drink only non-alcoholic beverages. The Utah Department of Human Services, Division of Substance Abuse and Mental Health and the Utah Department of Public Safety, Highway Safety Office provide resources for preventing DUI through their websites: <http://publicsafety.utah.gov/> and <http://dsamh.utah.gov/>.

**Driving Under the Influence  
2010, 2012**



### Percentage of Adults Driving Under the Influence, 2010, 2012

Race/Ethnicity	Sample Size	Average Annual 18+Population	# DUI	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	15,543	1,935,446	21,290	1.1 % (0.9 -1.4 %)	1.1 % (0.9 -1.3 %)	n/a
Am. Indian/AK Native***	142	22,703	***	***	***	
Asian***	172	44,593	***	***	***	
Black/ African Am.***	77	18,954	***	***	***	
N. Hawaiian/Pac. Islander***	57	16,253	***	***	***	
White	14,279	1,732,619	19,059	1.1 % (0.9 -1.3 %)	1.1 % (0.8 -1.3 %)	
Hispanic/Latino**	1,004	223,136	3,347	1.5 % (0.8 -2.7 %)	1.2 % (0.7 -2.1 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population estimates averaged from 2010 and 2011 ACS 1-Year Estimates.

\* Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

\*\*\* Estimate has been suppressed because standard error is greater than 50% or undetermined.



A scenic photograph of a multi-tiered waterfall cascading over mossy rocks, with water creating white foam as it falls. The image is used as a background for the top and bottom portions of the page.

# Protective Factors for Health



UTAH DEPARTMENT OF  
**HEALTH**

Office of Health Disparities

# PROTECTIVE FACTORS FOR HEALTH

## Daily Fruit Consumption

### Why is it important?

Fruits and vegetables contain essential vitamins, minerals, fiber, and other compounds that may help prevent many chronic diseases. Compared with people who consume a diet with only small amounts of fruits and vegetables, those who eat more generous amounts as part of a healthful diet are likely to have reduced risk of chronic diseases, including stroke and perhaps other cardiovascular diseases, and certain cancers. Fruits and vegetables also help people to achieve and maintain a healthy weight because they are relatively low in energy density.

### How are we doing?

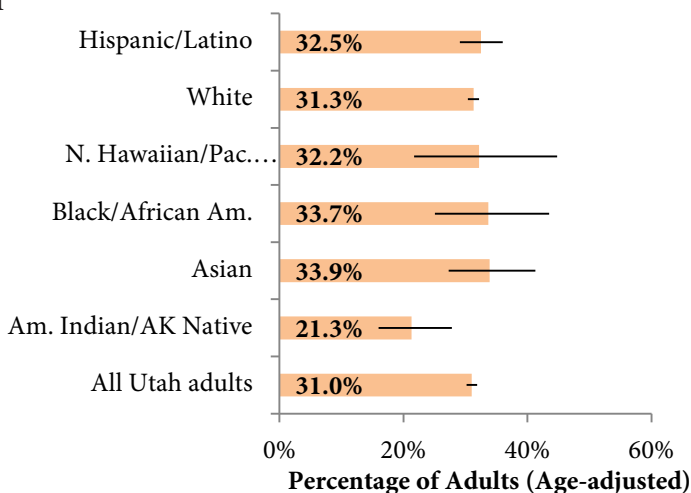
Only 31.0% of Utah adults reported eating two or more servings of fruit each day in 2011-2013. American Indians/Alaska natives had a significantly lower rate of fruit consumption (21.3%) than all Utahns.

### How can we improve?

All Utahns should eat more fruits, with the goal of at least four servings of fruits each day.<sup>20</sup>

The UDOH WIC (Women, Infants and Children) Program offers nutritious foods and nutrition education for pregnant women, new mothers, and young children ([www.health.utah.gov/wic](http://www.health.utah.gov/wic)). The UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs can provide information on healthy foods at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

**Daily Fruit Consumption, 2011-2013**



**Percentage of Adults Who Reported Eating Two+ Fruits Daily, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Eating Fruit	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig.*
All Utah adults 18+	26,836	1,968,094	610,109	31.0 % (30.1 -31.9 %)	31.0 % (30.2 -31.9 %)	n/a
Am. Indian/AK Native	280	21,909	4,776	21.8 % (16.0 -29.1 %)	21.3 % (16.0 -27.8 %)	↓
Asian	264	46,949	15,493	33.0 % (25.7 -41.1 %)	33.9 % (27.3 -41.3 %)	
Black/ African Am.	149	19,717	6,625	33.6 % (24.3 -44.4 %)	33.7 % (25.1 -43.5 %)	
N. Hawaiian/Pac. Islander	129	16,524	4,709	28.5 % (18.8 -40.7 %)	32.2 % (21.7 -44.8 %)	
White	24,778	1,753,928	547,226	31.2 % (30.3 -32.1 %)	31.3 % (30.4 -32.2 %)	
Hispanic/Latino	1,748	228,844	73,459	32.1 % (28.6 -35.8 %)	32.5 % (29.1 -36.0 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# PROTECTIVE FACTORS FOR HEALTH

## Daily Vegetable Consumption

### Why is it important?

Fruits and vegetables contain essential vitamins, minerals, fiber, and other compounds that may help prevent many chronic diseases. Compared with people who consume a diet with only small amounts of fruits and vegetables, those who eat more generous amounts as part of a healthful diet are likely to have reduced risk of chronic diseases, including stroke and perhaps other cardiovascular diseases, and certain cancers. Fruits and vegetables also help people to achieve and maintain a healthy weight, because they are relatively low in energy density.

### How are we doing?

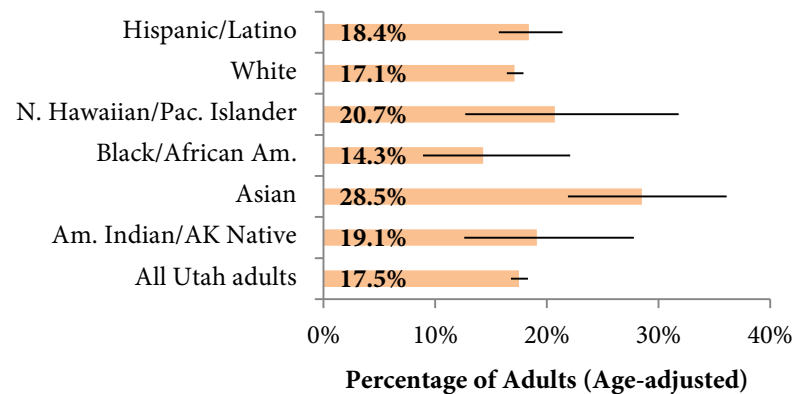
Only 17.5% of Utah adults reported eating three or more daily servings of vegetables in 2011-2013. Asians had a significantly higher rate of vegetable consumption (28.5%) than all Utahns.

### How can we improve?

All Utahns should eat more vegetables, with the goal of at least four servings each day.<sup>20</sup> The UDOH WIC (Women, Infants and Children) Program offers nutritious foods and nutrition education for pregnant women, new mothers, and young children ([www.health.utah.gov/wic](http://www.health.utah.gov/wic)). The UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs can provide information on healthy foods at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Daily Vegetable Consumption

2011-2013



### Percentage of Adults Who Reported Eating 3+ Vegetables Daily, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# Eating Vegetables	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	26,676	1,968,094	344,416	17.5 % (16.7 -18.3 %)	17.5 % (16.8 -18.3 %)	n/a
Am. Indian/AK Native	270	21,909	3,922	17.9 % (12.1 -25.7 %)	19.1 % (12.6 -27.8 %)	
Asian	262	46,949	12,817	27.3 % (20.2 -35.9 %)	28.5 % (21.9 -36.1 %)	↑
Black/ African Am.	149	19,717	2,879	14.6 % (9.0 -22.8 %)	14.3 % (8.9 -22.1 %)	
N. Hawaiian/Pac. Islander	127	16,524	3,569	21.6 % (12.9 -33.9 %)	20.7 % (12.7 -31.8 %)	
White	24,637	1,753,928	299,922	17.1 % (16.3 -17.9 %)	17.1 % (16.4 -17.9 %)	
Hispanic/Latino	1,742	228,844	42,565	18.6 % (15.8 -21.9 %)	18.4 % (15.7 -21.4 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# PROTECTIVE FACTORS FOR HEALTH

## Recommended Aerobic Physical Activity

### Why is it important?

Physical activity protects independently against cardiovascular disease. Physical activity has been shown to reduce the risk of some cancers, type 2 diabetes, stroke, and heart disease. Physical activity improves general physical and mental health. Regular physical activity helps to relieve pain from osteoarthritis. Regular physical activity is also known to improve effective disorders such as depression and anxiety, and increase quality of life and independent living among the elderly. Physical inactivity is a leading cause of premature death and also results in greater occurrence of illness.

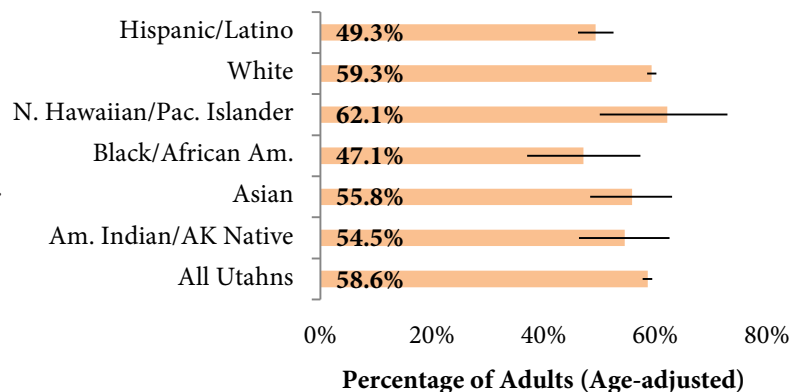
### How are we doing?

In 2011-2013, 58.6% of Utah adults reported getting the recommended amount of aerobic activity (age-adjusted rate). Hispanics/Latinos and Blacks/African Americans had significantly lower rates of recommended aerobic physical activity than all Utahns.

### How can we improve?

In 2013, the American Heart Association Task Force on Practice Guidelines reconfirmed that regular physical activity can improve blood pressure and blood lipid levels.<sup>21</sup> The US Department of Health and Human Services recommends at least 30 minutes of light or moderate physical activity five or more times per week, or at least 20 minutes of vigorous physical activity three or more times per week.<sup>22</sup> The UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs can provide information on physical activity at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Recommended Aerobic Activity 2011-2013



### Percentage of Adults Getting the Recommended Amount of Aerobic Activity, 2011-2013

Race/Ethnicity	Sample Size	Adult 18+ Population	# Getting Activity	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	28,032	1,968,094	1,147,399	58.3 % (57.5 -59.2 %)	58.6 % (57.7 -59.4 %)	n/a
Am. Indian/AK Native	278	21,909	12,050	55.0 % (47.1 -62.8 %)	54.5 % (46.3 -62.5 %)	
Asian	263	46,949	26,291	56.0 % (48.3 -63.5 %)	55.8 % (48.3 -63.0 %)	
Black/ African Am.	152	19,717	9,129	46.3 % (35.9 -57.0 %)	47.1 % (37.0 -57.3 %)	↓
N. Hawaiian/Pac. Islander	126	16,524	10,410	63.0 % (51.8 -72.9 %)	62.1 % (50.0 -72.9 %)	
White	25,942	1,753,928	1,036,571	59.1 % (58.3 -60.0 %)	59.3 % (58.5 -60.2 %)	
Hispanic/Latino	1,820	228,844	113,049	49.4 % (46.3 -52.5 %)	49.3 % (46.1 -52.5 %)	↓

Utah BRFS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

# Health of Mothers and Infants



UTAH DEPARTMENT OF  
**HEALTH**  

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Office of Health Disparities

# HEALTH OF MOTHERS AND INFANTS

## Infant Mortality

### Why is it important?

The infant death rate is an important measure of a nation's health and a worldwide indicator of health status and social well-being. It is a critical indicator of the health of a population. The top four causes of infant mortality in Utah include birth defects, infant medical conditions, perinatal conditions (includes disorders related to preterm birth and can reflect the overall state of maternal health, as well as the quality and accessibility of primary health care for pregnant women), and sudden unexpected infant death (formerly SIDS, now commonly referred to as Sudden Unexpected Infant Death, or SUID). These causes historically account for the greatest number of infant deaths in Utah; their proportions fluctuate somewhat from year to year.<sup>23</sup>

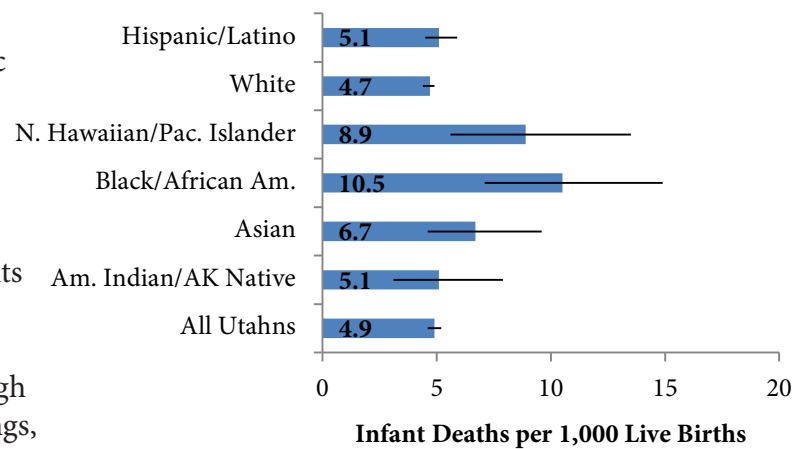
### How are we doing?

From 2008 to 2012, the infant mortality rate for all Utahns was 4.9 per 1,000 live births. Blacks/African Americans and Native Hawaiians/Pacific Islanders had significantly higher infant mortality rates than all Utahns.

### How can we improve?

Infant mortality is a complex issue with many contributing factors including social determinants of health, environmental conditions, as well as maternal health indicators. The most common causes of infant mortality may be reduced through access to early prenatal care and genetic screenings, pre-conception consumption of folic acid, and precautionary measures intended to reduce the risk of SUID. The UDOH Maternal and Infant Health Program (<http://www.health.utah.gov/mihp>) can provide resources for pregnant women and their families to promote healthy pregnancies and births. The UDOH Baby Your Baby program offers information about healthy pregnancy at [www.babyyourbaby.org](http://www.babyyourbaby.org) and 1-800-826-9662.

**Infant Mortality, Utah 2008-2012**



**Utah Infant Mortality Rate, 2008-2012**

Race/Ethnicity	Average Annual # of Deaths	Average Annual # of Live Births	Crude Rate/ 1,000 Live Births (95% CI)	Sig. *
All Utah infants	258	52,840	4.9 (4.6-5.2)	n/a
Am. Indian/AK Native	4	748	5.1 (3.1-7.9)	
Asian	6	890	6.7 (4.6-9.6)	
Black/ African Am.	6	591	10.5 (7.1-14.9)	↑
N. Hawaiian/Pac. Islander	4	494	8.9 (5.6-13.5)	↑
White	228	49,027	4.7 (4.4-4.9)	
Hispanic/Latino	43	8,315	5.1 (4.5-5.9)	

Utah Linked Birth and Death Certificate Database (Birth Cohort), Office of Vital Records and Statistics, UDOH.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

# HEALTH OF MOTHERS AND INFANTS

## Low Birth Weight

### Why is it important?

Low birth weight increases the risk for infant mortality and morbidity. As birth weight decreases, the risk for death increases. Low birth weight infants who survive often require intensive care at birth, may develop chronic illnesses, and later may require special education services. Health care costs and length of hospital stay are higher for low birth weight infants. Utah inpatient hospital discharge data (2011) indicate that average hospital charges for a low birth weight infant were \$58,770 (DRG 386, 387, 388) compared to \$2,389 for a normal weight newborn infant (DRG 391).<sup>24</sup>

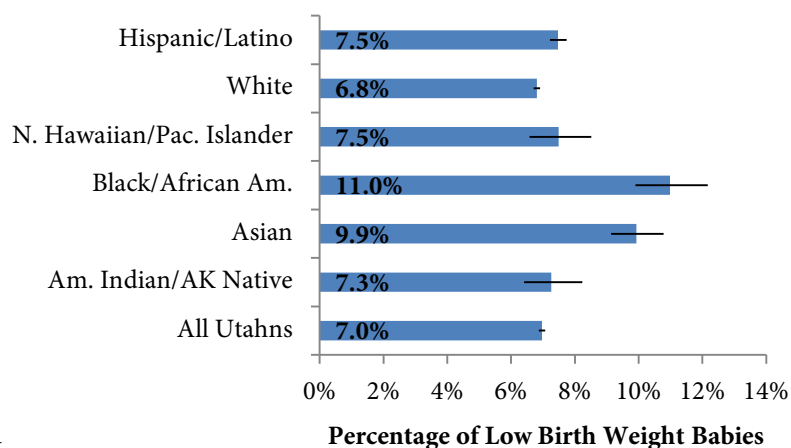
### How are we doing?

From 2009-2013, 7.0% of live born Utah infants weighed less than 2,500 grams. Asians and Blacks/African Americans, and Hispanics/Latinos had significantly higher rates of low birth weight than all Utahns.

### How can we improve?

Infant mortality is a complex issue with many contributing factors including social determinants of health, environmental conditions, as well as maternal health indicators. The most common causes of infant mortality may be reduced through access to early prenatal care and screenings, pre-conception consumption of folic acid, and precautionary measures intended to reduce risk of SUID. The UDOH Maternal and Infant Health Program can provide resources for pregnant women and their families to promote healthy pregnancies and births. The UDOH Baby Your Baby program offers information about healthy pregnancy at [www.babyyourbaby.org](http://www.babyyourbaby.org) and 1-800-826-9662.

### Low Birth Weight, Utah 2009-2013



### Percentage of Live Born Infants with Low Birth Weight, 2009-2013.

Race/Ethnicity	Total Infants <2500 g	Total Live Births	% of Infants <2500 g	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	18,084	259,509	7.0%	6.9%	7.1%	n/a
Am. Indian/AK Native	235	3,235	7.3%	6.4%	8.2%	
Asian	519	5,227	9.9%	9.1%	10.8%	↑
Black/ African Am.	331	3,014	11.0%	9.9%	12.2%	↑
N. Hawaiian/Pac. Islander	222	2,965	7.5%	6.6%	8.5%	
White	16,384	240,700	6.8%	6.7%	6.9%	↓
Hispanic/Latino	2,968	39,723	7.5%	7.2%	7.7%	↑

Utah Birth Certificate Database.

\*Arrows indicate where rate was higher or lower than for all Utahns.

# HEALTH OF MOTHERS AND INFANTS

## Preterm Birth

### Why is it important?

Preterm birth is the leading cause of perinatal death in otherwise normal newborns. Babies born preterm also have increased risks for long term morbidities and often require intensive care after birth. Average hospital stays for preterm infants without complications are three times longer than a term infant, and for a preterm birth with complications, hospital stays are over eight times longer. The March of Dimes estimates that each preterm birth carries a cost of \$51,600 for medical care, early intervention services, and special education.<sup>25</sup>

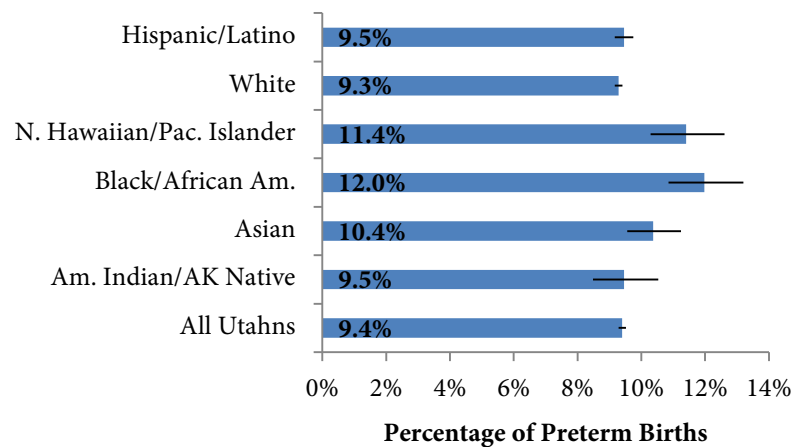
### How are we doing?

In 2009-2013, 9.4% of all Utah live births were preterm. Black/African American, Native Hawaiian/Pacific Islander, and Asian populations had higher preterm birth rates than other Utahns.

### How can we improve?

A combination of primary, secondary, and tertiary interventions is most likely to have lasting, widespread effect on preterm birth. Primary prevention efforts targeted at all women have not been embraced in the USA to the extent that they are in Europe, but have the greatest potential of raising overall awareness.<sup>26</sup> UDOH Maternal and Infant Health Program (<http://www.health.utah.gov/mihp>) provides resources to help women have healthier pregnancies. The Baby Your Baby program offers information about healthy pregnancy at [www.babyyourbaby.org/](http://www.babyyourbaby.org/).

**Preterm Birth, Utah 2009-2013**



**Percentage of Live Infants Born at Less Than 37 Weeks, 2009-2013**

Race/Ethnicity	Total Births <37 Weeks	Total Live Births	% of Births <37 Weeks	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah live births	24,402	259,509	9.4%	9.3%	9.5%	n/a
Am. Indian/AK Native	306	3,235	9.5%	8.5%	10.5%	
Asian	542	5,227	10.4%	9.6%	11.2%	↑
Black/ African Am.	361	3,014	12.0%	10.9%	13.2%	↑
N. Hawaiian/Pac. Islander	338	2,965	11.4%	10.3%	12.6%	↑
White	22,360	240,700	9.3%	9.2%	9.4%	
Hispanic/Latino	3,756	39,723	9.5%	9.2%	9.8%	

Utah Birth Certificate Database.

\*Arrows indicate where the rate was higher or lower than for all Utahns.



# HEALTH OF MOTHERS AND INFANTS

## Obesity in Pregnancy

### Why is it important?

Women who are not at a healthy weight prior to pregnancy are at increased risk of adverse maternal and infant outcomes. Women who are obese prior to pregnancy have longer hospital stays and higher utilization of medical care during pregnancy.<sup>27</sup>

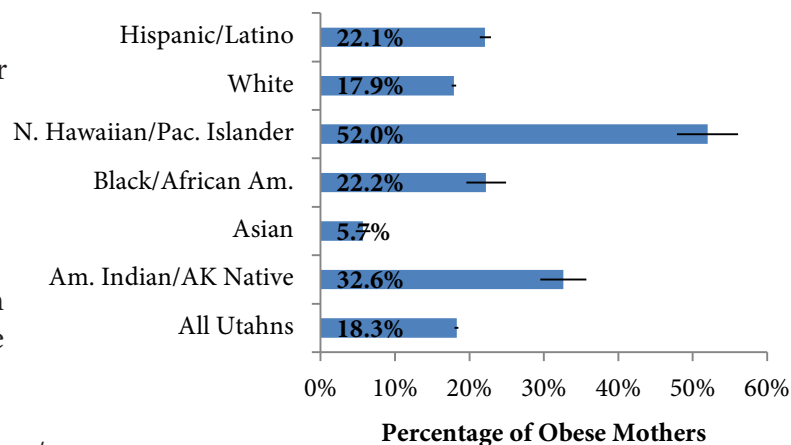
### How are we doing?

In 2012-2013, 18.3% of Utah childbearing women over 18 years-old were obese prior to pregnancy. American Indian/Alaska Native, Black/African American, Hispanic/Latino, and especially Native Hawaiian/Pacific Islander mothers had significantly higher rates of obesity in pregnancy than all Utahns. Asian mothers had significantly lower rates of obesity in pregnancy than all Utahns.

### How can we improve?

Maternal nutrition is a public health risk factor that can be modified through a combination of integrated efforts,<sup>28</sup> including individual behavior change, social support, and access to healthy foods and opportunities for physical activity. The UDOH Maternal and Infant Health Program (<http://www.health.utah.gov/mihp>) provides resources to help women have healthier pregnancies. The UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs can provide information on addressing obesity, maintaining healthy weight, and physical activity at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Obesity in Pregnancy, 2012-2013



### Percentage of Live Births to Utah Women With BMI >30 Prior to Pregnancy, 2012-2013

Race/Ethnicity	Average Annual # Obese Mothers	Average Annual # Live Births	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah live births	9,345	51,176	18.3%	18.0%	18.5%	n/a
Am. Indian/AK Native	213	652	32.6%	29.5%	35.7%	↑
Asian	64	1,128	5.7%	4.7%	6.7%	↓
Black/ African Am.	134	603	22.2%	19.6%	24.9%	↑
N. Hawaiian/Pac. Islander	306	589	52.0%	47.9%	56.1%	↑
White	8,497	47,427	17.9%	17.6%	18.2%	↓
Hispanic/Latino	1,683	7,614	22.1%	21.4%	22.9%	↑

Utah Birth Certificate Database.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

Obesity for adults is defined as a body mass index (BMI) of 30 or more.

# HEALTH OF MOTHERS AND INFANTS

## Smoking During Pregnancy

### Why is it important?

The 2013 birth certificates data indicate that 3.2% of women smoked during the last trimester of their pregnancy. According to the 2010 Surgeon General's Report,<sup>29</sup> cigarette smoking during pregnancy increases the risk for: low birth weight, neurologic deficits in offspring, increased maternal blood pressure and heart rate, preterm birth, premature rupture of membranes, placental abruption, placenta previa, miscarriage, stillbirth, neonatal mortality, cleft lip/palate, fetal growth restriction/small for gestational age, and Sudden Infant Death Syndrome (SIDS). Maternal smoking may also lead to low birth weight (LBW) through complications requiring premature delivery such as preterm, premature rupture of membranes, placental abruption, or placenta previa.

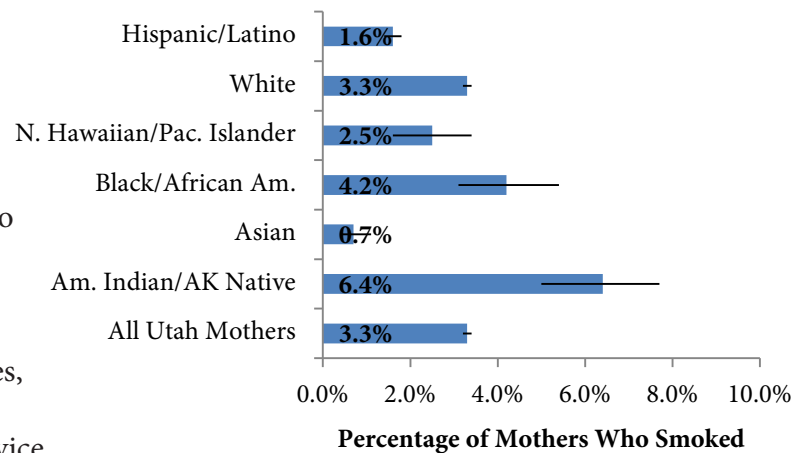
### How are we doing?

In 2012-2013, 3.3% of all Utah childbearing women smoked during the third trimester of pregnancy. American Indian/Alaska Native and White mothers had a significantly higher rate of smoking during the third trimester than all Utahns. Hispanic/Latino and Asian mothers had a significantly lower rate of smoking during pregnancy than all Utahns.

### How can we improve?

The benefits of quitting have been shown for smokers of all ages, and quitting smoking prior to or during pregnancy has significant benefits for mothers and babies.<sup>29</sup> The UDOH Tobacco Prevention and Control Program (TPCP) funds statewide and local tobacco-use cessation services, including the Utah Tobacco Quit Line (1-800-QUIT-NOW), a web-based cessation service ([www.utahquitnet.com](http://www.utahquitnet.com)), and school and community-based programs for teens and pregnant women.

Smoking in Pregnancy, 2012-2013



### Percentage of Women Who Smoked During the Third Trimester, 2012-2013

Race/Ethnicity	Average Annual # Born to Smoker	Average Annual # Live Births	Crude Rate (95% CI)	Sig. *
All Utah mothers	1,683	51,176	3.3% (3.2% - 3.4%)	n/a
Am. Indian/AK Native	42	652	6.4% (5.0% - 7.7%)	↑
Asian	8	1,128	0.7% (0.4% - 1.1%)	↓
Black/ African Am.	26	603	4.2% (3.1% - 5.4%)	
N. Hawaiian/Pac. Islander	15	589	2.5% (1.6% - 3.4%)	
White	1,563	47,427	3.3% (3.2% - 3.4%)	
Hispanic/Latino	119	7,614	1.6% (1.4% - 1.8%)	↓

Utah Birth Certificates Database.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

# HEALTH OF MOTHERS AND INFANTS

## Gestational Diabetes

### Why is it important?

Gestational diabetes is having abnormally high blood glucose levels during pregnancy. This abnormality usually disappears after pregnancy, although as many as 5% to 10% of women with gestational diabetes may actually have had undiagnosed type 2 diabetes. Women with gestational diabetes have a higher risk of developing diabetes later in life. Women with gestational diabetes have a 35% to 60% chance of developing diabetes within 20 years.<sup>30</sup> Mothers with gestational diabetes are more likely to have large babies (> 4,000 grams), a risk factor for cesarean section delivery and birth complications. Infants born to women with gestational diabetes have a higher risk of developing diabetes and obesity themselves.

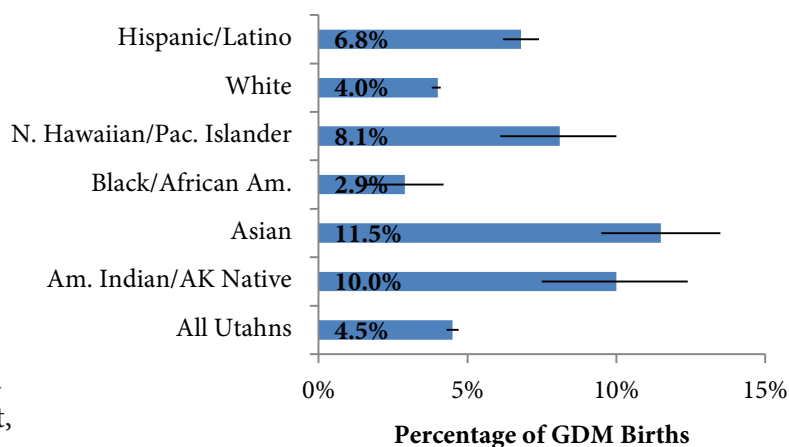
### How are we doing?

The prevalence of gestational diabetes in Utah has risen steadily since 1990, increasing from 1.4% to 4.5% of births in 2013. Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Hispanic/Latino women had significantly higher rates of gestational diabetes than all Utahns. Blacks/African Americans and Whites had significantly lower rates.

### How can we improve?

Addressing diabetes can reduce complications like kidney failure, amputation, blindness, heart disease, and stroke.<sup>30</sup> The UDOH Maternal and Infant Health Program addresses gestational diabetes (<http://www.health.utah.gov/mihp>), and the UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs can provide information on diabetes prevention and management at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

**Gestational Diabetes (GDM), 2013**



**Percentage of Births to Mothers Who Had Gestational Diabetes (GDM), 2013**

Race/Ethnicity	# Births to GDM Mothers	Total # Live Births	Crude Rate (95% CI)	Sig. *
All Utah live births	2,301	50,913	4.5% (4.3% - 4.7%)	n/a
Am. Indian/AK Native	63	633	10.0% (7.5% - 12.4%)	↑
Asian	127	1,104	11.5% (9.5% - 13.5%)	↑
Black/ African Am.	18	628	2.9% (1.5% - 4.2%)	↓
N. Hawaiian/Pac. Islander	50	615	8.1% (5.9% - 10.4%)	↑
White	2,003	47,137	4.2% (4.1% - 4.4%)	↓
Hispanic/Latino	519	7,642	6.8% (6.2% - 7.4%)	↑

Utah Birth Certificates Database.

\*Arrows indicate where the rate was higher or lower than for All Utahns.

# HEALTH OF MOTHERS AND INFANTS

## Folic Acid Consumption

### Why is it important?

Consuming a multivitamin with folic acid daily from at least one month before conception through the first months of pregnancy can substantially decrease the risk of neural tube defects, such as anencephaly and spina bifida. Most neural tube defects have severe consequences for the affected pregnancy or child. Many affected pregnancies are lost before birth. Babies with anencephaly usually die within days from birth. Babies with spina bifida are at much increased risk of illness, long term disability, and premature death. These children often need lifelong health and rehabilitation services to improve outcomes and reduce complications.<sup>31</sup>

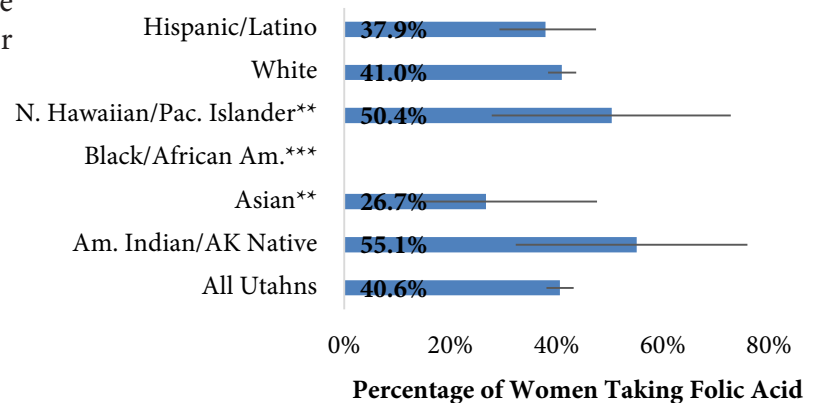
### How are we doing?

In 2010 and 2012, 40.6% of Utah women age 18-44 reported taking folic acid daily (age-adjusted rate). (Age-adjusted using two age groups: 18-34 and 35-44 years.)

### How can we improve?

All women of childbearing age should take a daily supplement containing 400 micrograms of folic acid. Promoting folic acid awareness and use of a multivitamin with folic acid can have a major impact on improving the health of babies and children in Utah.<sup>31</sup> The UDOH Bureau of Children with Special Health Care Needs operates the Utah Birth Defect Network which tracks neural tube defects and can provide resources on folic acid and birth defects ([www.health.utah.gov/cshcn](http://www.health.utah.gov/cshcn)).

### Daily Folic Acid Consumption 2010, 2012



### Percentage of Women (18-44 Years) Taking Folic Acid - 2010, 2012

Race/Ethnicity	Sample Size	2010,2012 Annual Female 18-44 Population	# Reporting Daily Consumption	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah women (18-44)	2,294	548,402	213,328	38.9 % (36.3 -41.6 %)	40.6 % (38.1 -43.2 %)	n/a
Am. Indian/AK Native	22	7,277	3,442	47.3 % (22.9 -73.0 %)	55.1 % (32.3 -75.9 %)	
Asian**	35	14,503	3,278	22.6 % (10.6 -41.9 %)	26.7 % (12.8 -47.6 %)	
Black/ African Am.***	13	4,672	***	***	***	
N. Hawaiian/Pac. Islander**	15	5,287	2,099	39.7 % (17.2 -67.6 %)	50.4 % (27.8 -72.8 %)	
White	2,081	480,441	190,255	39.6 % (36.9 -42.4 %)	41.0 % (38.4 -43.7 %)	
Hispanic/Latino	210	77,024	26,804	34.8 % (26.6 -43.9 %)	37.9 % (29.2 -47.4 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH. Population estimates averaged from 2010 and 2012 ACS 1-Year Estimates.

\*Arrows indicate where age-adjusted rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

\*\*\*Estimate has been suppressed because standard error is greater than 50% or undetermined.

# HEALTH OF MOTHERS AND INFANTS

## Births to Adolescents

### Why is it important?

Bearing a child during adolescence is often associated with long-term difficulties for the mother, her child, and society. These consequences are often attributable to poverty and other adverse socioeconomic circumstances that frequently accompany early childbearing.<sup>32</sup> Compared to babies born to older mothers, babies born to adolescent mothers, particularly young adolescent mothers, are at higher risk of low birthweight and infant mortality. These babies are more likely to grow up in homes that offer lower levels of emotional support and cognitive stimulation, and they are less likely to earn a high school diploma. For the mothers, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce future employment prospects and earning potential.

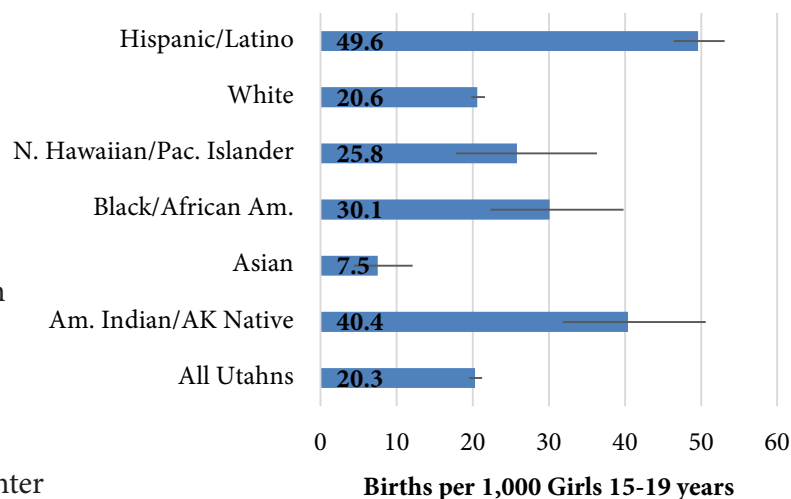
### How are we doing?

In 2013, the rate of adolescent girls (15-19 years) who gave birth was 20.3 per 1,000. American Indians/Alaska Natives, Hispanics/Latinos and Blacks/African Americans had a significantly higher rate of adolescent births than all Utahns. Asians had a significantly lower adolescent birth rate than all Utahns.

### How can we improve?

The UDOH Maternal and Infant Health program ([www.health.utah.gov/mih](http://www.health.utah.gov/mih)) can provide information on adolescent reproductive health issues and teen pregnancy prevention programs. The US Dept. of Health & Human Services also hosts a Teen Pregnancy Prevention Resource Center ([www.hhs.gov/ash/oah](http://www.hhs.gov/ash/oah)).

**Births to Adolescents, Utah 2013**



### Adolescent Birth Rate, 2013

Race/Ethnicity	# of Births to Girls 15-19 Years	Total Population of Girls 15-19	Crude Rate/ 1,000 (95% CI)	Sig. *
All Utah girls, 15-19 years	2,226	109,556	20.3 (19.5-21.2)	n/a
Am. Indian/AK Native	76	1,881	40.4 (31.8-50.6)	↑
Asian	17	2,254	7.5 (4.4-21.1)	↓
Black/ African Am.	49	1,629	30.1 (22.3-39.8)	↑
N. Hawaiian/Pac. Islander	33	1,278	25.8 (17.8-36.3)	
White	2,036	98,669	20.6 (19.8-21.6)	
Hispanic/Latino	858	17,290	49.6 (46.4-53.1)	↑

Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

# HEALTH OF MOTHERS AND INFANTS

## Unintended Pregnancy

### Why is it important?

In the United States, unintended pregnancy is a major public health issue. Unintended pregnancy is a general term that includes pregnancies that a woman reports were either mistimed or unwanted at the time of conception. Women with unintended pregnancies are less likely to seek early prenatal care or receive adequate prenatal care, they are more likely to smoke or drink during pregnancy, and are less likely to initiate or maintain breastfeeding.<sup>33</sup>

### How are we doing?

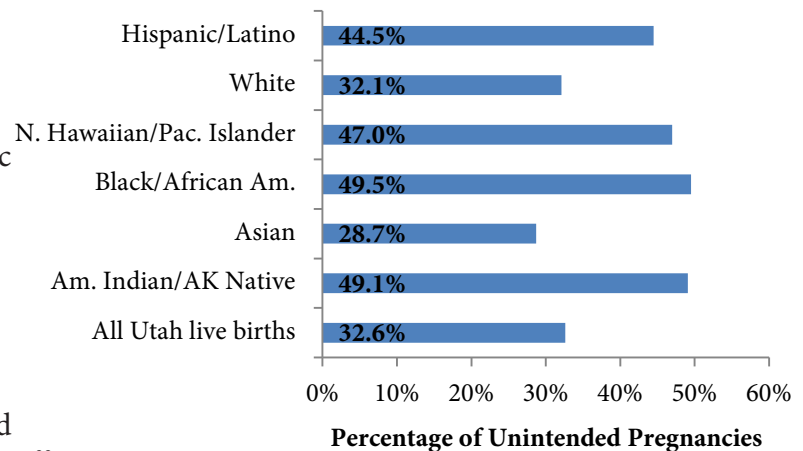
From 2009-2011, the crude rate of Utah women who reported having an unintended pregnancy was 32.6%, or roughly one-third of all pregnancies. Unintended pregnancy rates among American Indian/Alaska Native, Black/African American, and Hispanic/Latino populations were significantly higher than all Utahns. In 2011, 31.8% of women reported that their birth resulted from an unintended pregnancy. Of the women who reported an unintended pregnancy, 56.4% were using some method to avoid pregnancy.<sup>33</sup>

### How can we improve?

In order to reduce unplanned pregnancies, public health efforts may include education to increase knowledge of human reproduction, conception, and proper use of contraception. Reproductive health services are intended to increase dialogue between health care providers and women in regards to topics like family planning. As of August 2012, ACA compliant health plans should provide coverage for contraception and counseling.<sup>33</sup>

The UDOH Maternal and Infant Health Program (<http://www.health.utah.gov/mihp/>) provides information on family planning, contraception, and birth spacing.

Unintended Pregnancy, 2009-2011



### Unintended Pregnancy Rate, 2009-2011

Race/Ethnicity	Sample Size	Average Annual # of Live Births	Estimated Annual # Unintended	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah live births	4,598	50,611	16,493	32.6%	31.1%	34.1%	n/a
Am. Indian/AK Native	48	535	263	49.1%	32.9%	65.3%	↑
Asian	78	811	233	28.7%	17.5%	39.9%	
Black/ African Am.	48	442	219	49.5%	33.2%	65.8%	↑
N. Hawaiian/Pac. Islander	31	299	140	47.0%	26.9%	67.1%	
White	4,275	47,542	15,245	32.1%	30.6%	33.6%	
Hispanic/Latino	976	8,323	3,707	44.5%	40.9%	48.1%	↑

Utah Pregnancy Risk Assessment Monitoring System. See *Methodology* section for details on PRAMS data.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

# HEALTH OF MOTHERS AND INFANTS

## Ever Breastfeeding

### Why is it important?

Breastfeeding ensures the best possible health as well as the best development and psychosocial benefits for the infant, in addition to benefits for mothers and society. Breastfeeding for at least 12 months confers additional benefits for infant and maternal health, as well as economic benefits. The American Academy of Pediatrics, Committee on Nutrition recommends that all infants be breastfed for at least 12 months, and thereafter as long as mutually desired.<sup>51</sup>

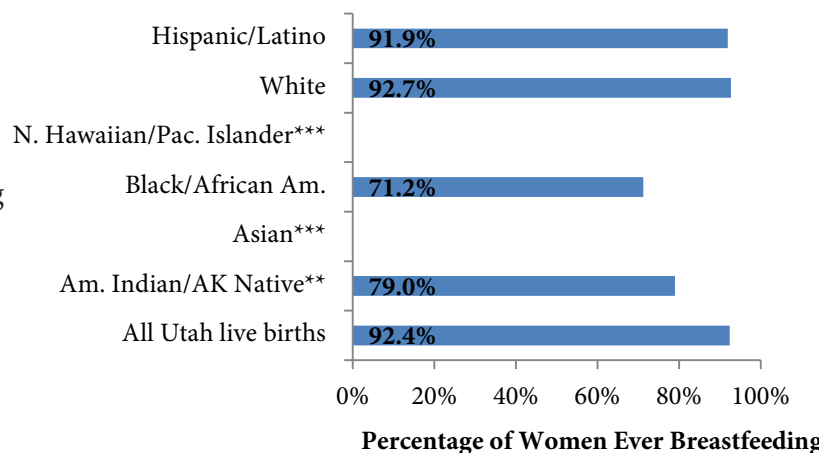
### How are we doing?

From 2009-2011, 92.4% of Utah women who had a life birth reported having ever breastfed. Black/African American mothers had a significantly lower rate of ever breastfeeding than all Utahns.

### How can we improve?

Utah WIC Program, through local health department WIC Clinics, provides breastfeeding education and support, community resources, breastfeeding classes, individualized consultation with a Lactation Consultant or Peer Counselor, nutritious food for breastfeeding mothers (up to 1 year postpartum), and breast pumps and supplies.<sup>51</sup> More information is available through 1-877-WIC-KIDS and the website, [www.health.utah.gov/wic/](http://www.health.utah.gov/wic/).

Ever Breastfeeding, 2009-2011



Percentage of Women Who Have Ever Breastfed, 2009-2011

Race/Ethnicity	Sample Size	Average Annual # Women w/ Live Birth	Estimated Annual # Ever Breastfed	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah live births	4,532	5,043	46,622	92.4%	91.6%	93.2%	n/a
Am. Indian/AK Native**	46	521	411	79.0%	65.3%	92.7%	
Asian***	75	***	***	***	***	***	
Black/ African Am.	45	410	292	71.2%	55.6%	86.8%	
N. Hawaiian/Pac. Islander***	26	***	***	***	***	***	
White	4,225	4,746	41,418	92.6%	91.7%	93.5%	
Hispanic/Latino	965	8,326	7,651	91.9%	89.9%	93.9%	

Utah Pregnancy Risk Assessment Monitoring System.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

\*\* Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

\*\*\*Estimate has been suppressed due to low frequency.

# HEALTH OF MOTHERS AND INFANTS

## Major Structural Birth Defects

### Why is it important?

Compared to other newborns, infants with birth defects are at a much greater risk of dying early in life. Such increased risk, combined with the frequency of birth defects, explains why birth defects are a major driver of overall infant mortality in developed countries, including the United States. Currently, birth defects are the leading cause of infant mortality in the United States.<sup>37</sup>

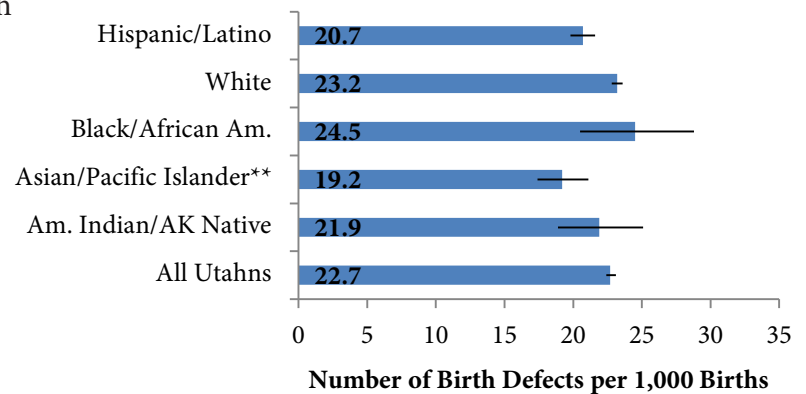
### How are we doing?

The overall Utah rate of structural birth defects from 1999-2011 was 22.7 per 1,000 births. \*\* Hispanics/Latinos have a significantly lower rate of major structural birth defects than all Utahns. Asian/Pacific Islanders may also have a significantly lower rate than all Utahns, however the aggregation of these two populations is problematic.

### How can we improve?

To reduce the occurrence of birth defects among infants in Utah, primary prevention activities must be targeted at women in their childbearing years who are not yet pregnant. Improving one's health before becoming pregnant improves the odds of having a healthy baby. Known strategies for reducing the risk of birth defects include taking a daily multivitamin with folic acid prior to pregnancy, maintaining a healthy pre-pregnancy weight, eating a healthy diet, and not smoking cigarettes and drinking alcohol. Information on the Utah Birth Defect Network and birth defects can be found at [www.health.utah.gov/ubdn/](http://www.health.utah.gov/ubdn/).

**Major Structural Birth Defects  
1999-2011**



### Major Structural Birth Defect Rate, 1999-2011

Race/Ethnicity	Average Annual # of Births***	Average Annual # Birth Defects	Crude Rate per 1,000 Births***	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah births***	51,071	1,161	22.7	22.4	23.1	n/a
Am. Indian/AK Native	661	14	21.9	18.9	25.1	
Asian/Pacific Islander**	1,653	32	19.2	17.4	21.1	↓
Black/ African Am.	421	10	24.5	20.5	28.8	
White	40,531	941	23.2	22.8	23.6	
Hispanic/Latino	7,596	157	20.7	19.8	21.6	↓

Utah Birth Defect Network.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

\*\*Asian and Native Hawaiian/Pacific Islander populations are aggregated in these calculations, interpret with caution.

\*\*\*"Births" includes live births and fetal deaths.

Note: Individuals were classified into only one race/ethnic category.



# HEALTH OF MOTHERS AND INFANTS

## Orofacial Clefts

### Why Is It Important?

Orofacial clefts (cleft lip and/or cleft palate) are among the most common birth defects. They can occur alone or in combination with other defects and can significantly affect a child's health and well being. Children with orofacial clefts require medical and surgical services to treat the structural malformations. Even after surgery, these children are at increased risk of illness and disability, particularly with respect to hearing and communication, and may require long-term health and rehabilitation services to improve outcomes and reduce complications.<sup>38</sup>

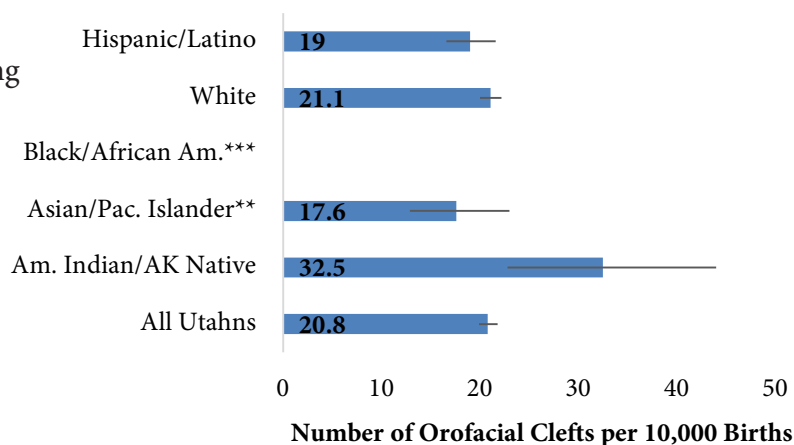
### How Are We Doing?

From 1995–2011, the rate of orofacial clefts in Utah was 20.8 per 10,000 births.<sup>A</sup> Utah has the highest rate of orofacial clefts in the United States and is higher than those reported in countries outside of the U.S. The reason for such a high prevalence is unclear. American Indian/Alaska Native Utah infants had a significantly higher rate of orofacial clefts than all Utah infants, however this estimate is based on few affected children.<sup>38</sup>

### How Can We Improve?

To reduce the occurrence of orofacial clefts among infants in Utah, primary prevention activities must be targeted at women in their child bearing years who are not yet pregnant. Strategies include taking a daily multivitamin with folic acid prior to pregnancy, maintaining healthy weight, eating a healthy diet, not smoking cigarettes and drinking alcohol. The Birth Defect Network is currently collaborating with Utah State University to study maternal nutrition and risk of clefting and the genes related to metabolic pathways.

Orofacial Clefts, Utah 1995-2011



### Orofacial Cleft Rate, 1995 - 2011

Race/Ethnicity	Average Annual # of Births <sup>A</sup>	Average Annual # Orofacial Clefts	Crude Rate per 10,000 Births <sup>A</sup>	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah births <sup>A</sup>	48,875	102	20.8	19.9	21.8	n/a
Am. Indian/AK Native	651	2	32.5	22.8	44.0	↑
Asian/Pacific Islander**	1,541	3	17.6	12.9	23.0	
Black/ African Am.***	379	***	***	***	***	
White	39,530	83	21.1	20.0	22.2	
Hispanic/Latino	6,775	14	19.0	16.6	21.6	

Utah Birth Defect Network. \* Arrows indicate where the rate was higher or lower than for all Utahns.

\*\* Asian and Native Hawaiian/Pacific Islander populations are aggregated in these calculations, interpret with caution.

\*\*\*Estimate has been suppressed because standard error is greater than 50% or undetermined, interpret with caution.

A. "Births" includes live births and fetal deaths. Individuals were classified into only one category.

# HEALTH OF MOTHERS AND INFANTS

## Congenital Heart Defects

### Why Is It Important?

Congenital heart defects are the most common birth defect. Congenital heart defects are the leading cause of infant death due to congenital anomalies accounting for approximately 1 in 3 such infant deaths. Affected children require medical and surgical treatment. Even after treatment, some children may be at increased risk of illness and death because of cardiovascular complications, rhythm abnormalities, or other long-term adverse events.<sup>39</sup>

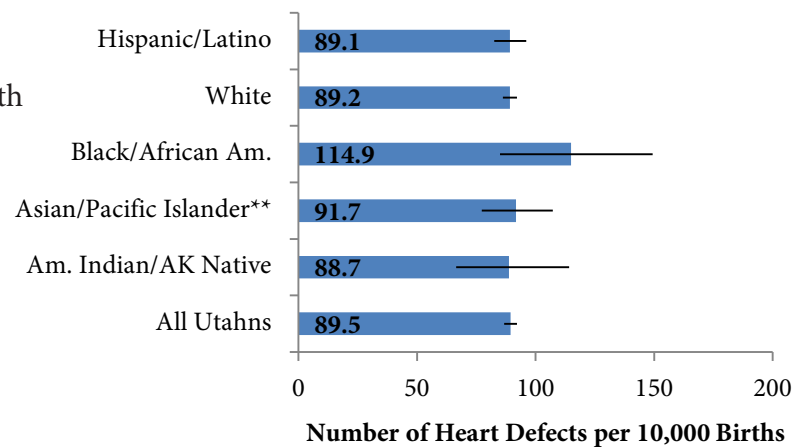
### How Are We Doing?

From 2003 - 2011, the rate of congenital heart defects in Utah was 89.5 per 10,000 births or 1 in 112 births. There were no statistically significant differences in congenital heart defects by race and ethnicity.<sup>39</sup>

### How Can We Improve?

To reduce the occurrence of congenital heart defects among infants in Utah, primary prevention activities must be targeted at women in their childbearing years who are not yet pregnant. Strategies include taking a daily multivitamin with folic acid prior to pregnancy, maintaining a healthy weight, eating a healthy diet, controlling blood sugar if diabetic, and not smoking and drinking alcohol. Usually, the cause of a congenital heart defect is unknown. Starting October 2014 all babies born in Utah are now mandated to be screened for Critical Congenital Heart Defects between 24 and 72 hours of birth. More information can be found at [www.health.utah.gov/cchd/](http://www.health.utah.gov/cchd/).

**Congenital Heart Defects, 2003-2011**



### Congenital Heart Defect Rate, 2003-2011

Race/Ethnicity	Average Annual # of Births***	Average Annual # Heart Defects	Crude Rate per 10,000 Births***	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah births***	52,313	468	89.5	86.8	92.2	n/a
Am. Indian/AK Native	664	6	88.7	66.5	114.1	
Asian/Pacific Islander**	1,746	16	91.7	77.3	107.2	
Black/ African Am.	474	5	114.9	85.0	149.3	
White	41,253	368	89.2	86.2	92.2	
Hispanic/Latino	8,176	73	89.1	82.5	96.1	

Utah Birth Defect Network.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

\*\*Asian and Native Hawaiian/Pacific Islander populations are aggregated in these calculations, interpret with caution.

\*\*\*"Births" includes live births and fetal deaths. Individuals were classified into only one racial/ethnic category.

# HEALTH OF MOTHERS AND INFANTS

## Down Syndrome

### Why Is It Important?

Down syndrome is the most frequent genetic condition of childhood associated with mental retardation. Studying the prevalence and trends of Down syndrome in Utah helps assess the impact of this condition, plan for the resources needed to serve affected people and families, and estimate future needs. Children with Down syndrome are frequently born with additional structural malformations that can significantly affect their health and require surgical and medical treatment. The most common malformations occurring in children with Down syndrome are congenital heart defects (50%).<sup>40</sup>

### How Are We Doing?

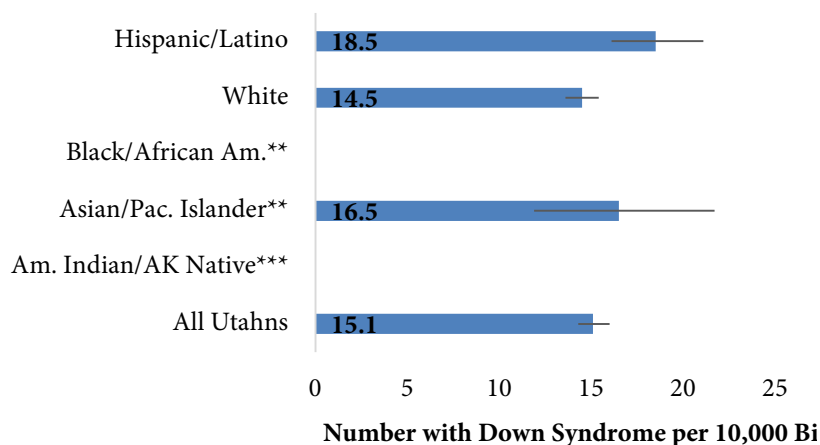
The prevalence Down syndrome is 15.1 per 10,000 births or 1 in every 660 births, for infants born from 1995 to 2011. The prevalence has remained stable since the UBDN began tracking Down syndrome in 1995.<sup>40</sup>

### What Is Being Done?

The American Academy of Pediatrics has developed recommendations for health, supervision, and anticipatory guidance for infants and children with Down syndrome. The goal is to prevent complications and improve long-term health and survival by identification of associated conditions and risk factors. With better clinical care and support, people with Down syndrome are living longer. With appropriate care, people with Down syndrome can live long lives with varying degrees of independence. Children with Down syndrome are eligible for Early Intervention Services.

More information can be found at [www.utahbabywatch.org/](http://www.utahbabywatch.org/).

### Down Syndrome, Utah 1995-2011



### Down Syndrome Rate, 1995-2011

Race/Ethnicity	Average Annual # of Births <sup>A</sup>	Average Annual # with Down Synd.	Crude Rate per 10,000 Births <sup>A</sup>	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah births <sup>A</sup>	48,875	74	15.1	14.3	16.0	n/a
Am. Indian/AK Native***	651	***	***	***	***	
Asian/Pacific Islander**	1,541	3	16.5	11.9	21.7	
Black/ African Am.***	379	***	***	***	***	
White	39,530	57	14.5	13.6	15.4	
Hispanic/Latino	6,775	13	18.5	16.1	21.1	↑

Utah Birth Defect Network.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

\*\*Asian and Native Hawaiian/Pacific Islander populations are aggregated in these calculations, interpret with caution.

\*\*\* Estimate has been suppressed because standard error is greater than 50% or undetermined.

A."Births" includes live births and fetal deaths. Individuals were classified into only one racial/ethnic category.

# INFECTIOUS DISEASES

## Tuberculosis

### Why is it important?

Tuberculosis (TB) is caused by a type of bacteria called *Mycobacterium tuberculosis*. TB is typically spread through the air when a person with TB disease of the lungs or throat expels tiny airborne particles (droplet nuclei). People nearby may breathe in these particles and become infected. People who have latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB. But they may develop active TB disease at some time in the future. The bacteria usually attack the lungs but may attack any part of the body. The U.S. experienced a resurgence of TB disease between 1985 and 1992, when the number of TB cases increased by 20%. Early detection and treatment of TB are essential to control the spread of the disease and to prevent outbreaks.<sup>41</sup>

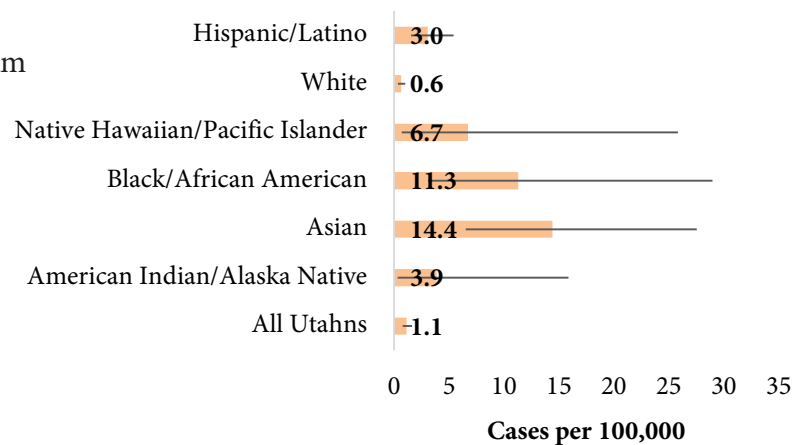
### How are we doing?

From 2009-2013, the rate of tuberculosis cases in Utah was 1.1 per 100,000 people. Asians, Blacks/African Americans, and Hispanics/Latinos had rates that were significantly higher than all Utahns. Whites had a significantly lower tuberculosis rate.

### How can we improve?

The UDOH Treatment and Care Services Program ([www. http://health.utah.gov/epi/diseases/TB](http://health.utah.gov/epi/diseases/TB)) works to reduce the incidence of TB through reporting and treatment. The program also provides screening and preventive therapy for those with TB infection. TB management should include diagnosis and treatment of latent TB infections and active TB disease.

**Tuberculosis, Utah 2009-2013**



**Tuberculosis Rate, 2009-2013**

Race/Ethnicity	Average Annual # of Cases	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Sig. *
All Utahns	32.2	2,813,674	1.1 (0.8 - 1.6)	n/a
Am. Indian/AK Native	1.6	41,497	3.9 (0.3 - 15.9)	
Asian	8.8	61,095	14.4 (6.5 - 27.5)	↑
Black/ African Am.	4.0	35,361	11.3 (3.1 - 29.0)	↑
N. Hawaiian/Pac. Islander	1.8	26,739	6.7 (0.7 - 25.8)	
White	16.0	2,587,898	0.6 (0.4 - 1.0)	↓
Hispanic/Latino	11.2	368,554	3.0 (1.5 - 5.4)	↑

Utah Department of Health, Bureau of Epidemiology.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

## Chlamydia

### Why is it important?

Infections caused by the bacterium *Chlamydia trachomatis* are the most frequently reported notifiable disease in Utah, with 7,542 cases reported in 2013. Two-thirds of the reported cases were among persons between 15 and 24 years of age. Females with chlamydia are at risk for developing pelvic inflammatory disease (PID), and both men and women may become infertile as a result of untreated chlamydia. Untreated chlamydia infections can damage the reproductive systems of both males and females. Susceptibility to more serious infections such as HIV also increases when an individual is infected with chlamydia. In addition, pregnant women with chlamydia can pass the infection to their infant during delivery, potentially resulting in pneumonia or neonatal ophthalmia.

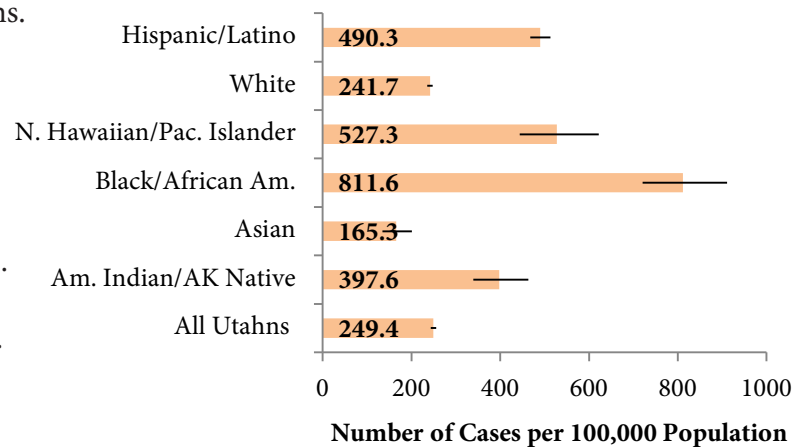
### How are we doing?

From 2009-2013, there were 249.4 cases of chlamydia per 100,000 Utahns. American Indian/Alaska Native, Black/African American, Native Hawaiian/Pacific Islander, and Hispanic/Latino populations had rates that were significantly higher than all Utahns. Asians and Whites had significantly lower rates than all Utahns.

### How can we improve?

The UDOH Communicable Disease Prevention Program provides information on STDs, testing, and treatment ([www.health.utah.gov/epi/testing](http://www.health.utah.gov/epi/testing)). Local health districts can also assist individuals with testing and treatment at minimal or no cost. STD presentations and additional information are available through the UDOH upon request.

**Chlamydia Rate, 2009-2013**



**Chlamydia Rate, 2009-2013**

Race/Ethnicity	Average Annual # of Cases	Average Annual Population	Crude Rate per 100,000 (95% CI)	Sig. *
All Utahns	7,018	2,813,674	249.4 (243.6 - 255.3)	n/a
Am. Indian/AK Native	165	41,497	397.6 (339.3 - 463.1)	↑
Asian	101	61,095	165.3 (134.7 - 200.9)	↓
Black/ African Am.	287	35,361	811.6 (720.4 - 911.2)	↑
N. Hawaiian/Pac. Islander	141	26,739	527.3 (443.9 - 621.9)	↑
White	6,255	2,587,898	241.7 (235.7 - 247.8)	↓
Hispanic/Latino	1,807	368,554	490.3 (467.9 - 513.4)	↑

Utah Bureau of Epidemiology, UT-NEDSS Database.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

# INFECTIOUS DISEASES

## Gonorrhea

### Why is it important?

Infections caused by the bacterium *Neisseria gonorrhoeae* are a priority health concern in Utah. Untreated gonorrhea can damage the reproductive systems of males and females. Females with gonorrhea are at risk for developing pelvic inflammatory disease (PID), and men and women may become infertile as a result of untreated gonorrhea. Susceptibility to infections such as HIV also increases when an individual has gonorrhea. Pregnant women with gonorrhea can pass the infection to their infant during delivery, and gonorrhea can spread to joints and disseminate throughout the body.

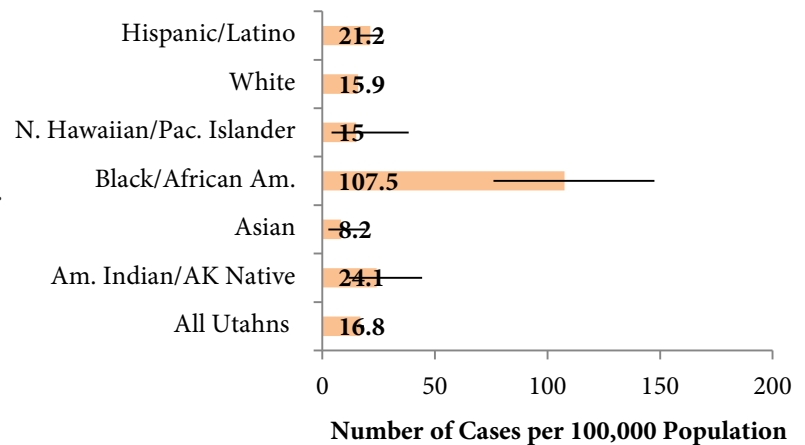
### How are we doing?

From 2009-2013, the rate of gonorrhea cases in Utah was 16.8 per 100,000 people. Blacks/African Americans had a significantly higher gonorrhea incidence rate than all Utahns.

### How can we improve?

The UDOH Communicable Disease Prevention Program provides information on STDs, testing, and treatment ([www.health.utah.gov/epi/testing](http://www.health.utah.gov/epi/testing)). Local health districts can also assist individuals with testing and treatment at minimal or no cost. STD presentations and additional information are available through the UDOH upon request.

### Gonorrhea Rate, 2009-2013



### Gonorrhea Rate, 2009-2013

Race/Ethnicity	Average Annual # of Cases	Average Annual Population	Crude Rate per 100,000 (95% CI)	Sig. *
All Utahns	472	2,813,674	16.8 (15.3 - 18.4)	n/a
Am. Indian/AK Native	10	41,497	24.1 (11.6 - 44.3)	
Asian	5	61,095	8.2 (2.7 - 19.1)	
Black/ African Am.	38	35,361	107.5 (76.0 - 147.5)	↑
N. Hawaiian/Pac. Islander	4	26,739	15.0 (4.1 - 38.3)	
White	411	2,587,898	15.9 (14.4 - 17.5)	
Hispanic/Latino	78	368,554	21.2 (16.7 - 26.4)	

Utah Bureau of Epidemiology, UT-NEDSS Database.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the rate was higher or lower than for all Utahns.

# Injury and Violence



UTAH DEPARTMENT OF  
**HEALTH**

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Office of Health Disparities

# INJURY AND VIOLENCE

## Unintentional Injury Deaths

### Why is it important?

In Utah, unintentional injuries are a leading cause of death and disability. They account for approximately 1,051 deaths and 9,678 hospitalizations each year. In addition, thousands of less severe injuries are being treated in doctor's offices, clinics, emergency departments, homes, schools, work sites, etc. In 2013, the top five leading causes of unintentional injury death for all ages in Utah were poisoning, falls, motor vehicle traffic crashes, suffocation, and drowning.

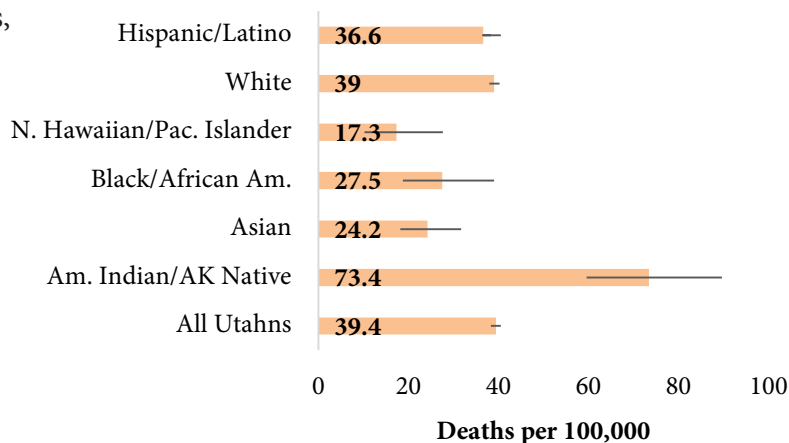
### How are we doing?

From 2009-2013, the age-adjusted rate of death by unintentional injury in Utah was 39.4 per 100,000. American Indians/Alaska Natives had a significantly higher unintentional injury death rate than all Utahns. Asians, Blacks/African Americans and Native Hawaiians/Pacific Islanders had significantly lower rates than all Utahns.

### How can we improve?

The UDOH Violence and Injury Prevention Program (VIPP) is working with several agencies, such as the Utah Department of Public Safety, Primary Children's Medical Center, and Utah's 12 local health departments to promote the use of safety belts, safety seats, and helmets in an effort to further reduce unintentional injury deaths. Most injuries can be prevented by choosing safe behaviors, using safety equipment, and obeying safety laws. High-priority prevention areas include motor vehicle crash injury, pedestrian injury, bicycle injury, and fall-related injury.<sup>42</sup>

### Unintentional Injury Death, 2009-2013



### Unintentional Injury Death Rate, 2009-2013

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	994	2,813,674	35.3 (34.4-36.3)	39.4 (38.3-40.5)	n/a
Am. Indian/AK Native	25	41,497	60.2 (50.2-71.8)	73.4 (59.5-89.6)	↑
Asian	12	61,095	19.3 (14.7-24.9)	24.2 (18.2-31.7)	↓
Black/ African Am.	8	35,361	22.6 (16.2-30.8)	27.5 (18.7-39.0)	↓
N. Hawaiian/Pac. Islander	5	26,739	17.2 (10.9-25.8)	17.3 (10.2-27.6)	↓
White	919	2,587,898	35.5 (34.5-36.5)	39.0 (37.9-40.2)	
Hispanic/Latino	91	368,554	24.6 (22.4-27.0)	36.6 (38.3-40.5)	

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

ICD-10 codes: V01-X59, Y85-86. Does not include legal intervention.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.



## Motor Vehicle Traffic Crash Deaths

### Why is it important?

In Utah in 2013, motor vehicle traffic crashes (MVTCS) accounted for 192 deaths. This was one of the main injury causes of death. Other types of injury death that year included accidental and undetermined poisoning (531), suicide (570), and unintentional falls (231).

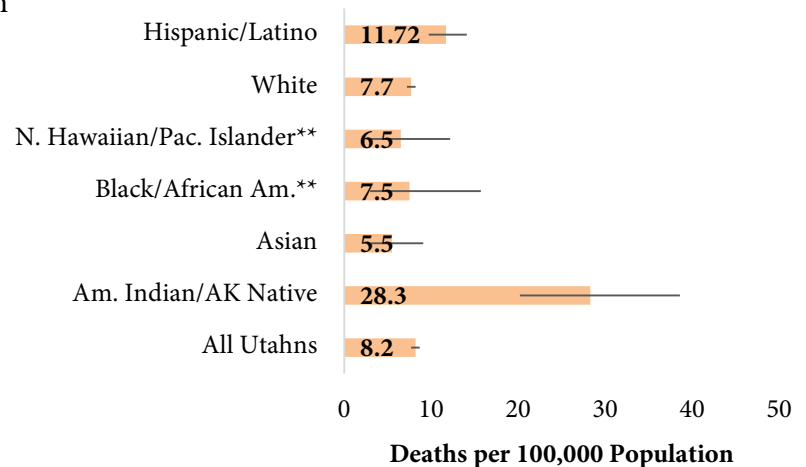
### How are we doing?

The age-adjusted rate of motor vehicle crash deaths in Utah from 2009-2013 was 8.2 deaths per 100,000. American Indians/Alaska Natives and Hispanics/Latinos had a significantly higher death rate from motor vehicle crashes than all Utahns.

### How can we improve?

The UDOH Violence and Injury Prevention Program (VIPP) provides funding to Utah's 12 local health departments to implement motor vehicle safety programs and Safe Kids coalitions/chapters activities. These programs focus on passenger safety and teen driving. The VIPP partners with the Utah Teen Driving Safety Task Force, Zero Fatalities Program, and Utah Highway Safety Office, among other agencies to prevent MVTCS deaths. Further information can be accessed from the website [www.dontdrivestupid.com/](http://www.dontdrivestupid.com/).

### Motor Vehicle Crash Death, 2009-2013



### Motor Vehicle Traffic Crash Death Rate, 2009-2013

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	220	2,813,674	7.8 (7.4-8.3)	8.2 (7.7-8.7)	n/a
Am. Indian/AK Native	10	41,497	25.1 (18.7-32.9)	28.3 (20.2-38.6)	↑
Asian	3	61,095	5.2 (3.0-8.5)	5.5 (3.1-9.1)	
Black/ African Am.**	2	35,361	5.1 (2.3-9.7)	7.5 (3.0-15.7)	
N. Hawaiian/Pac. Islander**	2	26,739	7.5 (3.6-13.8)	6.5 (3.0-12.2)	
White	191	2,587,898	7.4 (6.9-7.9)	7.7 (7.2-8.2)	
Hispanic/Latino	35	368,554	9.6 (8.2-11.1)	11.7 (9.7-14.1)	↑

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

ICD-10 codes: V02-04[.1-9], V09.2, V12-14[.3-9], V19[.4-6], V20-V28[.3-9], V29-79[.4-9], V80[.3-5], V81-82[.1], V83-86[.0-3], V87[.0-8], V89.2.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

# INJURY AND VIOLENCE

## Poisoning Death

### Why is it important?

In 2002 the age-adjusted rate of drug poisoning deaths (14.0 per 100,000 population) surpassed the rate of motor vehicle crash (MVC) deaths (13.5 per 100,000 population) in Utah. Until this time, motor vehicle crashes had been responsible for more lives lost than any other cause of injury. By 2013, the age-adjusted death rate from drug poisonings (21.7 per 100,000 population) was more than three times as high as it was from MVC deaths (7.1 per 100,000 population). Prescription pain medications are responsible for many of the drug poisoning deaths in Utah.<sup>43</sup>

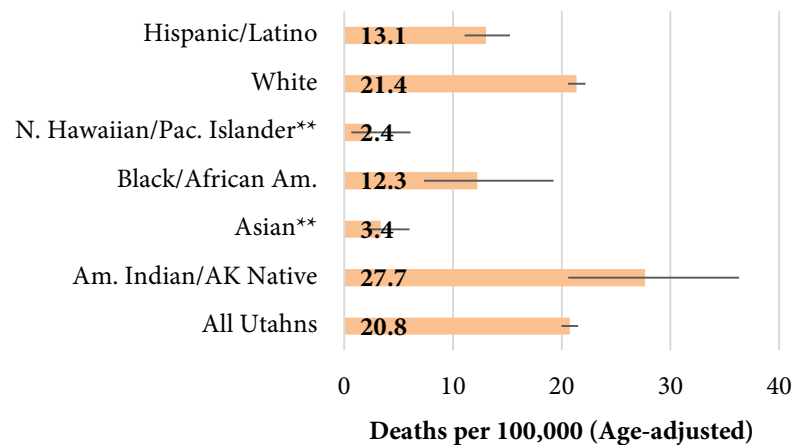
### How are we doing?

In 2012, an average of 21 Utah adults died as a result of prescription pain medications each month (12.7 per 100,000 adults). The prescription pain medication death rate decreased significantly from 2007, when the Prescription Pain Medication Program (PPMP) was established, to 2012 (17.6 and 12.7 per 100,000 adults).

### How can we improve?

In 2009, the Utah Pharmaceutical Drug Crime Project was established to further efforts to reduce prescription drug overdose deaths. This project works with law enforcement and other organizations on initiatives such as the National Take Back Days, which collect unused medications, turned in by community members who have cleaned out their medicine cabinets. For information about where to dispose of unused prescriptions visit [www.useonlyasdirected.org/drop-off-locator/](http://www.useonlyasdirected.org/drop-off-locator/).

### Death by Poisoning, Utah 2009-2013



### Deaths by Poisoning, 2009-2013

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	576	2,813,674	20.5 (19.7-21.3)	20.8 (20.0-21.5)	n/a
Am. Indian/AK Native	11	41,497	27.0 (20.4-35.1)	27.7 (20.6-36.3)	
Asian**	2	61,095	3.6 (1.8-6.4)	3.4 (1.7-6.0)	↓
Black/ African Am.	4	35,361	11.3 (6.9-17.5)	12.3 (7.3-19.3)	↓
N. Hawaiian/Pac. Islander**	1	26,739	3.0 (0.8-7.7)	2.4 (0.7-6.1)	↓
White	548	2,587,898	21.2 (20.4-22.0)	21.4 (20.6-22.2)	
Hispanic/Latino	41	368,554	11.2 (9.8-12.9)	13.1 (11.1-15.3)	↓

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census, IBIS Version 2013.

ICD10 Codes: X40-X49, X60-X69, X85-X90, Y10-Y19, Y35.2, \*U01(.6-.7).

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

## Suicide

### Why is it important?

From 2011 to 2013, Utah's age-adjusted suicide rate was 20.4 per 100,000 persons. This is an average of 535 suicides per year. Utah has one of the highest age-adjusted suicide rates in the U.S. In 2013, it is the leading cause of death for Utahns ages 10 to 17 years old, the second-leading cause of death for ages 18-24 and 25-44, and the fourth-leading cause of death for ages 45-64. Overall, suicide is the seventh-leading cause of death for Utahns ages 10+. Completed suicides are only part of the problem. More people are hospitalized or treated in an emergency room for suicide attempts than are fatally injured. In 2012, 13 Utahns were treated for self-inflicted injuries every day (2,743 emergency department visits and 1,605 hospitalizations).<sup>44</sup>

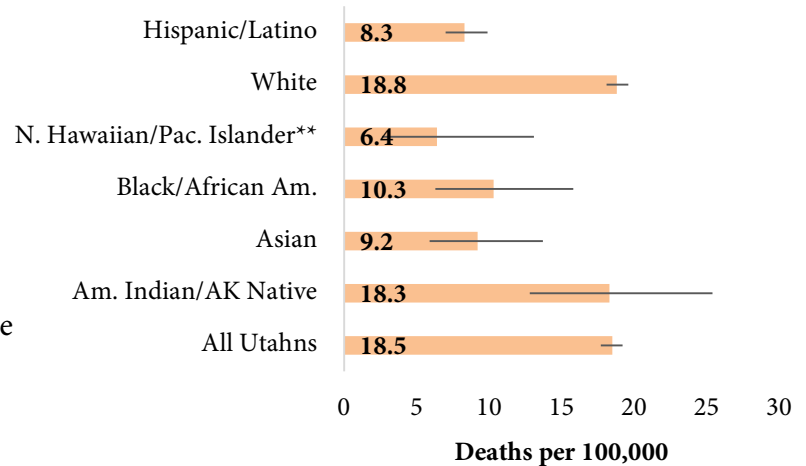
### How are we doing?

From 2009-2013, the suicide rate in Utah was 18.5 per 100,000 persons (age-adjusted rate). Native Hawaiians/Pacific Islanders, Blacks/African Americans, Asians, and Hispanic Latinos had significantly lower rates of suicide than all Utahns.

### How can we improve?

The UDOH Violence and Injury Prevention Program (VIPP) conducts the Utah Violent Death Reporting System (UTVDRS) to monitor data that will help Utahns better understand the issue of violence by informing decision makers about violent deaths such as suicide. The VIPP also partners with the Utah Division of Substance and Mental Health ([www.dsamh.utah.gov/](http://www.dsamh.utah.gov/)) to facilitate the Suicide Prevention Coalition.

**Suicide, 2009-2013**



### Suicide Death Rate, 2009-2013

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	503	2,813,674	17.9 (17.2-18.6)	18.5 (17.7-19.2)	n/a
Am. Indian/AK Native	8	41,497	19.3 (13.8-26.3)	18.3 (12.8-25.4)	
Asian	5	61,095	8.5 (5.6-12.5)	9.2 (5.9-13.7)	↓
Black/ African Am.	4	35,361	11.9 (7.4-18.2)	10.3 (6.3-15.8)	↓
N. Hawaiian/Pac. Islander**	2	26,739	6.0 (2.6-11.8)	6.4 (2.6-13.1)	↓
White	475	2,587,898	18.3 (17.6-19.1)	18.8 (18.1-19.6)	
Hispanic/Latino	33	368,554	8.8 (7.5-10.3)	8.3 (7.0-9.9)	↓

Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health. *Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census, IBIS Version 2013. ICD-10 codes: \*U03, Y87.0, X60-X84.*

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

# CHRONIC DISEASES AND CONDITIONS

## Fair or Poor Health

### Why is it important?

Self-rated health (SRH) has been collected for many years on National Center for Health Statistics surveys and since 1993 on the state-based BRFSS. SRH is an independent predictor of important health outcomes including mortality, morbidity, and functional status. It is considered to be a reliable indicator of a person's perceived health and is a good global assessment of a person's well being.

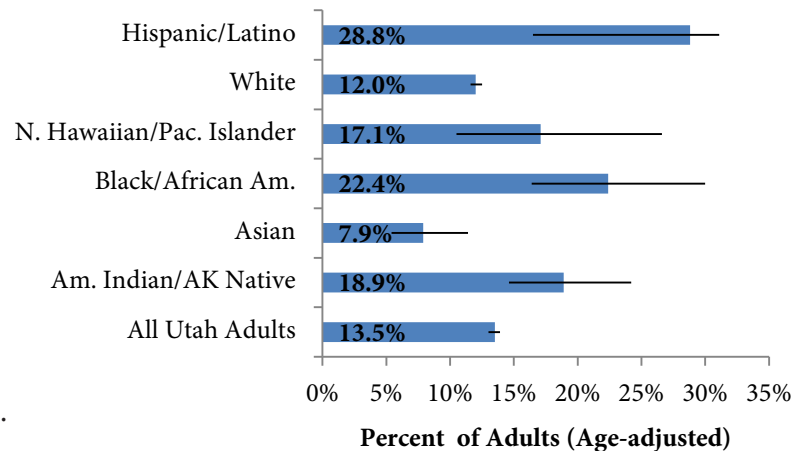
### How are we doing?

From 2011-2013, the age-adjusted rate of Utah adults who reported fair or poor general health status was 13.5%. American Indians/Alaska Natives and Hispanics/Latinos had significantly higher rates of fair or poor health than all Utahns. Asians and Whites had significantly lower rates of self-reported fair or poor health than all Utahns.

### How can we improve?

Health agencies interested in addressing fair or poor health in American Indian/Alaska Native, Black/African Am., and Hispanic/Latino populations can work with communities to develop or expand culturally responsive interventions and educational campaigns. UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

Fair or Poor Health, 2011-2013



Percentage of Adults Reporting Fair or Poor Health, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual in Fair/Poor Health	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,741	1,968,094	255,852	13.0 % (12.6 -13.5 %)	13.5 % (13.0 -13.9 %)	n/a
Am. Indian/AK Native	374	21,909	3,900	17.8 % (13.5 -23.0 %)	18.9 % (14.6 -24.2 %)	↑
Asian	417	46,949	3,005	6.4 % (4.3 -9.5 %)	7.9 % (5.4 -11.4 %)	↓
Black/ African Am.	212	19,717	4,377	22.2 % (16.2 -29.6 %)	22.4 % (16.4 -30.0 %)	↑
N. Hawaiian/Pac. Islander	172	16,524	2,066	12.5 % (7.6 -19.8 %)	17.1 % (10.5 -26.6 %)	
White	34,741	1,753,928	206,964	11.8 % (11.4 -12.3 %)	12.0 % (11.6 -12.5 %)	↓
Hispanic/Latino	2,483	228,844	56,067	24.5 % (22.4 -26.7 %)	28.8 % (26.5 -31.1 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Poor Physical Health Status

### Why is it important?

Self-rated health (SRH) has been collected for many years on National Center for Health Statistics surveys and since 1993 on the state-based BRFSS. SRH is an independent predictor of important health outcomes including mortality, morbidity, and functional status. It is considered to be a reliable indicator of a person's perceived health and is a good global assessment of a person's well being.

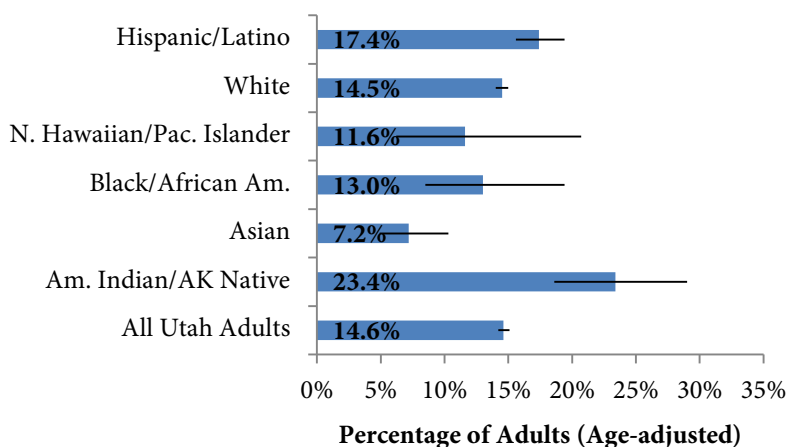
### How are we doing?

From 2011-2013, 14.6% of Utah adults reported poor physical health status (age-adjusted rate). American Indian/Alaska Native and Hispanic/Latino Utahns had significantly higher rates of self reported poor physical health than all Utahns. Asians had significantly lower rates of self reported poor physical health than all Utahns.

### How can we improve?

The UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Poor Physical Health Status, 2011-2013



### Percentage of Adults Reporting 7+ Days When Physical Health Was Not Good in the Past Month, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual # in Poor Phy. Health	Crude Rate (95% CI)	Age-adjusted Rate	Sig. *
All Utah adults 18+	37,037	1,968,094	281,437	14.3 % (13.9 -14.8 %)	14.6 % (14.2 -15.1 %)	n/a
Am. Indian/AK Native	361	21,909	4,820	22.0 % (17.3 -27.5 %)	23.4 % (18.6 -29.0 %)	↑
Asian	403	46,949	3,286	7.0 % (4.8 -10.3 %)	7.2 % (4.9 -10.3 %)	↓
Black/ African Am.	202	19,717	2,543	12.9 % (8.4 -19.4 %)	13.0 % (8.5 -19.4 %)	
N. Hawaiian/Pac. Islander	168	16,524	1,471	8.9 % (5.0 -15.3 %)	11.6 % (6.2 -20.7 %)	
White	34,133	1,753,928	252,566	14.4 % (13.9 -14.9 %)	14.5 % (14.0 -15.0 %)	
Hispanic/Latino	2,423	228,844	34,784	15.2 % (13.5 -16.9 %)	17.4 % (15.6 -19.4 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Poor Mental Health Status

### Why is it important?

Mental health is one of the 12 Healthy People 2020 Leading Health Indicators. Mental health refers to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioral incapacity. Mental health and mental disorders can be influenced by numerous conditions including biologic and genetic vulnerabilities, acute or chronic physical dysfunction, and environmental conditions and stresses. Approximately 32% of the U.S. population is affected by mental illness in any given year. The BRFSS mental health question is an attempt to obtain a global measure of recent mental and emotional distress.

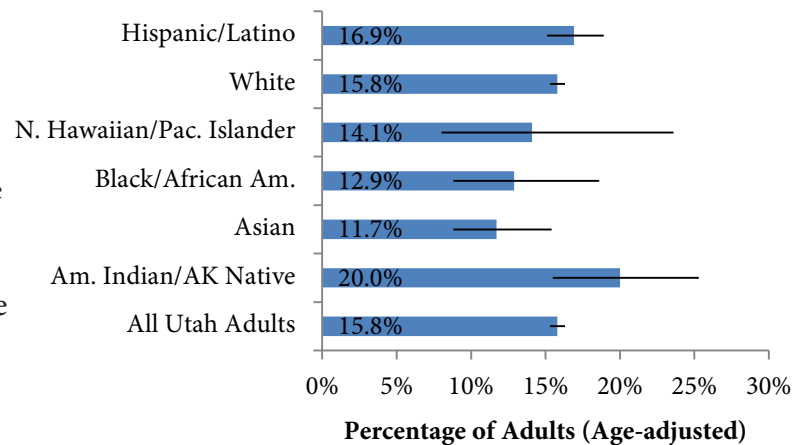
### How are we doing?

From 2011-2013, 15.8% of Utah adults reported seven or more days in the past 30 days when their mental health was not good (age-adjusted rate). American Indians/Alaska Natives reported the highest percentage of seven or more days when their mental health was not good in the last 30 days. Asians had a significantly lower rate than all Utah adults.

### How can we improve?

The Utah Department of Human Services Division of Substance Abuse and Mental Health ([www.dsamh.utah.gov](http://www.dsamh.utah.gov)) is the agency responsible for ensuring that mental health services are available statewide. The Division also provides information, research results, and statistics to the public regarding substances of abuse and mental health services. Community Mental Health Centers are also resources that can be accessed through the Division of Substance Abuse and Mental Health.

**Poor Mental Health Status, 2011-2013**



**Percentage of Adults Reporting 7+ Days of Poor Mental Health Status in the Last 30 Days, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual # in Poor Mental Health	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,279	1,968,094	316,863	16.1 % (15.6 -16.6 %)	15.8 % (15.3 -16.3 %)	n/a
Am. Indian/AK Native	366	21,909	4,535	20.7 % (16.0 -26.4 %)	20.0 % (15.5 -25.3 %)	
Asian	408	46,949	6,855	14.6 % (10.8 -19.4 %)	11.7 % (8.8 -15.4 %)	↓
Black/ African Am.	208	19,717	2,465	12.5 % (8.4 -18.1 %)	12.9 % (8.8 -18.6 %)	
N. Hawaiian/Pac. Islander	170	16,524	2,462	14.9 % (9.5 -22.5 %)	14.1 % (8.0 -23.6 %)	
White	34,350	1,753,928	282,382	16.1 % (15.5 -16.6 %)	15.8 % (15.3 -16.3 %)	
Hispanic/Latino	2,438	228,844	37,530	16.4 % (14.7 -18.4 %)	16.9 % (15.1 -18.9 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Activity Limitation

### Why is it important?

Persons whose activities are limited due to physical, mental, or emotional problems may need more specialized health care than persons without such limitation. Their medical costs are generally higher and they are more likely to miss days from school or work.

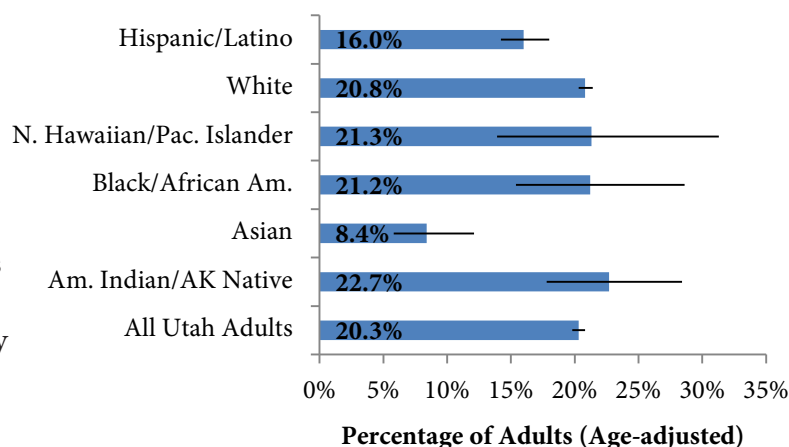
### How are we doing?

From 2011-2013, 20.3% of Utah adults reported that their activities were limited due to physical, mental, or emotional problems (age-adjusted rate). Asian and Hispanic/Latino Utahns had significantly lower rates of activity limitation than all Utahns.

### How can we improve?

The UDOH Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) programs promote physical activity and healthy foods through epidemiology and surveillance, environmental approaches that promote health, health systems, and community-clinical linkages. More information available at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/). The Utah Dept. of Human Services, Division of Aging & Adult Services ([www.hsdaas.utah.gov](http://www.hsdaas.utah.gov)) provides seniors with resources on health, nutrition and meal delivery, and services to help seniors with activity limitation.

Activity Limitation, 2011-2013



Percentage of Adults Reporting Activity Limitation, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual # with Act. Limit.	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	36,747	1,968,094	387,715	19.7 % (19.2 -20.2 %)	20.3 % (19.8 -20.8 %)	n/a
Am. Indian/AK Native	364	21,909	4,689	21.4 % (16.6 -27.0 %)	22.7 % (17.8 -28.4 %)	
Asian	391	46,949	3,380	7.2 % (4.9 -10.6 %)	8.4 % (5.8 -12.1 %)	↓
Black/ African Am.	202	19,717	3,943	20.0 % (14.2 -27.3 %)	21.2 % (15.4 -28.6 %)	
N. Hawaiian/Pac. Islander	167	16,524	2,693	16.3 % (10.8 -24.0 %)	21.3 % (13.9 -31.3 %)	
White	33,879	1,753,928	357,801	20.4 % (19.9 -21.0 %)	20.8 % (20.3 -21.4 %)	
Hispanic/Latino	2,399	228,844	30,436	13.3 % (11.8 -15.0 %)	16.0 % (14.2 -18.0 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Major Depression

### Why is it important?

Approximately 20% of the U.S. population is affected by mental illness during any given year. Of all mental illnesses, depression is the most common disorder. Major depression is defined as having severe symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy life. Symptoms of major depression may include fatigue or loss of energy, feelings of worthlessness or guilt, impaired concentration, loss of interest in daily activities, appetite or weight changes, sleep changes, and recurring thoughts of death or suicide. Despite the availability of effective treatments for major depression, such as medications and/or psychotherapeutic techniques, it often goes unrecognized and untreated.

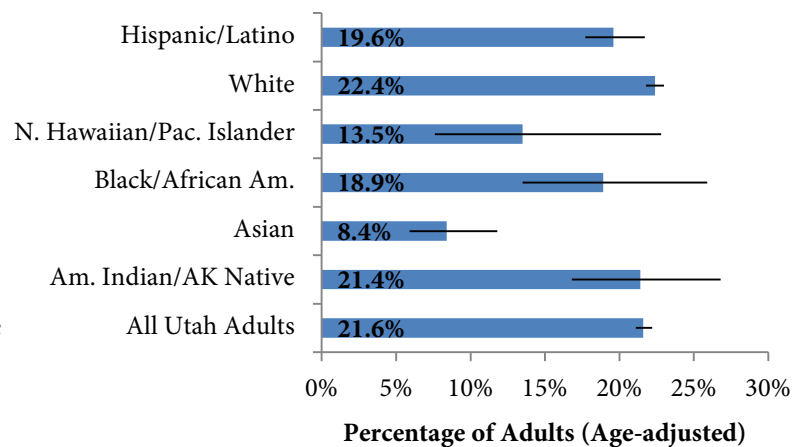
### How are we doing?

Utah has consistently higher rates of self-reported lifetime depression than the U.S. rate (21.7% vs. 17.6% in 2013).<sup>45</sup> From 2011-2013, the age-adjusted rate of major depression among Utah adults was 21.6%. Asians had a significantly lower rate of major depression than all Utahns.

### How can we improve?

The Utah Department of Human Services Division of Substance Abuse and Mental Health ([www.dsamh.utah.gov](http://www.dsamh.utah.gov)) is the agency responsible for ensuring that mental health services are available statewide. The Division also provides information, research results, and statistics to the public regarding substances of abuse and mental health services. Community Mental Health Centers are also resources that can be accessed through the Division of Substance Abuse and Mental Health.

### Depression, Ever Diagnosed, 2011-2013



### Percentage of Adults Who Have Ever Reported Having Depression, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual # w/ Depression	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,718	1,968,094	425,108	21.6 % (21.1 -22.2 %)	21.6 % (21.1 -22.2 %)	n/a
Am. Indian/AK Native	378	21,909	4,820	22.0 % (17.2 -27.6 %)	21.4 % (16.8 -26.8 %)	
Asian	415	46,949	3,991	8.5 % (5.9 -11.9 %)	8.4 % (5.9 -11.8 %)	↓
Black/ African Am.	206	19,717	3,667	18.6 % (13.2 -25.5 %)	18.9 % (13.5 -25.9 %)	
N. Hawaiian/Pac. Islander	172	16,524	2,479	15.0 % (9.3 -23.3 %)	13.5 % (7.6 -22.8 %)	
White	34,735	1,753,928	391,126	22.3 % (21.7 -22.9 %)	22.4 % (21.8 -23.0 %)	↑
Hispanic/Latino	2,473	228,844	43,480	19.0 % (17.1 -21.0 %)	19.6 % (17.7 -21.7 %)	

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.



# CHRONIC DISEASES AND CONDITIONS

## Arthritis Prevalence

### Why is it important?

Arthritis affects 52.5 million adults in the U.S. and is the leading cause of disability. Arthritis is also associated with substantial activity limitation, work disability, and reduced quality of life.<sup>46</sup>

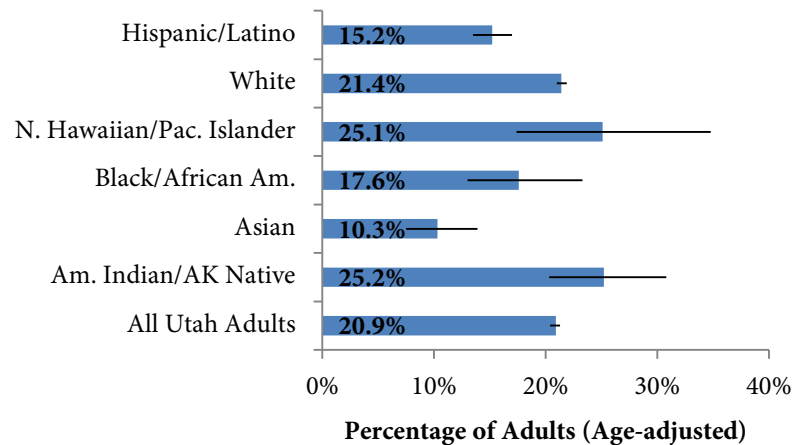
### How are we doing?

From 2011-2013, the age-adjusted percentage of Utah adults who reported their doctor or other health care professional had told them they had arthritis was 20.9%. Asian and Hispanic/Latino Utahns had significantly lower rates of arthritis than all Utahns.

### How can we improve?

The Utah Arthritis Program is working with partners to provide community-based education to promote evidence-based self-management programs. More information and resources on arthritis can be found at [www.health.utah.gov/arthritis/](http://www.health.utah.gov/arthritis/).

**Arthritis Prevalence, 2011-2013**



**Percentage of Adults with Arthritis, 2011-2013**

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual# w/ Arthritis	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,683	1,968,094	389,683	19.8 % (19.3 -20.2 %)	20.9 % (20.4 -21.3 %)	n/a
Am. Indian/AK Native	375	21,909	4,886	22.3 % (17.7 -27.9 %)	25.2 % (20.3 -30.8 %)	
Asian	415	46,949	3,380	7.2 % (5.1 -10.0 %)	10.3 % (7.5 -13.9 %)	↓
Black/ African Am.	210	19,717	3,273	16.6 % (11.8 -22.8 %)	17.6 % (13.0 -23.3 %)	
N. Hawaiian/Pac. Islander	172	16,524	2,991	18.1 % (12.3 -25.8 %)	25.1 % (17.4 -34.8 %)	
White	34,691	1,753,928	366,571	20.9 % (20.4 -21.4 %)	21.4 % (21.0 -21.9 %)	↑
Hispanic/Latino	2,481	228,844	24,486	10.7 % (9.4 -12.1 %)	15.2 % (13.5 -17.0 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Asthma Prevalence

### Why is it important?

Asthma is a serious personal and public health issue that has far reaching medical, economic, and psychosocial implications. The burden of asthma can be seen in the number of asthma-related medical events, including emergency department visits, hospitalizations, and deaths.<sup>47</sup>

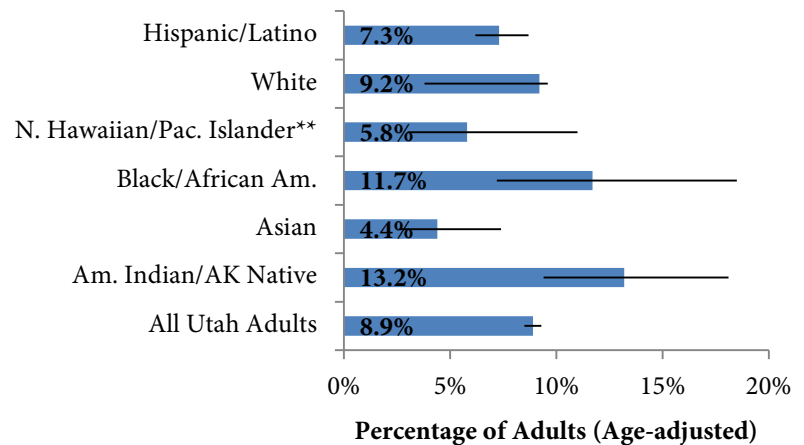
### How are we doing?

Adult asthma rates show no sign of declining in Utah or in the U.S. In Utah and the U.S., adult asthma prevalence is higher for women than men in almost every age category.<sup>47</sup> From 2011-2013, 8.9% of Utah adults reported that they currently had asthma (age-adjusted rate). Asian and Hispanic/Latino Utahns had significantly lower age-adjusted rates of current asthma than all Utahns; American Indian/Alaska Natives had a higher rate.

### How can we improve?

The Utah Asthma Program, in conjunction with the Utah Asthma Task Force and other partners strives to maximize the reach, impact, efficiency, and sustainability of asthma services. The UDOH Asthma Program ([www.health.utah.gov/asthma](http://www.health.utah.gov/asthma)) provides tools and resources to assist people with asthma management, appropriate health care, and identifies asthma risk factors.<sup>47</sup>

### Asthma Prevalence, 2011-2013



### Percentage of Adults Who Reported Having Asthma, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual # with Asthma	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,619	1,968,094	175,160	8.9 % (8.5 -9.3 %)	8.9 % (8.5 -9.3 %)	n/a
Am. Indian/AK Native	377	21,909	3,067	14.0 % (9.9 -19.3 %)	13.2 % (9.4 -18.1 %)	↑
Asian	414	46,949	2,394	5.1 % (2.9 -9.0 %)	4.4 % (2.6 -7.4 %)	↓
Black/ African Am.	208	19,717	2,267	11.5 % (7.0 -18.2 %)	11.7 % (7.2 -18.5 %)	
N. Hawaiian/Pac. Islander**	171	16,524	859	5.2 % (2.8 -9.5 %)	5.8 % (3.0 -11.0 %)	
White	34,630	1,753,928	161,361	9.2 % (8.8 -9.6 %)	9.2 % (8.8 -9.6 %)	
Hispanic/Latino	2,474	228,844	15,790	6.9 % (5.8 -8.2 %)	7.3 % (6.2 -8.7 %)	↓

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

# CHRONIC DISEASES AND CONDITIONS

## Diabetes Prevalence

### Why is it important?

About 142,000 Utahns have been diagnosed with diabetes. Diabetes is a disease that can have devastating consequences. It is the leading cause of non-traumatic lower-extremity amputation and renal failure, as well as the leading cause of blindness among adults younger than 75. Diabetes places an enormous burden on health care resources, approximately \$245 billion is spent annually (in direct medical costs (\$176 billion) and in indirect costs (\$69 billion) such as disability, work loss, and premature death). In Utah, more than a billion dollars each year are spent on direct and indirect costs of diabetes.<sup>48</sup>

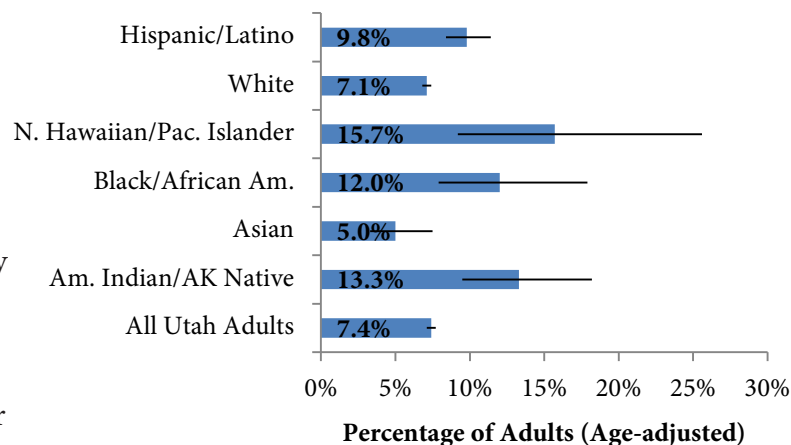
### How are we doing?

From 2011-2013, 7.4% of Utah adults reported that they had been diagnosed with diabetes by a doctor (age-adjusted rate). American Indian/Alaskan Native, Black/African American, Native Hawaiian/Pacific Islander, and Hispanic/Latino Utahns have significantly higher rates of adults with diabetes than the Utah population overall.

### How can we improve?

Diabetes educators can play a prominent role in providing information about nutrition, exercise, and blood glucose monitoring. The Utah Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program promotes diabetes education through Diabetes Self-Management Education programs and other resources found at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Diabetes Prevalence Rate, 2011-2013



### Percentage of Adults Who Reported Having Diabetes, 2011-2013

Race/Ethnicity	Sample Size	Average Annual 18+ Population	Average Annual # w/Diabetes	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	37,837	1,968,094	137,767	7.0 % (6.7 -7.3 %)	7.4 % (7.1 -7.7 %)	n/a
Am. Indian/AK Native	377	21,909	2,388	10.9 % (7.9 -15.0 %)	13.3 % (9.5 -18.2 %)	↑
Asian	417	46,949	1,643	3.5 % (2.2 -5.4 %)	5.0 % (3.3 -7.5 %)	
Black/ African Am.	212	19,717	2,248	11.4 % (7.3 -17.2 %)	12.0 % (7.9 -17.9 %)	↑
N. Hawaiian/Pac. Islander	172	16,524	1,768	10.7 % (6.0 -18.4 %)	15.7 % (9.2 -25.6 %)	↑
White	34,828	1,753,928	121,021	6.9 % (6.6 -7.2 %)	7.1 % (6.8 -7.4 %)	
Hispanic/Latino	2,489	228,844	15,561	6.8 % (5.8 -8.0 %)	9.8 % (8.4 -11.4 %)	↑

Utah BRFSS, Office of Public Health Assessment, UDOH.

Population Estimates: US Census Bureau, 2011-2013 ACS 3-Year Estimates.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Diabetes Death

### Why is it important?

About 142,000 Utahns have been diagnosed with diabetes. Diabetes is a disease that can have devastating consequences. It is the leading cause of non-traumatic lower-extremity amputation and renal failure, as well as the leading cause of blindness among adults younger than 75. Diabetes places an enormous burden on health care resources, approximately \$245 billion is spent annually (in direct medical costs [\$176 billion] and in indirect costs [\$69 billion] such as disability, work loss, and premature death). In Utah, more than a billion dollars each year are spent on direct and indirect costs of diabetes.<sup>48</sup>

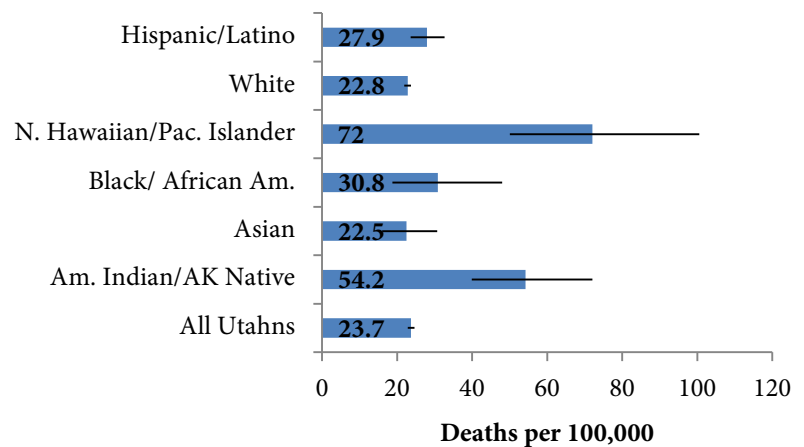
### How are we doing?

Diabetes death rates for Utah have exceeded rates for the U.S., but have been declining in general. During 2009-2013, the age-adjusted diabetes death rate was 23.7 per 100,000 population. The highest death rates were seen in Native Hawaiians/Pacific Islanders and American Indians/Alaska Natives.

### How can we improve?

Diabetes educators can play a prominent role in providing information about nutrition, exercise, and blood glucose monitoring. The Utah Healthy Living through Environment, Policy, and Improved Clinical Care (EPICCC) Program promotes diabetes education through Diabetes Self-Management Education programs and other resources found at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

**Diabetes Death Rate, 2009-2013**



**Diabetes Death Rate, 2009-2013**

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	519	2,813,674	18.5 (17.8-19.2)	23.7 (22.8-24.6)	n/a
Am. Indian/AK Native	11	41,497	27.5 (20.8-35.6)	54.2 (39.9-72.0)	↑
Asian	8	61,095	13.1 (9.4-17.8)	22.5 (16.0-30.7)	
Black/ African Am.	5	35,361	14.1 (9.2-20.9)	30.8 (18.7-48.0)	
N. Hawaiian/Pac. Islander	8	26,739	29.9 (21.4-40.7)	72.0 (50.0-100.5)	↑
White	477	2,587,898	18.4 (17.7-19.2)	22.8 (21.9-23.7)	
Hispanic/Latino	36	368,554	9.8 (8.4-11.3)	27.9 (23.6-32.6)	

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: E10-E14.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Coronary Heart Disease Death

### Why is it important?

Coronary heart disease (CHD) is a condition in which blood flow to the heart is reduced. When the coronary arteries become narrowed or clogged, an inadequate amount of blood oxygen reaches the heart tissue. The part of the heart not receiving oxygen begins to die, and some of the heart muscle may be permanently damaged. Prevention of CHD is key to reducing mortality from heart disease.

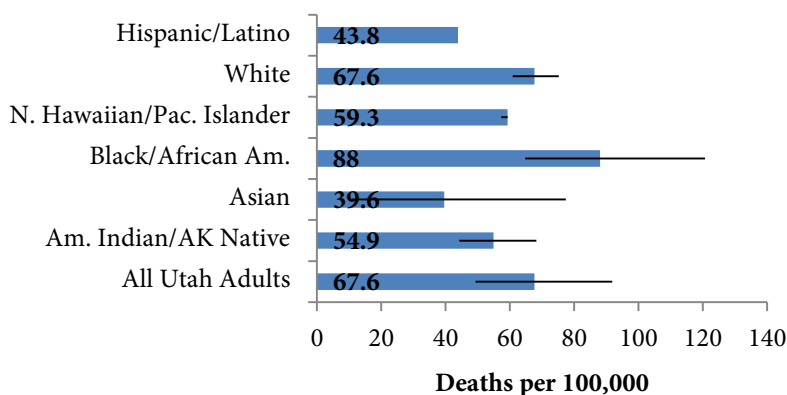
### How are we doing?

From 2011-2013, the age-adjusted Utah coronary heart disease death rate was 67.6 per 100,000 population. Asian and Hispanic/Latino Utahns had a significantly lower rate of coronary heart disease death than all Utahns.

### How can we improve?

Prevention of CHD is key to reducing mortality from heart disease. The Utah Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program promotes heart health education and also provides resources which can be accessed at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Coronary Heart Disease Death 2011-2013



### Coronary Heart Disease Death Rate, 2011-2013

Race/Ethnicity	Average Annual # of Deaths	2011-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	1503	2,856,842	52.6 (51.1-54.2)	67.6 (65.7-69.7)	n/a
Am. Indian/AK Native	11	42,355	25.2 (17.2-35.6)	54.9 (36.6-79.1)	
Asian	16	63,594	24.6 (18.1-32.8)	39.6 (28.9-52.9)	↓
Black/ African Am.	11	36,650	30.9 (21.4-43.2)	88.0 (59.3-125.8)	
N. Hawaiian/Pac. Islander	8	27,428	29.2 (18.7-43.4)	59.3 (36.0-92.0)	
White	1437	2,623,003	54.8 (53.2-56.4)	67.6 (65.6-69.7)	
Hispanic/Latino	57	378,251	15.1 (12.9-17.5)	43.8 (37.1-51.4)	↓

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: I20-I25.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# CHRONIC DISEASES AND CONDITIONS

## Stroke Deaths

### Why is it important?

Stroke, the death of brain tissue usually resulting from artery blockage, is the third age-adjusted leading cause of death in Utah. About 700,000 new or first-time strokes occur in the US each year. Stroke is a leading cause of long-term disability and can occur in all age groups.<sup>48</sup>

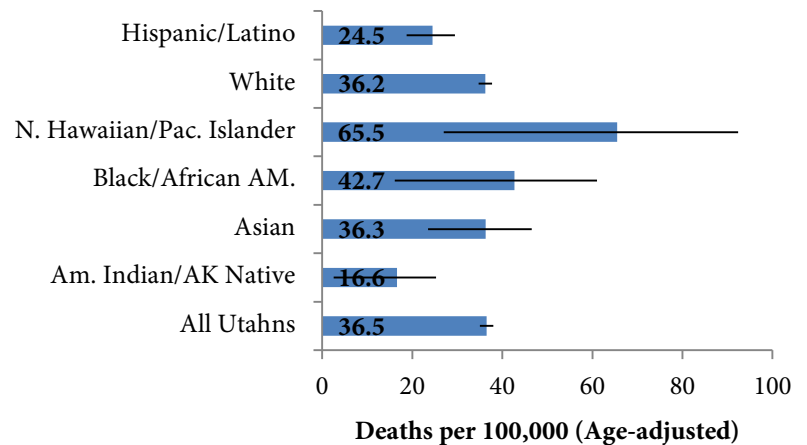
### How are we doing?

Death rates for stroke have generally declined in recent decades. This trend is likely related to improvements in acute stroke care and in improved detection and treatment of hypertension. Utah's age-adjusted stroke death rate was 36.5 per 100,000 persons from 2011-2013. American Indians/Alaska Natives and Hispanics/Latinos had significantly lower rates than all Utahns. Native Hawaiians/Pacific Islanders had the highest rate of stroke death.

### How can we improve?

Early recognition of stroke symptoms is key to reducing stroke mortality. The Utah Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program promotes heart health education and also provides resources which can be accessed at [www.choosehealth.utah.gov/](http://www.choosehealth.utah.gov/).

### Stroke Deaths, 2011-2013



### Stroke Death Rate, 2011-2013

Race/Ethnicity	Average Annual # of Deaths	2011-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	801	2,856,842	28.0 (26.9-29.2)	36.5 (35.0-38.0)	n/a
Am. Indian/AK Native	4	42,355	9.4 (4.9-16.5)	16.6 (7.9-30.7)	↓
Asian	14	63,594	22.5 (16.3-30.4)	36.3 (26.1-49.1)	
Black/ African Am.	7	36,650	19.1 (11.8-29.2)	42.7 (24.4-69.3)	
N. Hawaiian/Pac. Islander	6	27,428	23.1 (13.9-36.1)	65.5 (38.6-104.0)	↑
White	760	2,623,003	29.0 (27.8-30.2)	36.2 (34.7-37.7)	
Hispanic/Latino	32	378,251	8.5 (6.9-10.3)	24.5 (19.5-30.3)	↓

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: I60-I69

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

# Cancer



UTAH DEPARTMENT OF  
**HEALTH**

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Office of Health Disparities

## Invasive Lung Cancer Incidence

### Why is it important?

Lung cancer is the leading cause of cancer-related death in Utah and the U.S. In 2014 it is estimated that 159,260 U.S. deaths will be due to lung cancer. Cigarette smoking is the single most important risk factor for lung cancer. Other risk factors include occupational or environmental exposure to secondhand smoke, radon, asbestos (particularly among smokers), certain metals (chromium, cadmium, arsenic), some organic chemicals, radiation, air pollution, and probably a medical history of tuberculosis. Genetic susceptibility plays a contributing role in the development of lung cancer, especially in those who develop the disease at a younger age.<sup>49</sup>

### How are we doing?

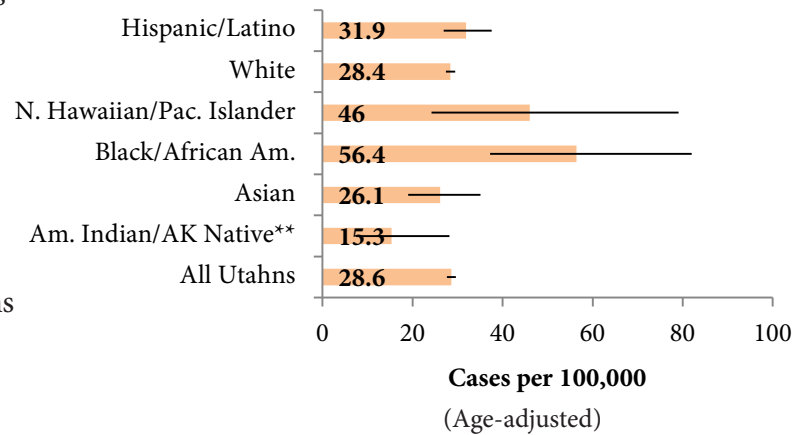
From 2008-2012, the overall lung cancer incidence rate (age-adjusted) in Utah was 28.6 per 100,000 persons. Blacks/African Americans had a significantly higher rate than all Utahns.

### How can we improve?

Utah's statewide Tobacco Prevention and Control Program ([www.tobaccofreeutah.org](http://www.tobaccofreeutah.org)) coordinates efforts to prevent youth from starting to use tobacco, to help tobacco users quit, to eliminate exposure to secondhand smoke, and to reduce tobacco-related disparities. Free services that assist smokers with quitting include the Utah Tobacco Quit Line (1-888-567-TRUTH), a web-based cessation service ([www.utahquitnet.com](http://www.utahquitnet.com)), and school- and community-based quit programs for teens, adults, and pregnant women.

### Invasive Lung Cancer Incidence

2008-2012



### Invasive Lung Cancer Incidence Rate, 2008-2012

Race/Ethnicity	Annual Average # of Cases	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	612	2,766,106	22.1 (21.3-22.9)	28.6 (27.6-29.6)	n/a
Am. Indian/AK Native**	2	40,511	5.9 (3.1-10.3)	15.3 (7.2-28.2)	↓
Asian	10	58,576	16.4 (12.1-21.7)	26.1 (19.0-35.1)	
Black/ African Am.	7	33,910	19.5 (13.4-27.3)	56.4 (37.2-82.0)	↑
N. Hawaiian/Pac. Islander	3	25,892	13.1 (7.6-21.0)	46.0 (24.2-79.1)	
White	583	2,549,111	22.9 (22.0-23.7)	28.4 (27.4-29.5)	
Hispanic/Latino	34	357,187	9.5 (8.1-11.0)	31.9 (26.9-37.6)	

Utah Cancer Registry, contract HHSN2612013000171, National Cancer Institute's SEER Program with support from the UDOH and University of Utah. *Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.* For more information about population estimates, refer to Methodology section of this report.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Use caution in interpreting. Due to low frequency, these rates are unstable.



## Lung Cancer Death

### Why is it important?

Lung cancer is the leading cause of cancer-related death in Utah and the U.S. In 2014 it is estimated that 159,260 U.S. deaths will be due to lung cancer. Cigarette smoking is the single most important risk factor for lung cancer. Other risk factors include occupational or environmental exposure to secondhand smoke, radon, asbestos (particularly among smokers), certain metals (chromium, cadmium, arsenic), some organic chemicals, radiation, air pollution, and probably a medical history of tuberculosis. Genetic susceptibility plays a contributing role in the development of lung cancer, especially in those who develop the disease at a younger age.<sup>49</sup>

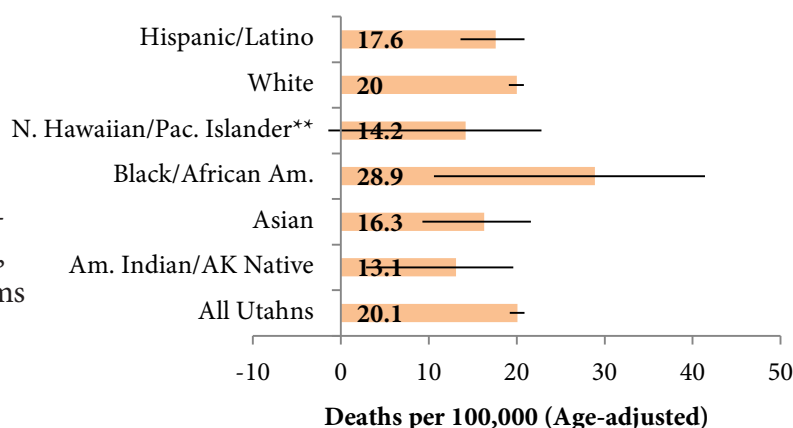
### How are we doing?

From 2009-2013, the age-adjusted lung cancer death rate in Utah was 20.1 per 100,000 population. There was no significant disparity between lung cancer death rates of race/ethnic groups.

### How can we improve?

Utah's statewide Tobacco Prevention and Control Program ([www.tobaccofreeutah.org](http://www.tobaccofreeutah.org)) coordinates efforts to prevent youth from starting to use tobacco, to help tobacco users quit, to eliminate exposure to secondhand smoke, and to reduce tobacco-related disparities. Free services that assist smokers with quitting include the Utah Tobacco Quit Line (1-888-567-TRUTH), a web-based cessation service ([www.utahquitnet.com](http://www.utahquitnet.com)), and school- and community-based quit programs for teens, adults, and pregnant women.

**Lung Cancer Death, 2009-2013**



**Lung Cancer Death Rate, 2009-2013**

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	440	2,813,674	15.6 (15.0-16.3)	20.1 (19.3-21.0)	n/a
Am. Indian/AK Native	3	41,497	6.3 (3.3-10.7)	13.1 (6.6-23.3)	
Asian	6	61,095	10.1 (6.9-14.4)	16.3 (11.0-23.3)	
Black/ African Am.	4	35,361	10.2 (6.0-16.1)	28.9 (16.4-47.2)	
N. Hawaiian/Pac. Islander**	2	26,739	6.0 (2.6-11.8)	14.3 (5.6-29.9)	
White	419	2,587,898	16.2 (15.5-16.9)	20.1 (19.2-20.9)	
Hispanic/Latino	21	368,554	5.7 (4.7-6.9)	17.7 (14.3-21.6)	

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: C33-C34.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

## Invasive Colorectal Cancer Incidence

### Why is it important?

Colorectal cancer is the second leading cause of cancer-related deaths in Utah and the U.S. When national cancer-related deaths are estimated separately for males and females, colorectal cancer is the third leading cause of cancer death behind lung and breast cancer for females and behind lung and prostate cancer for males. Deaths from colorectal cancer can be substantially reduced when precancerous polyps are detected early and removed. When colorectal cancer is diagnosed early, 90% of patients survive at least five years.<sup>50</sup>

### How are we doing?

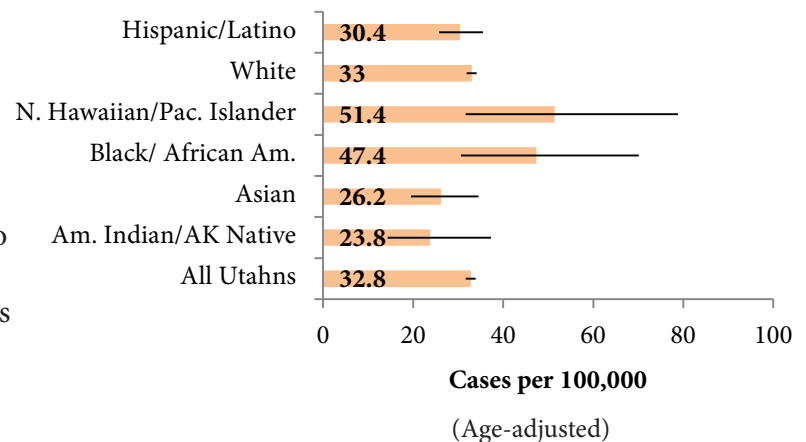
Utah's rate of colorectal cancer is significantly lower than the U.S. In 2011, Utah's age-adjusted rate of colorectal cancer was 31.8 per 100,000 persons compared with 39.9 per 100,000 persons for the U.S.<sup>50</sup> The incidence rate for invasive colorectal cancer for all Utahns between 2008-2012 was 32.8 per 100,000 population. No significant differences were observed between race/ethnic groups.

### How can we improve?

The American Cancer Society recommends that routine screening for colorectal cancer begin at age 50 for adults at average risk. Routine screening can include annual fecal tests, stool DNA testing every three years, imaging tests every five years (flexible sigmoidoscopy, barium enema, CT colonography), and/or colonoscopy every 10 years.<sup>13</sup> Persons at high risk may need to begin screening at a younger age and individuals should discuss risk factors and screening options with their health care provider.

### Invasive Colorectal Cancer Incidence

2008-2012



### Invasive Colorectal Cancer Incidence Rate, 2008-2012

Race/Ethnicity	Annual Average # of Cases	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	717	2,766,106	25.9 (25.1-26.8)	32.8 (31.7-33.9)	n/a
Am. Indian/AK Native	5	40,511	11.8 (7.6-17.6)	23.8 (14.3-37.3)	
Asian	11	58,576	18.8 (14.1-24.4)	26.2 (19.5-34.5)	
Black/ African Am.	6	33,910	18.9 (12.9-26.6)	47.4 (30.6-70.1)	
N. Hawaiian/Pac. Islander	6	25,892	21.6 (14.4-31.3)	51.4 (31.7-78.8)	
White	686	2,549,111	26.9 (26.0-27.8)	33.0 (31.9-34.1)	
Hispanic/Latino	42	357,187	11.8 (10.3-13.5)	30.4 (25.8-35.5)	

Utah Cancer Registry, contract HHSN2612013000171, National Cancer Institute's SEER Program with support from the UDOH and University of Utah. *Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.* For more information about population estimates, refer to Methodology section of this report.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

## Colorectal Cancer Death

### Why is it important?

Colorectal cancer is the second leading cause of cancer-related deaths in Utah and the U.S. When national cancer-related deaths are estimated separately for males and females, colorectal cancer is the third leading cause of cancer death behind lung and breast cancer for females and behind lung and prostate cancer for males. Deaths from colorectal cancer can be substantially reduced when precancerous polyps are detected early and removed. When colorectal cancer is diagnosed early, 90% of patients survive at least five years.<sup>50</sup>

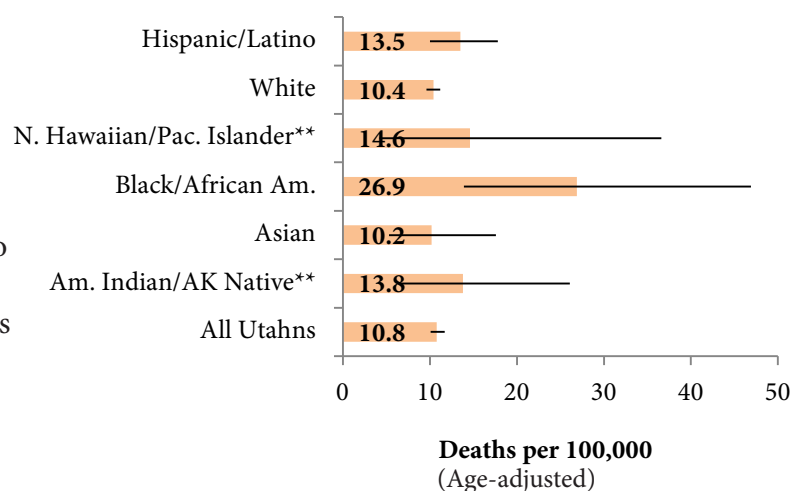
### How are we doing?

From 2011-2013, the age-adjusted rate of colorectal cancer death in Utah was 10.8 per 100,000 population. Black/African American Utahns had a significantly higher rate of colorectal cancer death than all Utahns.

### How can we improve?

The American Cancer Society recommends that routine screening for colorectal cancer begin at age 50 for adults at average risk. Routine screening can include annual fecal tests, stool DNA testing every three years, imaging tests every five years (flexible sigmoidoscopy, barium enema, CT colonography), and/or colonoscopy every 10 years.<sup>13</sup> Persons at high risk may need to begin screening at a younger age and individuals should discuss risk factors and screening options with their health care provider.

### Colorectal Cancer Death, 2011-2013



### Colorectal Cancer Death Rate, 2011-2013

Race/Ethnicity	Average Annual # of Deaths	2011-2013 Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	249	2,856,842	8.7 (8.1-9.4)	10.8 (10.1-11.7)	n/a
Am. Indian/AK Native**	4	42,355	8.7 (4.3-15.5)	13.8 (6.4-26.1)	
Asian	4	63,594	6.8 (3.6-11.7)	10.2 (5.3-17.6)	
Black/ African Am.	5	36,650	14.6 (8.3-23.6)	26.9 (13.9-46.9)	↑
N. Hawaiian/Pac. Islander**	2	27,428	6.1 (2.0-14.2)	14.6 (4.2-36.6)	
White	227	2,623,003	8.7 (8.0-9.3)	10.4 (9.6-11.2)	
Hispanic/Latino	19	378,251	5.1 (3.9-6.6)	13.5 (10.0-17.8)	

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: C18-C21.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

## Invasive Female Breast Cancer Incidence

### Why is it important?

Breast cancer is the most commonly occurring cancer in U.S. women (excluding basal and squamous cell skin cancers) and the leading cause of female cancer death in Utah. Deaths from breast cancer can be substantially reduced if the tumor is discovered at an early stage. Mammography is currently the best method for detecting cancer early. Clinical trials have demonstrated that routine screening with mammography can reduce breast cancer deaths by 20% to 30% in women aged 50 to 69 years, and by about 17% in women aged 40 to 49 years.

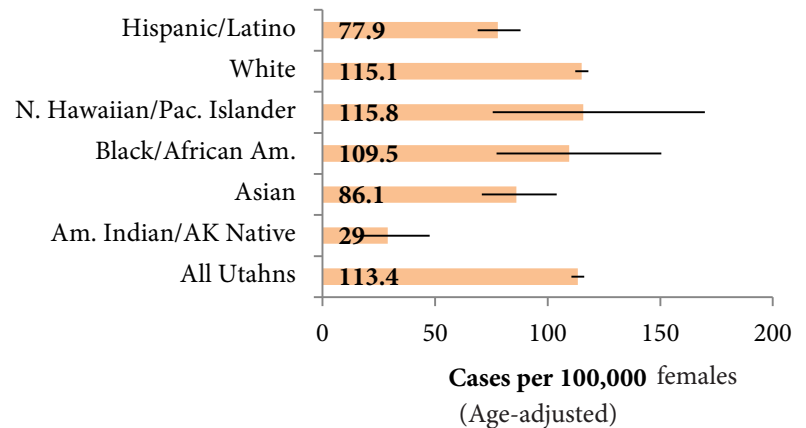
### How are we doing?

During 2008-2012, the breast cancer incidence rate (age-adjusted) was 113.4 cases per 100,000 females. American Indian/Alaska Native, Asians, and Hispanic women had significantly lower rates than all Utahns.

### How can we improve?

The American Cancer Society recommends that women aged 40 or older have an annual mammogram.<sup>14</sup> Women who are at higher than average risk of breast cancer should seek expert medical advice about whether they should begin screening before age 40 and the frequency of that screening. The UDOH Utah Cancer Control Program offers breast cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

### Invasive Breast Cancer Incidence 2008-2012



### Invasive Female Breast Cancer Incidence Rate, 2008-2012

Race/Ethnicity	Annual Average # of Cases	Average Annual Female Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahn women	1,318	1,376,350	95.8 (93.5-98.1)	113.4 (110.6-116.2)	n/a
Am. Indian/AK Native	4	20,107	17.9 (10.6-28.3)	29.0 (16.4-47.5)	↓
Asian	23	31,246	74.9 (61.9-89.8)	86.1 (70.7-104.0)	↓
Black/ African Am.	9	14,708	58.5 (42.3-78.8)	109.5 (77.3-150.5)	
N. Hawaiian/Pac. Islander	7	12,412	53.2 (36.6-74.7)	115.8 (75.6-169.8)	
White	1,268	1,269,171	99.9 (97.5-102.4)	115.1 (112.3-118.0)	
Hispanic/Latino	66	172,447	38.3 (34.3-42.7)	77.9 (68.9-87.9)	↓

Utah Cancer Registry, contract HHSN2612013000171, National Cancer Institute's SEER Program with support from the UDOH and University of Utah. *Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.* For more information about population estimates, refer to Methodology section of this report.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

## Female Breast Cancer Death

### Why is it important?

Breast cancer is the most commonly occurring cancer in U.S. women (excluding basal and squamous cell skin cancers) and the leading cause of female cancer death in Utah. Deaths from breast cancer can be substantially reduced if the tumor is discovered at an early stage. Mammography is currently the best method for detecting cancer early. Clinical trials have demonstrated that routine screening with mammography can reduce breast cancer deaths by 20% to 30% in women aged 50 to 69 years, and by about 17% in women aged 40 to 49 years.

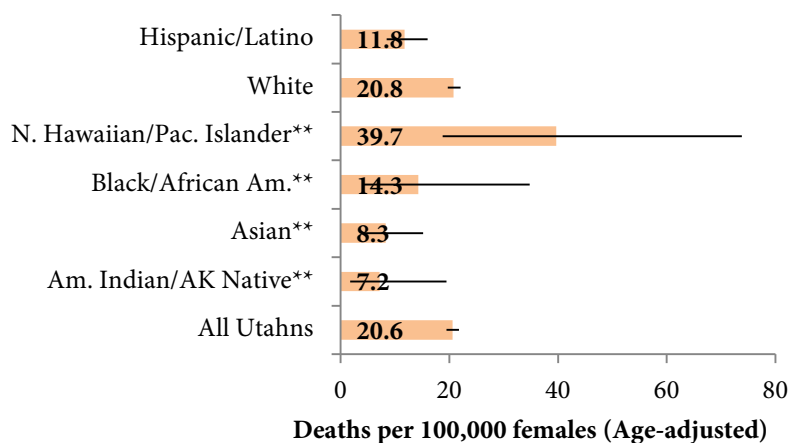
### How are we doing?

From 2009-2013, the age-adjusted breast cancer death rate in Utah was 20.6 per 100,000 females. Asian and Hispanic/Latino women had significantly lower rates of breast cancer death than all Utah women.

### How can we improve?

The American Cancer Society recommends that women aged 40 or older have an annual mammogram.<sup>14</sup> Women who are at higher than average risk of breast cancer should seek expert medical advice about whether they should begin screening before age 40 and the frequency of that screening. The UDOH Utah Cancer Control Program offers breast cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

### Female Breast Cancer Death, 2009-2013



### Female Breast Cancer Death Rate, 2009-2013

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Female Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utah females	245	1,399,602	17.5 (16.6-18.5)	20.6 (19.5-21.8)	n/a
Am. Indian/AK Native**	1	20,575	3.9 (1.1-10.0)	7.2 (1.8-19.5)	↓
Asian**	2	32,549	6.8 (3.4-12.1)	8.3 (4.1-15.2)	↓
Black/ African Am.**	1	15,351	6.5 (2.1-15.2)	14.3 (4.3-34.8)	
N. Hawaiian/Pac. Islander**	2	12,837	17.1 (8.6-30.7)	39.7 (18.8-73.8)	
White	236	1,288,104	18.3 (17.3-19.4)	20.8 (19.7-22.1)	
Hispanic/Latino	10	178,045	5.6 (4.2-7.4)	11.8 (8.5-16.0)	↓

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: C50.

Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

## Prostate Cancer Incidence

### Why is it important?

Prostate cancer is the most commonly occurring form of cancer (excluding skin cancer) among men and is the second leading cause of cancer death for men in Utah and the U.S. All men over 40 should visit their doctor for a routine health visit which may include a discussion on prostate health.

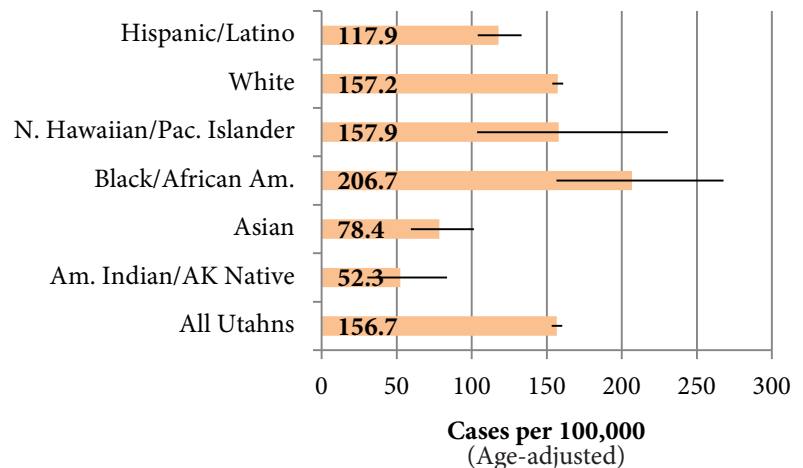
### How are we doing?

Between 2008-2012, the prostate cancer incidence rate (age-adjusted) in Utah was 156.7 per 100,000 males. American Indians/Alaska Natives, Asians, and Hispanics had significantly lower incidence rates than all Utahns.

### How can we improve?

The American Cancer Society recommends that health care professionals discuss the potential benefits and limitations of prostate cancer screening starting when male patients are 50. The recommended screening is for prostate specific antigen (PSA), with the option of digital rectal examination. African American men and those with one first degree relative with prostate cancer should be screened starting at age 45. The UDOH Utah Cancer Control Program offers prostate cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

**Prostate Cancer Incidence, 2008-2012**



**Prostate Cancer Incidence Rate, 2008-2012**

Race/Ethnicity	Annual Average # of Cases	Average Annual Male Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahn males	1,645	1,389,755	118.4 (115.8-120.9)	156.7 (153.3-160.2)	n/a
Am. Indian/AK Native	4	20,404	21.6 (13.5-32.6)	52.3 (30.5-83.6)	↓
Asian	13	27,331	46.1 (35.4-59.0)	78.4 (59.4-101.5)	↓
Black/ African Am.	16	19,202	83.3 (66.1-103.7)	206.7 (156.5-267.8)	
N. Hawaiian/Pac. Islander	7	13,480	50.4 (34.9-70.5)	157.9 (103.5-230.7)	
White	1,583	1,279,941	123.7 (121.0-126.4)	157.2 (153.7-160.8)	
Hispanic/Latino	63	184,740	34.3 (30.6-38.3)	117.9 (103.9-133.2)	↓

Utah Cancer Registry, contract HHSN2612013000171, National Cancer Institute's SEER Program with support from the UDOH and University of Utah. *Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.* For more information about population estimates, refer to Methodology section of this report.

\*Arrows indicate where the age-adjusted rate was higher or lower than for all Utahns.

## Prostate Cancer Death

### Why is it important?

Prostate cancer is the most commonly occurring form of cancer (excluding skin cancer) among men and is the second leading cause of cancer death for men in Utah and the U.S. All men over 40 should visit their doctor for a routine health visit which may include a discussion on prostate health.

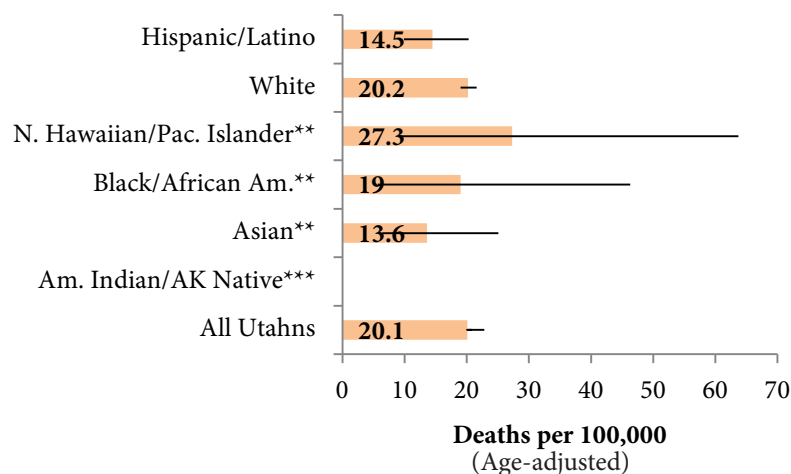
### How are we doing?

Between 2009-2013, the age-adjusted prostate cancer death rate in Utah was 20.1 per 100,000 males. There were no significant disparities noted between race/ethnic groups.

### How can we improve?

The American Cancer Society recommends that health care professionals discuss the potential benefits and limitations of prostate cancer screening starting when male patients are 50. The recommended screening is for prostate specific antigen (PSA), with the option of digital rectal examination. African American men and those with one first degree relative with prostate cancer should be screened starting at age 45. The UDOH Utah Cancer Control Program offers prostate cancer screening resources and information at [www.cancerutah.org/](http://www.cancerutah.org/).

### Prostate Cancer Death, 2009-2013



### Prostate Cancer Death Rate, 2009-2013

Race/Ethnicity	Average Annual # of Deaths	2009-2013 Average Annual Male Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utah males	194	1,414,072	13.7 (12.9-14.6)	20.1 (18.9-21.4)	n/a
Am. Indian/AK Native***	***	20,922	***	***	
Asian**	2	28,546	7.0 (3.4-12.9)	13.6 (6.4-25.1)	
Black/ African Am.**	1	20,010	5.0 (1.6-11.7)	19.0 (5.7-46.3)	
N. Hawaiian/Pac. Islander**	1	13,903	7.2 (2.3-16.8)	27.3 (8.9-63.7)	
White	188	1,299,795	14.5 (13.6-15.4)	20.2 (19.0-21.6)	
Hispanic/Latino	7	190,510	3.7 (2.6-5.1)	14.5 (9.9-20.3)	

Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH. ICD-10: C61. *Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2013.*

\*Arrows indicate where the rate was higher or lower than for All Utahns.

\*\*Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.

\*\*\* Estimate has been suppressed because standard error is greater than 50% or undetermined.

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