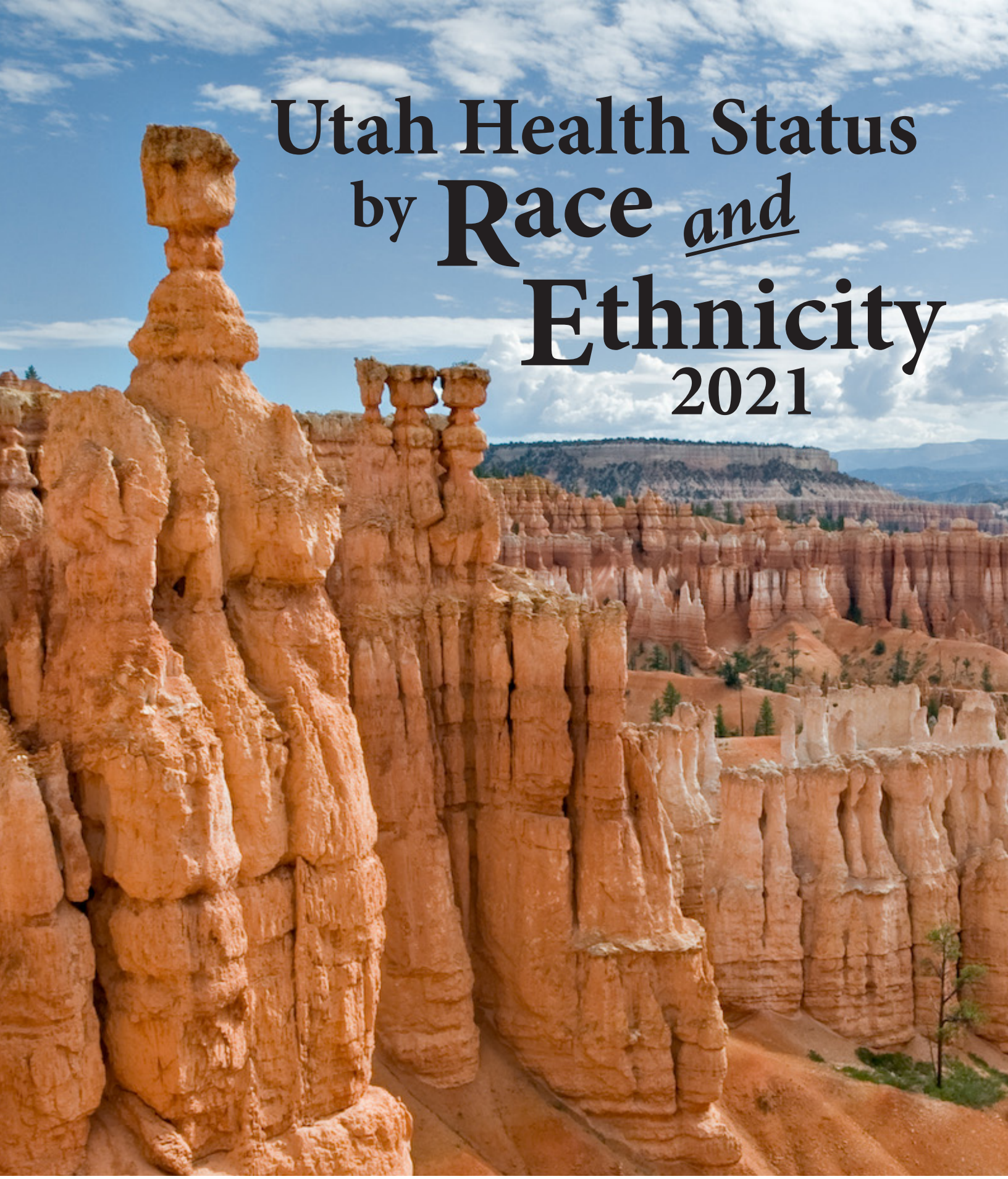
Utah Health Status by Race and Ethnicity 2021



UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Utah Health Status by Race & Ethnicity 2021

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List of Abbreviations

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List of Abbreviations and Acronyms Used in This Report

#	number
AAP	American Academy of Pediatrics
ACS	American Community Survey
African Am.	African American
AK Native	Alaska Native
Am. Indian	American Indian
AUCH	Association for Utah Community Health
BRFSS	Behavioral Risk Factor Surveillance System
CCHD	Critical congenital heart defects
CDC	United States Centers for Disease Control and Prevention
CHD	Coronary heart disease
CHIP	Children's Health Insurance Program
CMHC	Ccommunity mental health centers
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic obstructive pulmonary disease
COVID-19	Coronavirus disease 2019
DAQ	Division of Air Quality
DSAMH	Utah Division of Substance Abuse and Mental Health
EPICC	Healthy Living through Environment, Policy, and Improved Clinical Care Program
FOBT	Fecal occult blood test
FPL	Federal poverty level
flu	Influenza
FQHC	Federally-Qualified Health Center
GDM	Gestational diabetes mellitus
HCV	Hepatitis C virus
HEDA	Health Equity Data Analysis
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IBIS-PH	Indicator-Based Information System for Public Health
IBIS-Q	IBIS Query
K-12	Kindergarten through 12th grade
LHD	Local health departments
mcg	Micrograms
MIHP	Maternal and Infant Health Program
MVTC	Motor vehicle traffic crash
N. Hawaiian	Native Hawaiian
OHD	Office of Health Disparities
Pac. Islander	Pacific Islander
PCN	Primary Care Network
PCP	Primary care provider
PCV13	Pneumococcal conjugate vaccine
PID	Pelvic inflammatory disease

List of Abbreviations

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List of Abbreviations and Acronyms Used in This Report (continued)

PPD	Postpartum depression
PPSV23	Pneumococcal polysaccharide vaccine
PRAMS	Pregnancy Risk Assessment Monitoring System
PSA	Prostate specific antigen
SNAP	Supplemental Nutrition Assistance Program
SRH	Self-rated health
STD	Sexually-transmitted disease
SUID	Sudden unexpected infant death
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TOP Star	Teaching Obesity Prevention in Early Child Care Settings
TPCP	Tobacco Prevention and Control Program
UAP	Utah Asthma Program
UBDN	Utah Birth Defect Network
UCAN	Utah Cancer Action Network
UCCP	Utah Cancer Control Program
UDOH	Utah Department of Health
UIP	Utah Immunization Program
UPP	Utah's Premium Partnership for Health Insurance
US	United States
USPSTF	United States Preventive Services Task Force
UTVDRS	Utah Violent Death Reporting System
UWNQC	Utah Women and Newborns Quality Collaborative
VIPP	Violence and Injury Prevention Program
WIC	Women, Infants and Children Program

Due to the demands of the COVID-19 pandemic on the Utah Department of Health, the report Utah Health Status by Race and Ethnicity 2020 was postponed until 2021. Additionally, data on COVID-19 health disparities by race and ethnicity is not included in this report as it is widely available to the public at coronavirus.utah.gov. COVID-19-related reports will be published in 2021 and 2022.

Introduction

This report, Utah Health Status by Race and Ethnicity 2021, compiles public health data to identify racial and ethnic health disparities experienced in Utah. "Health disparities are differences in health outcomes closely linked to economic, socio-cultural, environmental, and geographic disadvantage."[1] In this report, "racial and ethnic health disparities" exist when one or more racial and ethnic minority populations experience poorer health outcomes when compared with the Utah population overall.

Utah's growing racial and ethnic minority communities often bear a disproportionate burden of disease and poor health outcomes. This limits the ability of individuals, families, and communities to reach their highest health potential, impacting well-being, longevity, and economic and social mobility. In order for Utah to become the "healthiest state in the nation," racial and ethnic health disparities must be addressed. Utah's multiracial and multiethnic communities are priorities of the Governor's One Utah Roadmap.

In addition to health indicators, this report includes indicators related to demographic information and access to health care. These indicators include age, poverty, health insurance coverage, etc. and are known to affect overall health.[2] These are all part of a larger context and historical backdrop including individual, community, and structural/systems-level determinants of health, which have and can create and perpetuate racial and ethnic health disparities.

The mission of the Utah Department of Health (UDOH) Office of Health Disparities (OHD) is "to advance health equity and reduce health disparities in Utah."[3] This report is intended to inform UDOH programs, public health organizations and professionals, healthcare systems, medical providers, community organizations, and anyone interested in addressing racial and ethnic health disparities. It is intended to guide decision-making, planning, implementation, and evaluation of equitable policies, evidence-based interventions, and community-based participatory research.

Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utah communities of every race and ethnicity. A comprehensive approach to address racial and ethnic health disparities must include individual, community and place-based, and system-based interventions that are culturally and linguistically responsive.

Factors affecting health disparities

This report does not explain all of the reasons for the racial and ethnic health disparities identified. Readers should not make assumptions about why these racial and ethnic health disparities exist. Assumptions can lead to misguided or ineffective efforts or unintentionally perpetuate negative biases, stereotyping, and discrimination.

Instead, readers should consider how structural determinants of health and social determinants of health impact health disparities, health equity, and quality of life as outlined in the UDOH OHD Health Equity Framework.

Through this report, the OHD primarily seeks to elevate the awareness of racial and ethnic health disparities in order to stimulate meaningful discussion, enhance existing programming, and facilitate future interventions and collaborations to better understand and address these health disparities. By 2022, the OHD intends to conduct a Health Equity Data Analysis (HEDA) to further identify and examine factors contributing to these and other health disparities in Utah.

The 2021 Report Indicators Versus the 2015 Report Indicators

For consistency, this report mirrors the format and content of Utah Health Status by Race and Ethnicity 2015. For the first time, it disaggregates birth defects data for people who identified as Asian and Pacific Islander. It presents additional indicators including adolescent suicide ideation, postpartum depression, neural tube defects, human immunodeficiency virus (HIV), acute hepatitis C, and chronic obstructive pulmonary disease (COPD). These new data indicators were either not available for the 2015 report or added for relevance to current public health issues and practice. The measure on adults driving under the influence is not included in the 2021 report because the data by race and ethnicity is statistically unreliable. The measure on adults reporting activity limitation is not included in the 2021 report because the measure has not been collected through the Behavioral Risk Factor Surveillance System (BRFSS) since 2015. The 2015 indicator "Colon Cancer Screening" previously used the measure "Percentage of Utahns Age 50+ Who Had Colon Cancer Screening in the Past Five Years," now uses a new measure "Percentage of Utahn Adults Aged 50–75 Who Completed a Recommended Colon Cancer Screening." The 2015 indicator "Poisoning Deaths" is now calculated and titled as "Unintentional Poisoning Deaths" to better reflect current public health issues including drug overdose deaths. In addition to these changes, the 2015 indicators "No Health Insurance Coverage" is now titled "Health Insurance Coverage;" "Overweight or Obese" is now titled "Overweight or Obesity;" "Chronic Drinking" is now titled "Heavy Drinking of Alcohol;" "Binge Drinking" is now titled "Binge Drinking of Alcohol;" "Ever Breastfeeing" is now titled "Ever Breastfed;" "Congenital Heart Defects" is now titled "Critical Congenital Heart Defects;" and "Suicide" is now titled "Deaths by Suicide."

Report language

This report, Utah Health Status by Race and Ethnicity 2021, aims to center language around people and use inclusive language when possible. However, many data collection and analysis procedures and processes limit the ability to be inclusive of individuals' characteristics such as race(s), ethnicity(ies), gender(s), etc. As data collection improves, future reports will also improve to reflect these changes.

Health Equity Framework

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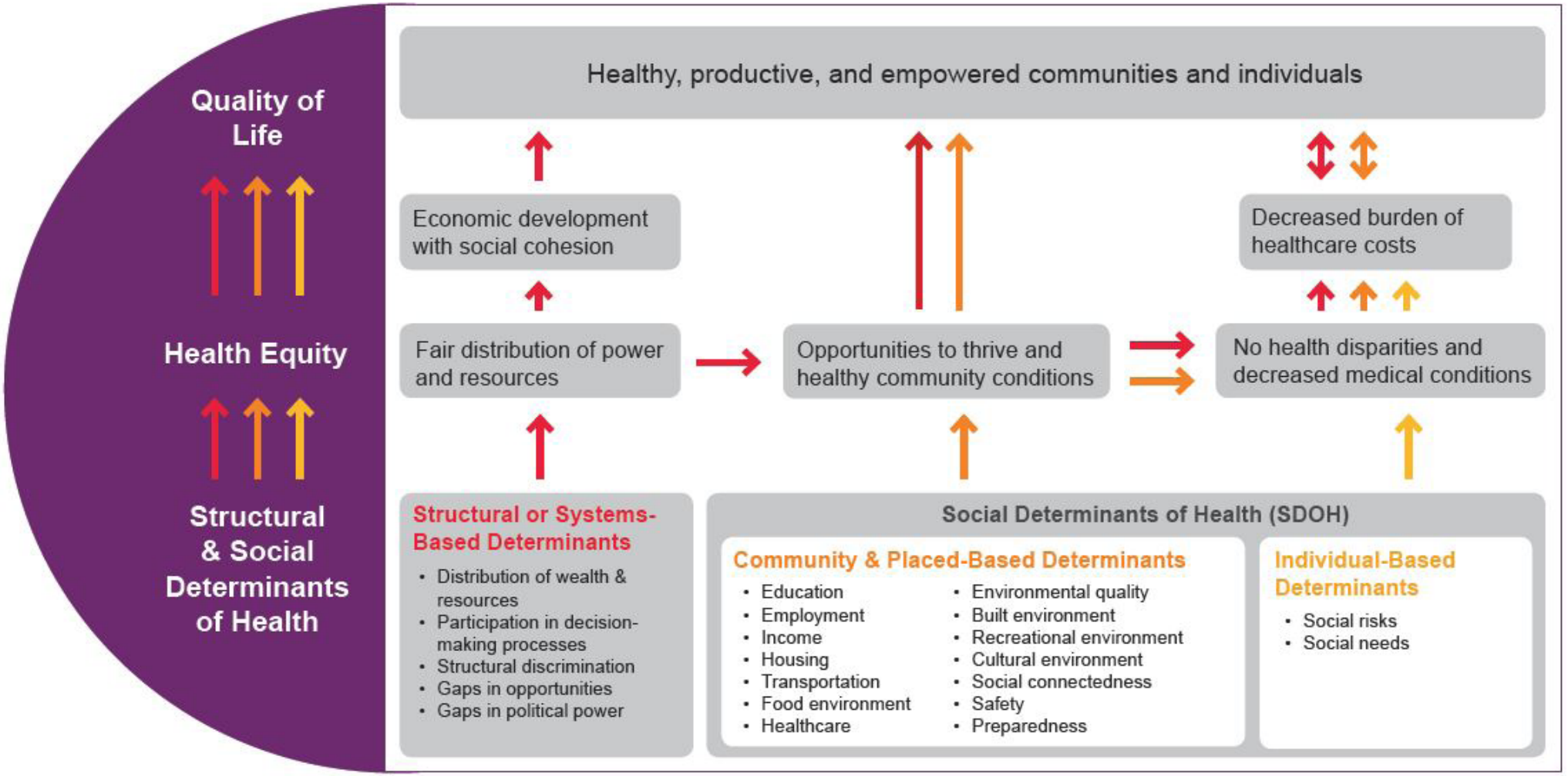
Health equity is a pathway to better quality of life and social cohesion.



The more determinants that are addressed, the more comprehensive the health equity approach.

The more comprehensive the health equity approach, the more opportunities individuals and communities have to be healthy, productive, and empowered.

Report format

Each page in the report is organized into three text elements. "Why is it important?" briefly explains the public health relevance of the indicator. "How are we doing?" describes the state's overall results and statistically significant racial or ethnic health disparities. "How can we improve?" orients readers to think about what creates health including social, economic, and environmental factors and points to the need for all systems in Utah to be adequate and accessible to promote health for everyone. It also offers short health messages that may be a health guideline, prevention advice, and/or information on support resources. The UDOH acknowledges and appreciates federal, tribal, and local governments; health care organizations; private, non-profit, and community-based organizations; and individuals who 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; therefore, this report primarily focuses on support resources and efforts of the UDOH.

For each health indicator, a bar graph depicts the calculated measure statewide 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 the graph includes a narrow line depicting the 95% confidence interval for that bar (or 90% if indicated). When racial and ethnic populations experience a significantly worse health outcome than the statewide health outcome, these bars on the graph are highlighted. 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 far right column of each table contains arrows indicating when a rate was significantly higher (upward arrow) or lower (downward arrow) than the statewide rate. A statistically significant difference was defined as, "The state rate (age-adjusted whenever possible) does not fall within the 95% confidence interval (age-adjusted whenever possible) of the rate for the racial/ethnic population." This is consistent with the standard used in the 2005, 2010, and 2015 Health Status by Race and Ethnicity reports.

Racial and ethnic categories

Per US Department of Health and Human Services Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status, "self-identification is the preferred means of obtaining information about an individual's race and ethnicity." Additionally this self-identified data is generally collected through two separate questions for race and ethnicity, meaning an individual ideally lists both their race and ethnicity separately.[4]

It is acknowledged significant diversity exists within each of the race and ethnicity categories used in this report and the use of broad categories will obfuscate health disparities among smaller subgroups and among multiracial and multiethnic communities. 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.[5] Abbreviations for race and ethnicity in data tables are as follows: Am. Indian (American Indian), AK Native (Alaska Native), African Am. (African American), N. Hawaiian (Native Hawaiian), and Pac. Islander (Pacific Islander). Data from people who identified as American Indian/Alaska Native are included in this report, with acknowledgment that people who self-identified as American Indian/Alaska Native may or may not be registered members of federally-recognized tribal jurisdictions. In this report, the race category "White, non-Hispanic" is used and includes only individuals who identified as "White" and "non-Hispanic." This differs from previous reports, which used the race category "White" which included individuals who identified as "White" and any ethnicity. Because an individual's race and ethnicity are collected separately and individuals may identify with more than one racial group, individuals may be included in both a race and ethnicity category or multiple race categories. Additional notes on race and ethnicity analysis are included in individual tables to identify when individuals are included in more than one race and ethnicity category. Finally, some data have "unknown" race information included in calculations or overlap data between categories 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 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 language other than English or Spanish.

Readers should also be cautious when comparing this report with the 2005, 2010, and 2015 editions in order to identify long-term trends or shifts in health status. Not all data sources are consistent across the 20-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.

Data notes (continued)

When appropriate, 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 is derived from a variety of data sources and was 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 BRFSS and the Pregnancy Risk Assessment Monitoring System (PRAMS).

Utah BRFSS datasets are age-adjusted to the US 2000 standard population based on three age groups: 18–34, 35–49, and 50+ (unless otherwise noted). For ethnicity, the UDOH Indicator-Based Information System for Public Health (IBIS-PH) uses five age groups for age-adjusting; thus, rates for people who identify as Hispanic/Latino and White, non-Hispanic for most indicators will not match IBIS-Q.

The Utah 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 people who are Utah residents who delivered a live-born infant within the state, including infants who die after delivery. A stratified random sampling approach is used in selecting people to participate, which allows separate estimates of population subgroups and comparisons across these subgroups. Once a full year of data is collected, it is weighted by the Centers for Disease Control and Prevention (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 People with Live Birth" category represents the proportion of people who answered specific survey questions during 2016–2018. The "Estimated Annual #" category represents an estimate of the number of people who reported the event. These numbers are weighted to represent the birth population for the year.

Beginning in 2012, the PRAMS survey added the response "I wasn't sure what I wanted" to the unintended pregnancy indicator. The addition of this response may have diluted the percentage of responses in the other categories, so data for 2012 and later is not comparable to previous years.

Census Bureau

Demographic information and population counts derived from the 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/ethnicity at the county level.

The estimates for years 2010 through 2019 on IBIS-Q for counties by race and ethnicity are the Vintage 2017 state and county resident population estimates by age, sex, race and Hispanic origin from the US Census Bureau based on the 2010 census counts. They were released in June 2020. They were included in IBIS-Q on September 11, 2020. For more information go to: https://www2.census.gov/programs-surveys/popest/technical-documentation/file-layouts/2010-2019/cc-est2019-alldata.pdf.

ACS 3-year estimates were discontinued after 2011–2013. Indicators in previous reports using ACS 3-year estimates now use ACS 5-year estimates or population estimate averages from the appropriate ACS 1-year estimates.

Demographic Context

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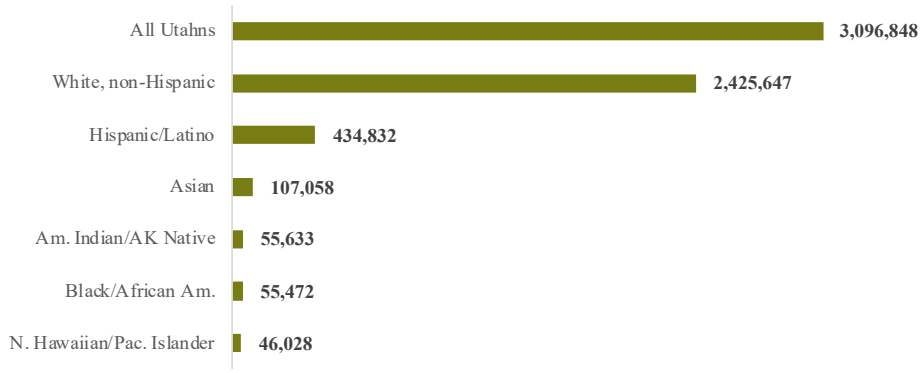
Utah Health Status by Race & Ethnicity 2021

Proportion of the Utah Population

Why is it Important?

Utah's growing racial and ethnic minority communities often bear a disproportionate burden of disease and poor health outcomes. This limits the ability of individuals, families, and communities to reach their highest health potential, impacting well-being, longevity, and economic and social mobility. In order for Utah to become the "healthiest state in the nation," racial and ethnic health disparities must be addressed. Utah's multiracial and multiethnic communities are priorities of the Governor's One Utah Roadmap.

Population, Utah, 2019



How are we doing?

Utah's racially and ethnically diverse populations continue to grow. Roughly one out of every five Utahns identifies as belonging to a racial or ethnic minority group (i.e., "something other than non-Hispanic White alone").[6] The Kem C. Garner Policy Institute reported, "half of Utah's population growth from 2015 to 2065 will come from minority populations."[7]

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. A comprehensive approach to address racial and ethnic health disparities must include individual, community and place-based, and system-based interventions that are culturally and linguistically responsive. As the Utah State Office of Minority Health, the UDOH OHD works to address racial and ethnic health disparities and advance health equity in Utah. OHD reports and resources are available at health.utah.gov/dispairites.

Utah Population by Race/Ethnicity, 2015–2019

Race/Ethnicity+	%	Average Annual Population	90% CI (Lower)	90% CI (Upper)
All Utahns		3,096.848	N/A	N/A
Am. Indian/AK Native	1.8	55,633	54,267	56,999
Asian	3.5	107,058	106,356	107,760
Black/African Am.	1.8	55,472	54,501	56,443
N. Hawaiian/Pac. Islander	1.5	46,028	45,031	47,025
White, non-Hispanic	78.3	2,425,647	2,424,759	2,426,535
Hispanic/Latino	14.0	434,832	N/A	N/A

US Census, 2019: ACS 5-Year Estimates Table DP05 (B02010, B02011, B02009, B02012, B01001H, B03001)

+ Groups are not mutually exclusive and will not sum to total.

The total Utah population estimates shown on this page are census estimates for Race Alone or in Combination. This provides a broader snapshot of Utah's growing diversity, including the many multiracial and multiethnic individuals who call Utah home. These estimates will be different from those found elsewhere in this report which are based on census estimates of persons who identify as one race alone and not in combination.

Age Distribution

Why is it important?

People's health and social needs vary across their lifetimes. Age distributions of populations are necessary to inform public health systems and interventions. Public health needs will vary for populations composed largely of youth, working-age adults, aging adults, etc. For example, 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), age-appropriate screenings to identify developmental delays at a time when treatment is most effective, and social services for children (e.g., Head Start).

How are we doing?

In general, Utah's racial and ethnic minority communities continue to have lower median ages when compared with Utah overall. The proportion of older adults ages 55–75+ years is highest among White, non-Hispanic populations. The highest proportions of children (<5 to 17 years) are among Hispanic/Latino, Black/African American, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native populations.

Utah Median Age by Race/Ethnicity, 2015–2019

Race/Ethnicity+	Median Age	90% CI (Lower)	90% CI (Upper)
All Utahns	30.8	30.6	31.0
Am. Indian/ AK Native	28.6	27.9	29.3
Asian	33.5	33.1	33.9
Black/African Am.	25.2	24.4	26.0
N. Hawaiian/ Pac. Islander	27.0	26.3	27.7
White, non-Hispanic	32.8	32.7	32.9
Hispanic/Latino	24.8	24.7	24.9

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
US Census, 2019: ACS 5-Year Estimates Table DP05 (B01002, B01002C, B1002D, B01002B, B01002E, B01002H, B01002I)

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. These relationships change and shift over an individual's lifetime. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity at every stage of life. A comprehensive approach to address racial and ethnic health disparities early on and through different stages of life must include individual, community and place-based, and system-based interventions that are culturally and linguistically responsive. As the Utah State Office of Minority Health, the UDOH OHD works to address racial and ethnic health disparities and advance health equity in Utah. OHD reports and resources are available at health.utah.gov/dispairites.

Utah Age Distribution by Race/Ethnicity, 2015–2019

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	8.1	21.7	11.3	14.7	13.6	10.2	9.5	6.5	4.3
Am. Indian/ AK Native	8.4	21.5	13.2	17.2	12.6	11.6	9.4	4.1	2.1
Asian	5.0	14.3	13.1	20.5	16.3	12.8	9.1	5.8	3.0
Black/African Am.	8.8	26.4	14.5	18.1	12.2	8.5	7.6	2.5	1.3
N. Hawaiian/ Pac. Islander	8.5	22.3	14.8	21.1	13.0	7.8	7.3	3.9	1.7
White, non-Hispanic	7.5	20.6	10.7	14.3	13.6	10.4	10.4	7.4	5.1
Hispanic/Latino	10.6	26.9	12.8	15.6	13.8	10.0	5.9	2.8	1.5

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
US Census, 2019: ACS 5-Year Estimates Table DP05 (B01001, B01001C, B01001D, B01001B, B01001E, B01001H, B01001I)

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Life Expectancy at Birth

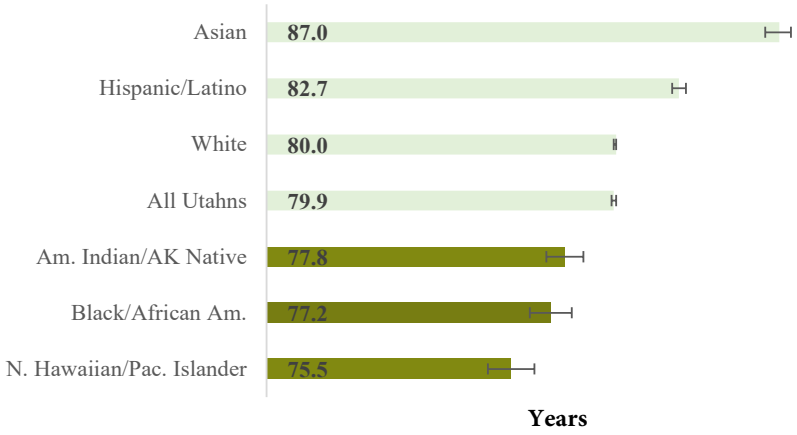
Why is it important?

Life expectancy is a measure often used to gauge the overall health of a community. Life expectancy at birth measures health status across all age groups. Shifts in life expectancy are often used to describe trends in mortality. Being able to predict how populations will age has enormous implications for the planning and provision of services and support. Small increases in life expectancy translate into large increases in the population. As the life expectancy of a population lengthens, the number of people living with chronic illnesses tends to increase because chronic illnesses are more common among older persons.[8]

How are we doing?

In Utah, as in many other parts of the developed world, people are living longer than before. In 2015–2019, life expectancy at birth for all Utahns was 79.9 years. American Indian/Alaska Native (77.8 years), Black/African American (77.2 years), and Native Hawaiian/Pacific Islander (75.5 years) populations had significantly lower life expectancy at birth than all Utahns. Asian (87.0 years) and Hispanic/Latino (82.7 years) populations had a significantly higher life expectancy at birth than all Utahns.

Life Expectancy at Birth, Utah, 2014–2018



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. Life expectancy measurements can be impacted by many factors ranging from genetics and risk-taking behaviors to one's environmental exposures and socioeconomic status. These relationships change and shift over an individual's lifetime. A comprehensive approach to address racial and ethnic health disparities early on and through different stages of life must include individual, community and place-based, and system-based interventions that are culturally and linguistically responsive. As the Utah State Office of Minority Health, the UDOH OHD works to address racial and ethnic health disparities and advance health equity in Utah. OHD reports and resources are available at health.utah.gov/dispairites.

Utah Life Expectancy at Birth, 2015–2019

Race/Ethnicity+	Life Expectancy (Years)	95% CI (Lower)	95% CI (Upper)	Sig*
All Utahns	79.9	79.8	80.0	n/a
Am. Indian/ AK Native	77.8	77.0	78.6	↓
Asian	87.0	86.4	87.5	↑
Black/African Am.	77.2	76.3	78.1	↓
N. Hawaiian/ Pac. Islander	75.5	74.5	76.5	↓
White	80.0	79.9	80.0	
Hispanic/Latino	82.7	82.4	83.0	↑

+Race is of any ethnicity and Hispanic/Latino is of any race.
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 2019.
The method developed by C.L. Chiang was used to compute life expectancy.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

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Poverty

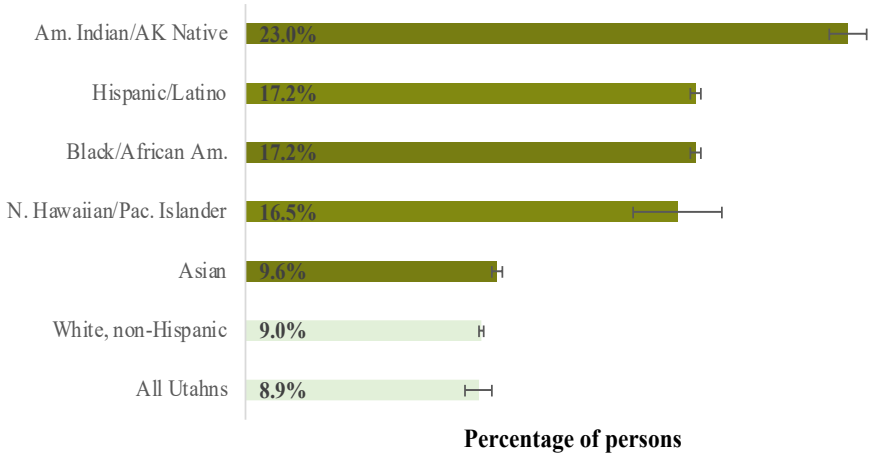
Why is it important?

The federal poverty level (FPL) takes into account both income and family size. Income provides an assessment of the financial resources available to individuals or families for basic necessities (e.g., food, clothing, and health care) to maintain or improve well-being. Access to financial resources has both immediate and long-lasting effects on health. People with incomes below the poverty level experience worse health outcomes than people with incomes above the poverty level for many of the indicators tracked by the UDOH.[9]

How are we doing?

According to the American Community Survey (ACS), approximately 8.9% of Utahns, or 279,435 Utahns, reported incomes below the poverty level in 2019. In 2019, all of Utah's racial and ethnic minority groups had a higher rate of incomes below the poverty level than all Utahns.

Utahns Living in Poverty, 2019



How can we improve?

Poverty is a complex issue with multifactorial causes and direct impacts on individual and community health.

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health such as the distribution of wealth and resources, employment and income impact health equity and quality of life. Ensuring individuals and families have a liveable wage, employment opportunities, and affordable housing are crucial to promoting public health. Some programs intended to serve people with low incomes in Utah include Medicaid, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), sliding-scale medical and dental services offered by federally qualified community health centers, and other programs like the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF).

Percentage of Utahns Living in Poverty, 2019

Race/Ethnicity+	%	90% CI (Lower)	90% CI (Upper)	Sig*
All Utahns	8.9%	8.4%	9.4%	
Am. Indian/AK Native	23.0%	22.3%	23.7%	↑
Asian	9.6%	9.4%	9.8%	↑
Black/African Am.	17.2%	17.0%	17.4%	↑
N. Hawaiian/Pac. Islander	16.5%	14.8%	18.2%	↑
White, non-Hispanic	9.0%	8.9%	9.1%	
Hispanic/Latino	17.2%	17.0%	17.4%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
US Census, 2019: ACS 5-Year Estimates Tables B17001, B17001C, B17001D, B17001B, B17001E, B17001H, and B17001I.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
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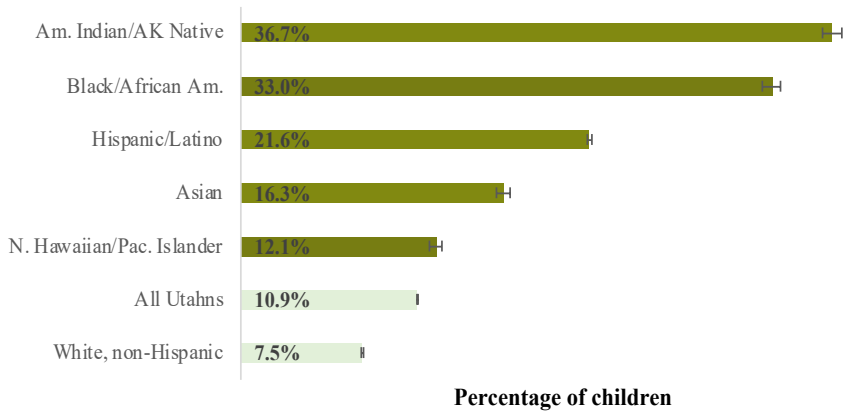
Child Poverty

Why is it important?

The federal poverty level (FPL) takes into account both income and family size. Income provides an assessment of the financial resources available to individuals or families for basic necessities (e.g., food, clothing, and health care) to maintain or improve their well-being. Access to financial resources has both immediate and long-lasting effects on health, especially for children's development and well-being. People with incomes below the poverty level experience worse health outcomes than people with incomes above the poverty level for many of the indicators tracked by the Utah Department of Health.[10]

Utah Children Living in Poverty, 2015–2019



How are we doing?

According to the American Community Survey (ACS), approximately 9.9% of Utah children aged 17 or younger, or 91,433 Utah children, were living in households who reported incomes below the poverty level in 2019. In 2019, all of Utah's racial and ethnic minority groups had a higher rate of children living in households with incomes below the poverty level than all Utah children.

How can we improve?

Child poverty is a complex issue with multifactorial causes and direct impacts on individual and community health. The UDOH OHD Health Equity Framework outlines how structural and social determinants of health such as the distribution of wealth and resources, employment, and income impact health equity and quality of life. Ensuring individuals and families have a liveable wage, employment opportunities, and affordable housing are crucial to promoting public health. Some of the programs intended to serve people with low incomes in Utah include Medicaid, CHIP, PCN, sliding-scale medical and dental services offered by federally-qualified community health centers, and other programs like SNAP and TANF.

Utah Children (17 and Under) in Poverty, 2015–2019

Race/Ethnicity+	# Living in Poverty	Total Child Population	% Living in Poverty	90% CI (Lower)	90% CI (Upper)	Sig. *
All Utahns <18	99,579	92,294	10.9%	10.9%	11.0%	n/a
Am. Indian/AK Native	3,606	9,820	36.7%	36.1%	37.3%	↑
Asian	2,227	13,665	16.3%	15.9%	16.7%	↑
Black/African Am.	4,150	12,588	33.0%	32.4%	33.5%	↑
N. Hawaiian/ Pac. Islander	1,006	8,298	12.1%	11.7%	12.5%	↑
White, non-Hispanic	50,776	674,997	7.5%	7.5%	7.6%	↓
Hispanic/Latino	34,689	160,240	21.6%	21.5%	21.8%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
US Census, 2019: ACS 5-Year Estimates Tables B17001, B17001C, B17001D, B17001B, B17001E, B17001H, and B17001I.
**Arrows indicate whether the rate was higher or lower than for all Utahns*

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Health Care Services and Systems

Utah Health Status by Race & Ethnicity 2021

Health Insurance Coverage

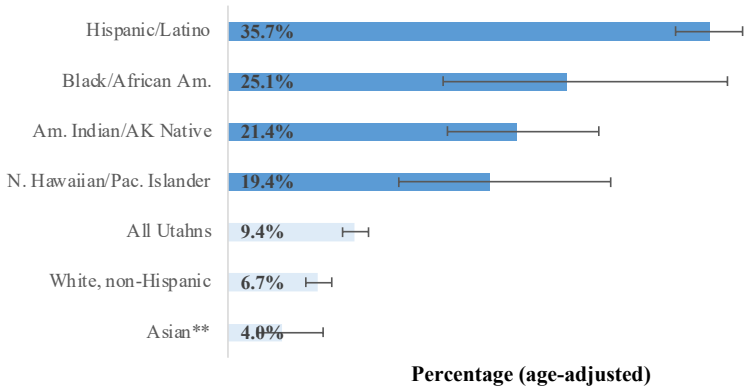
Why is it important?

Most people need medical care and mental/behavioral healthcare 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 have routine preventive care. Persons without coverage often delay seeking needed care and find services difficult to afford.[11]

How are we doing?

From 2017–2019, 9.4% of Utahns reported having no health insurance coverage (age-adjusted rate). People who identified as Hispanic/Latino (35.7%), Black/African American (25.1%), American Indian/Alaska Native (21.4%), and Native Hawaiian/Pacific Islander (19.4%) had significantly higher rates of no health insurance coverage than all Utahns. People who identified as White, non-Hispanic (6.7%) and Asian (4.0%) had significantly lower rates than all Utahns.

Utahns Without Health Insurance, 2017—2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Through state and federal legislation that increases access to health insurance, Utah can directly reduce the number of Utahns without health insurance. The UDOH administers programs to improve access to care, such as Medicaid, CHIP, PCN, and Utah's Premium Partnership for Health Insurance (UPP). In 2019, UDOH implemented a full Medicaid expansion.[12] Members of the Association for Utah Community Health (AUCH), including Federally-Qualified Health Centers (FQHCs) and other providers, also strive to meet the needs of the people without health insurance.

Percentage of Utahns Without Health Insurance, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual Population	# without health insurance	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utahns	20,027	3,153,517	299,904	9.5% (8.5–10.7%)	9.4% (8.5–10.4%)	n/a
Am. Indian/AK Native	232	48,739	10,527	21.6% (16.5–27.8%)	21.4% (16.3–27.5%)	↑
Asian**	183	82,244	3,593	4.4% (2.4–7.7%)	4.0% (2.2–7.1%)	↓
Black/African Am.	116	45,575	14,289	31.4% (20.3–45.1%	25.1% (16.0–37.1%)	↑
N. Hawaiian/Pac. Islander	84	32,968	5,888	17.9% (10.8–28.2%)	19.4 (12.7–28.4%)	↑
White, non-Hispanic	13,481	2,463,707	164,806	6.7% (5.8–7.7%)	6.7% (5.8–7.7%)	↓
Hispanic/Latino	1,388	449,018	164,855	36.7% (34.3–39.2%)	35.7% (33.2–38.2%)	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019 (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.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

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Cost as a Barrier to Health Care

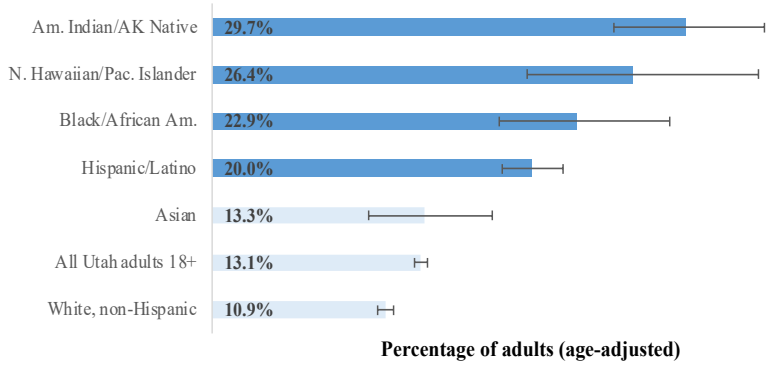
Why is it important?

Access to health care is still a problem for many Utahns. In systems with limited access to health care, individuals who cannot obtain needed health care tend to have higher rates of death and disability from chronic disease. Cost is the most commonly reported barrier to getting needed health care.[13]

How are we doing?

From 2016–2019, 13.1% of Utah adults reported they were unable to access needed health care in the past year (age-adjusted rate). Adults who identified as American Indian/Alaska Native (29.7%), Native Hawaiian/Pacific Islander (26.4%), Black/ African American (22.9%), and Hispanic/Latino (20.0%) had significantly higher percentages of those unable to get health care due to cost than all Utah adults. Adults who identified as White, non-Hispanic had a significantly lower percentage (10.9%) than all Utah adults.

Adults Unable Access to Care Due to Cost, Utah, 2016—2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH administers programs to improve access to care, such as Medicaid, CHIP, PCN, and UPP. The UDOH also works to improve the "safety net" for persons without health insurance through primary care grants to rural areas and clinics for children with disabilities. Local health departments provide preventive services such as immunizations and screenings at low or no cost to eligible persons who cannot afford them. Members of the AUCH, including FQHCs and other providers, also strive to meet the needs of people facing cost as a barrier to health care.

Percentage of Adults Unable to Access Health Care in the Past Year Due to Cost, 2016–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# without access to care	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	43,483	2,202,758	290,764	13.2% (12.8–13.6%)	13.1% (12.7–13.5%)	n/a
Am. Indian/AK Native	734	23,576	7,026	29.8% (25.2–34.8%)	29.7% (25.2–34.7%)	↑
Asian	490	60,488	8,650	14.3% (10.7–18.8%)	13.3% (9.8–17.6%)	
Black/African Am.	338	23,921	5,334	22.3% (17.4–28.0%)	22.9% (18.0–28.7%)	↑
N. Hawaiian/ Pac. Islander	239	20,217	4,791	23.7% (18.1–30.5%)	26.4% (19.8–34.3%)	↑
White, non-Hispanic	37,362	1,762,488	197,399	11.2% (10.8–11.7%)	10.9% (10.4–11.4%)	↓
Hispanic/Latino	3,496	277,586	58,015	20.9% (19.3–22.5%)	20.0% (18.2–22.0%)	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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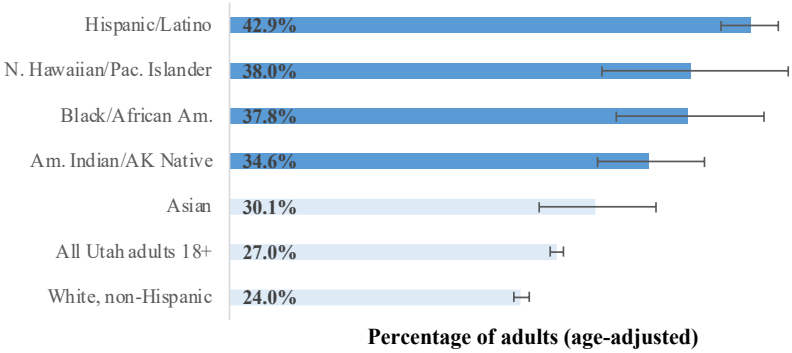
No Primary Care Provider

Why is it important?

As each new health care need arises, an individual's first point of contact with the healthcare system is ideally a primary care provider (PCP). In most cases PCPs can effectively and efficiently manage a patient's medical care because they understand that person's medical history and social background. Having a regular source of health care is also an indicator of overall access to care. 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.[14]

Adults Without a Health Provider, Utah, 2016—2019



How are we doing?

From 2016–2019, 27.0% of Utah adults reported having no personal doctor or health care provider (age-adjusted rate). Adults who identified as Hispanic/Latino (42.9%), Native Hawaiian/Pacific Islander (38.0%), Black/African American (37.8%), and American Indian/Alaska Native (34.6%) had significantly higher rates of no personal doctor or health care provider than all Utah adults. Adults who identified as White, non-Hispanic had significantly lower rates (24.0%) than all Utah adults.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH administers programs to improve access to care, such as Medicaid, CHIP, PCN, and UPP. The UDOH also works to improve the "safety net" for persons without health insurance. Local health departments provide preventive services at low or no cost to eligible persons who cannot afford them. Members of the AUCH, including FQHCs and other providers, also strive to meet the medical needs of the people without health insurance and those facing cost as a barrier to health care.

Percentage of Utah Adults With No Personal Health Care Provider, 2016–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# without provider	Crude Rate (95% CI)	Age-Adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	43,420	2,202,758	610,164	27.7% (27.1–28.3%)	27.0% (26.4–27.5%)	n/a
Am. Indian/AK Native	734	23,576	8,652	36.7% (32.1–41.6%)	34.6% (30.3–39.1%)	↑
Asian	485	60,488	22,078	36.5% (31.4–41.9%)	30.1% (25.5–35.1%)	
Black/African Am.	338	23,921	9,951	41.6% (35.4–48.1%)	37.8% (31.9–44.0%)	↑
N. Hawaiian/ Pac. Islander	238	20,217	8,673	42.9% (35.4–50.7%)	38.0% (30.7–46.0%)	↑
White, non-Hispanic	37,327	1,762,488	422,997	24.0% (23.4–24.6%)	24.0% (23.4–24.7%)	↓
Hispanic/Latino	3,485	277,586	126,024	45.4% (43.4–47.4%)	42.9% (40.5–45.2%)	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
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Routine Medical Checkup

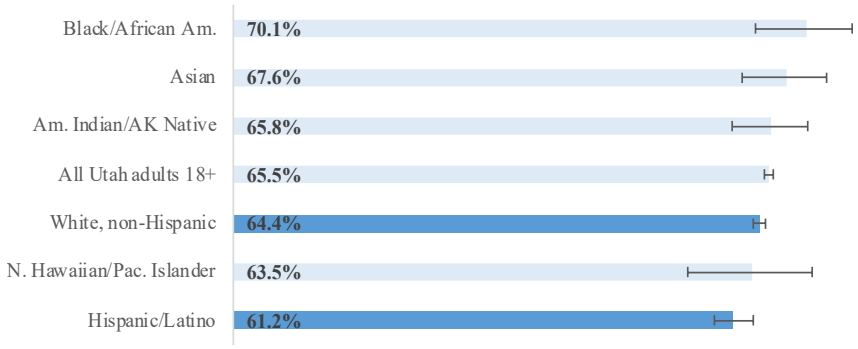
Why is it important?

Clinical preventive services are important for maintaining good health. Early detection and treatment of disease improve the chances of full recovery. Well-child visits for children are also important for evaluating developmental milestones and establishing healthy habits. 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 care provider who understands their medical history and problems and can give them appropriate care that fits their medical and social context.[15]

How are we doing?

From 2016–2019, 65.5% of Utah adults reported having a routine medical checkup within the past 12 months (age-adjusted rate). Adults who identified as White, non-Hispanic (64.4%) and Hispanic/Latino (61.2%) had significantly lower rates of having a checkup than all Utah adults.

Adults With a Routine Medical Checkup, Utah, 2016—2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. This OHD report provides further insight. The UDOH administers programs to improve access to care, such as Medicaid, CHIP, PCN, and UPP. The UDOH also works to improve the "safety net" for persons without health insurance. This is done through primary care grants to rural areas and clinics for children with disabilities. Local health departments provide preventive services such as immunizations and screenings at low or no cost to eligible persons who cannot afford them. Members of the AUCH, including FQHCs and other providers, also strive to meet the medical needs of the people without health insurance and those facing cost as a barrier to health care.

Percentage of Utah Adults Who Had a Medical Checkup in the Previous Year, 2016–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# with routine check up	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	42,713	2,202,758	1,436,198	65.2% (64.6–65.8%)	65.5% (64.9–66.1%)	n/a
Am. Indian/AK Native	724	23,576	15,395	65.3% (60.3–70.0%)	65.8% (61.0–70.3%)	
Asian	479	60,488	38,894	64.3% (59.1–69.3%)	67.6% (62.2–72.6%)	
Black/African Am.	327	23,921	16,386	68.5% (62.1–74.4%)	70.1% (63.9–75.7%)	
N. Hawaiian/Pac. Islander	235	20,217	11,584	57.3% (49.5–64.7%)	63.5% (55.6–70.8%)	
White, non-Hispanic	36,738	1,762,488	1,163,242	66.0% (65.4–66.7%)	64.4% (63.6–65.1%)	↓
Hispanic/Latino	3,413	277,586	168,217	60.6% (58.6–62.6%)	61.2% (58.8–63.6%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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Routine Dental Checkup

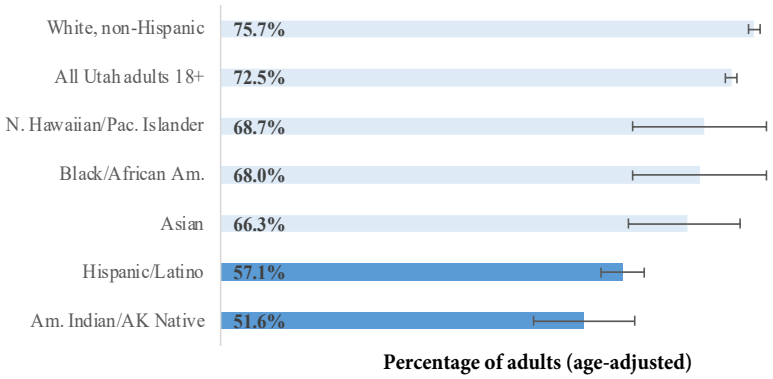
Why is it important?

Regular dental visits are important in the prevention, early detection, and treatment of oral and craniofacial diseases and conditions for all ages. Children and 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.[16]

How are we doing?

In 2016 and 2018, 72.5% (age-adjusted) of all Utah adults had a routine dental checkup within the past 12 months. Adults who identified as Hispanic/Latino (57.1%) and American Indian/Alaska Native (51.6%) had significantly lower rates of routine dental care than all Utah adults. Adults who identified as White, non-Hispanic had significantly higher rates of routine dental care (75.7%) than all Utah adults.

Adults With a Routine Dental Checkup, Utah, 2016, 2018



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH Oral Health Program promotes fluoride and dental sealants, preventing tooth decay in young children, and encouraging annual dental visits for both children and adults. The UDOH administers programs with some dental benefits to improve access to care, such as Medicaid and CHIP. The UDOH also works to improve the "safety net" for persons without dental insurance. Various members of the AUCH, including FQHCs and other providers, also strive to meet the dental needs of the people without insurance and those facing cost as a barrier to care.

Percentage of Utah Adults Who Had a Dental Checkup in the Previous Year, 2016, 2018

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# with dental check up	Crude Rate (95% CI)	Age-Adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	21,341	2,179,322	1,577,829	72.4% (71.6–73.2%)	72.5% (71.7–73.3%)	n/a
Am. Indian/AK Native	375	22,877	11,782	51.5% (44.3–58.6%)	51.6% (44.4–58.8%)	↓
Asian	241	59,502	38,676	65.0% (57.0–72.2%)	66.3% (57.8–73.8%)	
Black/ African Am.	172	23,095	15,566	67.4% (58.5–75.2%)	68.0% (58.5–77.4%)	
N. Hawaiian/Pac. Islander	115	20,451	13,375	65.4% (55.0–74.5%)	68.7% (58.5–77.4%)	
White, non-Hispanic	18,443	1,747,726	1,319,533	75.5% (74.7–76.3%)	75.7% (74.9–76.5%)	↑
Hispanic/Latino	1,586	272,181	158,409	58.2% (55.2–61.1%)	57.1% (54.0–60.1%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016 and 2018 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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First Trimester Prenatal Care

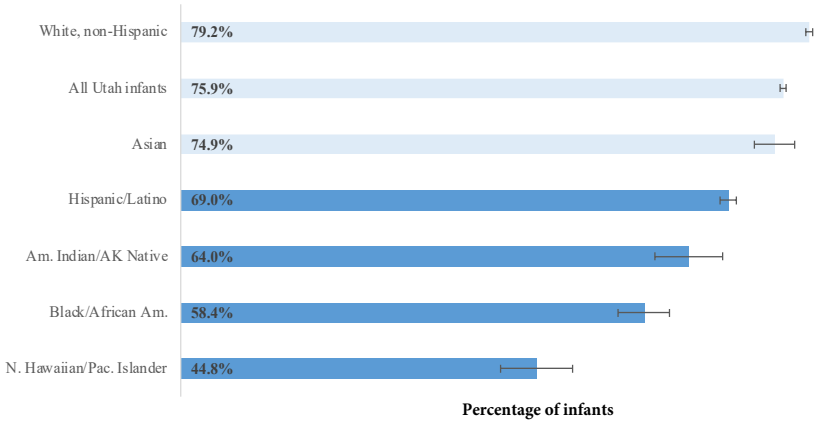
Why is it important?

Receiving early and consistent prenatal care (PNC) enhances the likelihood of giving birth to a healthy child. Health care providers recommend people begin prenatal care in the first trimester of their pregnancy.[17]

How are we doing?

In 2019, the overall rate of first trimester prenatal care was 75.9%. Hispanic/Latino (69.0%), American Indian/Alaska Native (64.0%), Black/African American (58.4%), and Native Hawaiian/Pacific Islander (44.8%) populations had significantly lower rates of first trimester prenatal care than all Utahns. White, non-Hispanic populations had a significantly higher rate (79.2%) than all Utahns.

Utah Infants Who Received 1st Trimester Prenatal Care, Utah, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity and facilitate access to prenatal care. The UDOH Baby Your Baby Program sponsors a statewide media campaign and provides information and referral services to pregnant people in Utah. MotherToBaby (formerly Pregnancy Risk Line) is a phone/texting service available to those who have questions about possible effects of medications, chemicals, or infectious agents on a developing baby or breastfed infant. The PRAMS collects and analyzes data to identify characteristics of Utah people with a live birth and their utilization of prenatal care and is used to target interventions in those populations identified as having poor first trimester entry.

Percentage of Utah Infants Who Received 1st Trimester Prenatal Care, 2019

Race/Ethnicity+	# with Prenatal Care	Total Live Births	% with Prenatal Care	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	35,560	46,832	75.9%	75.5%	76.3%	n/a
Am. Indian/AK Native	311	486	64.0%	59.7%	68.3%	↓
Asian	866	1,156	74.9%	72.3%	77.4%	
Black/ African Am.	517	886	58.4%	55.1%	61.6%	↓
N. Hawaiian/Pac. Islander	204	455	44.8%	40.3%	49.4%	↓
White, non-Hispanic	26,645	33,640	79.2%	78.8%	79.6%	↑
Hispanic/Latino	5,563	8,061	69.0%	68.0%	70.0%	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

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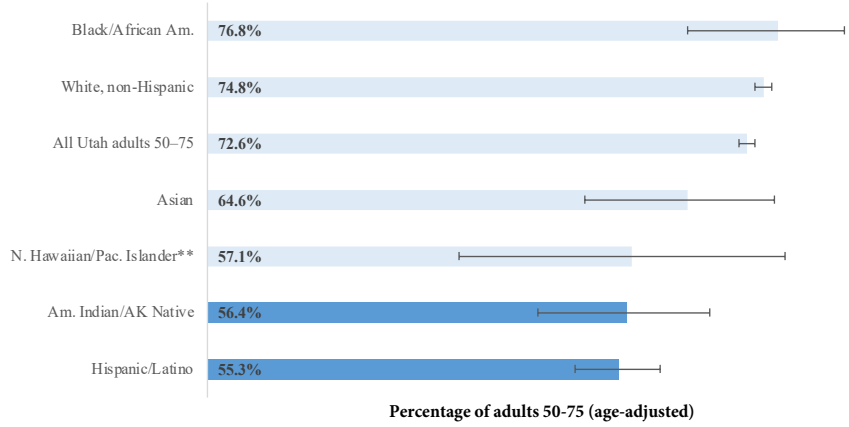
Colon Cancer Screening

Why is it important?

Colorectal cancer is one of the leading causes of cancer-related deaths in the US and Utah. Screening for this cancer is important as deaths can be substantially reduced when precancerous polyps are detected at early stages and removed. The chance of surviving colorectal cancer exceeds 90% when the cancer is diagnosed before it has extended beyond the intestinal wall.[18]

Adults Age 50-75 Who Had Colon Cancer Screening, Utah, 2016, 2018–2019



How are we doing?

In 2016, 2018, and 2019, 72.6% of Utah adults aged 50–75 years old had received a recommended sigmoidoscopy or colonoscopy screening (age-adjusted rate). Adults 50–75 who identified as American Indian/Alaska Native (56.4%) and Hispanic/Latino (55.3%) had significantly lower rates of recommended colon cancer screening than all Utahn adults 50–75 years old. Adults 50–75 who identified as White, non-Hispanic had significantly higher rates (74.8%) than all Utah adults 50–75 years old.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Screening for colorectal cancer has been identified by the CDC as a priority public health issue. The UDOH initiated the Utah Cancer Action Network (UCAN) to lower cancer incidence and mortality in Utah through collaborative efforts. Objectives and strategies have been developed by community partners regarding the early detection of cervical, breast, and colorectal cancers as well as the promotion of physical activity, healthy eating habits, skin cancer prevention, and cancer survivorship advocacy.

Percentage of Utah Adults Age 50–75 Who Completed a Recommended Colon Cancer Screening, 2016, 2018–2019

Race/Ethnicity+	Sample Size	Average Annual 50-75 Population	# with screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 50–75	10,285	667,002	470,903	70.6% (69.4–71.8%)	72.6% (71.5–73.7%)	n/a
Am. Indian/AK Native	169	8,366	4,292	51.3% (39.9–62.6%)	56.4% (44.5–67.6%)	↓
Asian	63	16,148	9,124	56.5% (40.9–70.9%)	64.6% (50.8–76.3%)	
Black/ African Am.	58	6,369	4,025	63.2% (44.9–78.3%)	76.8% (64.6–85.7%)	
N. Hawaiian/Pac. Islander**	26	5,099	3,044	59.7% (35.5–79.9%)	57.1% (33.8–77.7%)	
White, non-Hispanic	9,354	570,111	419,032	73.5% (72.3–74.7%)	74.8% (73.7–75.9%)	↑
Hispanic/Latino	445	60,234	27,647	45.9% (40.2–51.6%)	55.3% (49.5–60.9%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019 (age-adjusted using two age groups: 50–64, 65+).
**Arrows indicate whether 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.*

UTAH DEPARTMENT OF HEALTH
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Pap Testing

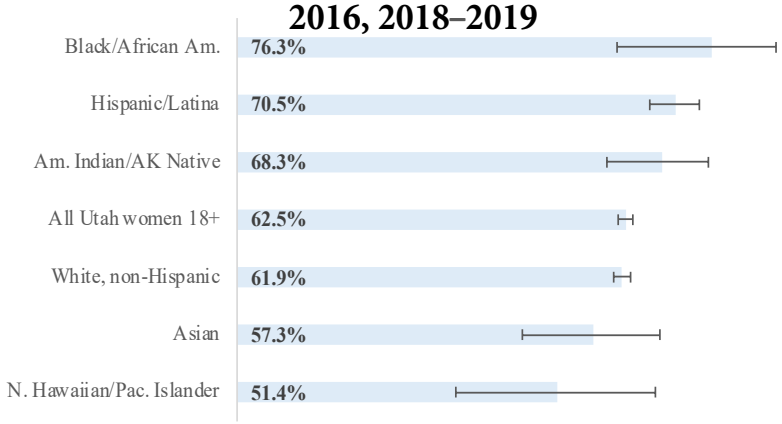
Why is it important?

Cervical cancer is one of the most curable cancers if detected early through routine screening. Almost all cases of cervical cancer are caused by infection of high-risk types of the human papillomavirus (HPV). HPV is transmitted through sexual contact. Any person with a cervix who is sexually active is at risk for developing cervical cancer. Other risk factors include giving birth to many children, having sexual relations at an early age, having multiple sex partners or partners with many other partners, cigarette smoking, and use of oral contraceptives.[19]

How are we doing?

In 2016, 2018, and 2019, 62.5% of Utah women^ (aged 18 years and older) received a Pap test in the past three years (age-adjusted rate). Women who identified as Hispanic/Latina had a significantly higher rate of cervical cancer screening by Pap test (70.5%) than all Utah women.

Women^ with Pap Test in Past Three Years, 2016, 2018–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The US Preventive Services Task Force recommends cervical cancer screening (Pap smear) every three years for women 21 to 65 years old. For women 30 to 65 years old, Pap smears may be conducted every five years in conjunction with human papillomavirus (HPV) testing. Women who have had an HPV vaccine still need to have routine Pap smears because the vaccine does not fully protect against all strains of the virus and other risk factors that can cause cervical cancer. The UDOH Utah Cancer Control Program (UCCP) provides vouchers for free Pap tests and pelvic exams to people who meet age and income guidelines and provides education about early detection and the availability of screening services. The UDOH initiated the UCAN to lower cancer incidence and mortality in Utah through collaborative efforts.

Percentage of Women^ 18+ Who Had Pap Testing in the Past Three Years, 2016, 2018–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Female Population	# with Pap Test	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah women 18+	10,106	1,107,414	691,026	62.4% (61.1–63.6%)	62.5% (61.3–63.7%)	n/a
Am. Indian/AK Native	194	11,862	7,876	66.4% (56.0–75.4%)	68.3% (59.5–75.9%)	
Asian	123	32,841	18,095	55.1% (44.2–65.6%)	57.3% (45.8–68.0%)	
Black/African Am.	57	9,981	6,977	69.9% (54.0–82.1%)	76.3% (61.1–86.8%)	
N. Hawaiian/Pac. Islander	52	9,907	4,845	48.9% (33.0–65.0%)	51.4% (35.2–67.2%)	
White, non-Hispanic	8,629	889,212	547,755	61.6% (60.2–63.0%)	61.9% (60.6–63.2%)	
Hispanic/Latina	878	136,508	95,283	69.8% (65.8–73.5%)	70.5% (66.3–74.4%)	↑

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Utah BRFSS, Office of Public Health Assessment, UDOH. Population estimates averaged from 2016, 2018, and 2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*
^Data was collected and analyzed based on binary (men or women) gender identification not on whether the person identified having a cervix.

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Mammogram

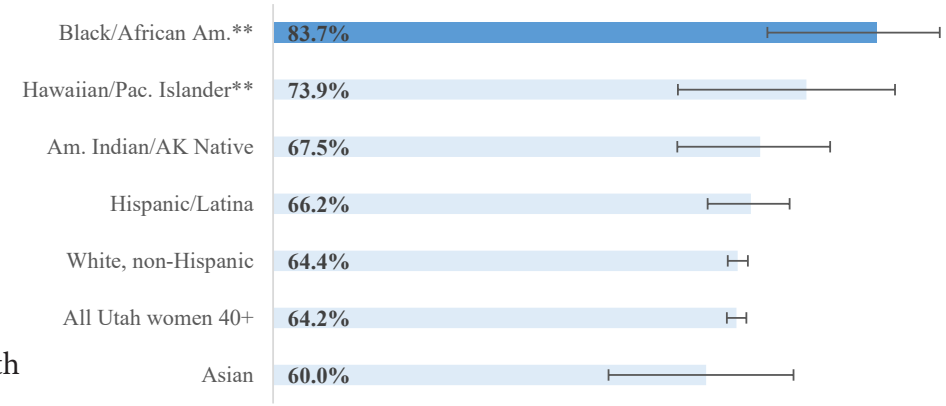
Why is it important?

Breast cancer is the most commonly occurring cancer in US women (excluding basal and squamous cell skin cancers). It is also 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 and observational studies have demonstrated that routine screening with mammography can reduce breast cancer mortality by about 20% for women of average risk.[20]

How are we doing?

In 2016, 2018, and 2019, 64.2% of Utah women aged 40 and older reported having a mammogram during the last two years (age-adjusted rate). Women aged 40 and over who identified as Black/African American had a significantly higher rate of mammography (83.7%) than all Utahn women aged 40 and over.

Women 40+ Who Had a Mammogram in the Past Two Years, 2016, 2018–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The American Cancer Society recommends for women aged 40 and over regarding annual or biennial screening for breast cancer vary according to age. The UDOH UCCP provides free breast cancer screening and diagnostics to women who meet age and income guidelines. Visit cancerutah.org or call 1-800-717-1811 for more information or to see who qualifies for free mammography services. The UDOH initiated the UCAN, a statewide partnership whose goal is to reduce the burden of cancer.

Percentage of Women Age 40+ Who Had a Mammogram in the Past Two Years, 2016, 2018–2019

Race/Ethnicity+	Sample Size	Average Annual 40+ Female Population	# with screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah women 40+	9,079	592,975	387,806	65.4% (64.0–66.7%)	64.2% (62.9–65.6%)	n/a
Am. Indian/AK Native	142	7,651	5,203	68.0% (55.9–78.0%)	67.5% (56.0–77.2%)	
Asian	59	16,634	9,814	59.0% (42.5–73.7%)	60.0% (46.5–72.1%)	
Black/African Am.**	34	4,851	3,672	75.7% (53.9–89.2%)	83.7% (68.5–92.4%)	↑
N. Hawaiian/Pac. Islander**	30	4,335	3,056	70.5% (49.0–85.6%)	73.9% (56.1–86.2%)	
White, non-Hispanic	8,213	498,476	328,994	66.0% (64.6–67.3%)	64.4% (63.0–65.8%)	
Hispanic/Latina	466	60,098	37,020	61.6% (55.6–67.2%)	66.2% (60.2–71.6%)	

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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 2019 (age-adjusted using three age groups: 40–49, 50–64, 65+).
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Prostate Cancer Screening

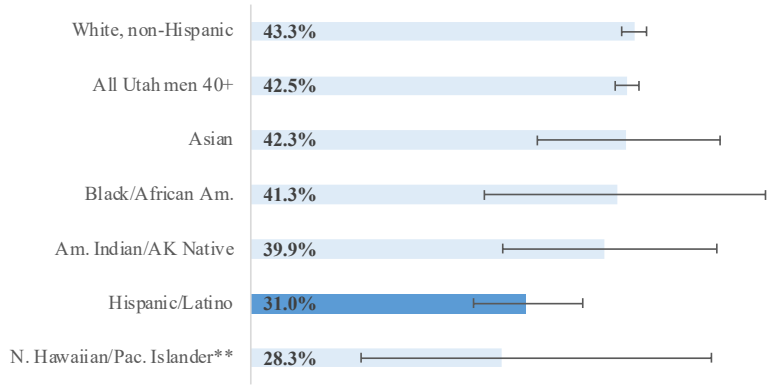
Why is it important?

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 US All people who are older than age 40 with a prostate should visit their doctor for a routine health visit which may include a discussion on prostate health.[21]

How are we doing?

In 2016 and 2018, 42.5% of all Utah men^ aged 40 and older had received a prostate specific antigen (PSA) test (age-adjusted rate). Men aged 40 and older who identified as Hispanic/Latino had a significantly lower rate (31.0%) than all Utah men aged 40 and older.

Men^ 40+ Who Have Ever Had a PSA Test, 2016, 2018



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The American Cancer Society recommends health care professionals discuss the potential benefits and limitations of prostate cancer screening starting when male patients are age 50. The recommended screening is for the prostate specific antigen (PSA), with the option of a digital rectal examination. People with a prostate who identify as African American and those with one first degree relative with prostate cancer should be screened starting at age 45. Medicare provides coverage for an annual PSA test for all Medicare-eligible men age 50 and older. Many private insurers cover PSA screening as well. Since 2012, the US Preventive Services Task Force (USPSTF) has recommended against PSA-based screening for prostate cancer. Healthy diet, exercise, and lifestyle play an important role in cancer prevention. The UDOH initiated the UCAN, a statewide partnership whose goal is to reduce the burden of cancer.

Percentage of Utah Men^ 40+ Who Have Ever Had a PSA Test, 2016, 2018

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+	6,107	570,584	247,633	43.4% (41.8–45.0%)	42.5% (41.1–43.8%)	n/a
Am. Indian/AK Native	91	7,112	3,236	45.5% (32.0–59.6%)	39.9% (28.4–52.6%)	
Asian	42	12,842	4,495	35.0% (20.0–53.8%)	42.3% (32.4–52.9%)	
Black/ African Am.	50	7,127	3,114	43.7% (29.0–59.5%)	41.3% (26.4–58.1%)	
N. Hawaiian/Pac. Islander**	17	4738	2,033	42.9% (17.1–73.2%)	28.3% (12.5–52.0%)	
White, non-Hispanic	5,493	477,982	217,482	45.5% (43.9–47.1%)	43.3% (41.9–44.7%)	
Hispanic/Latino	307	60,630	14,794	24.4% (19.2–30.4%)	31.0% (25.2–37.4%)	↓

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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 2019 (age-adjusted using three age groups: 40–49, 50–64, 65+).
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^ Data was collected and analyzed based on binary (men or women) gender identification not on whether the person identified having a prostate.

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Blood Cholesterol Screening

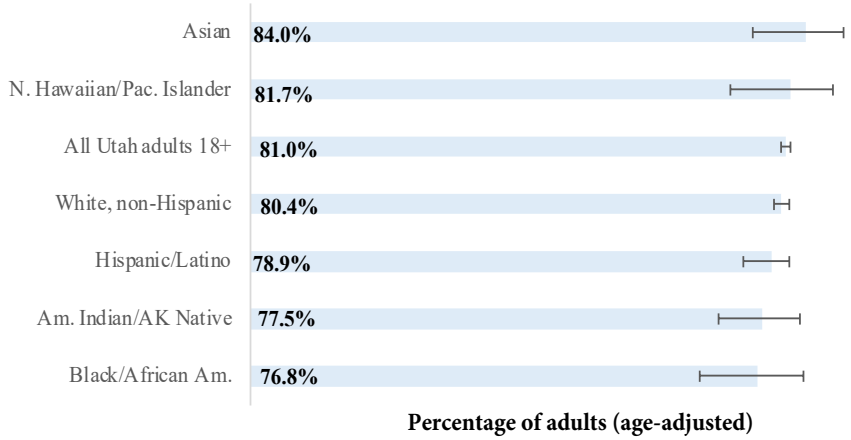
Why is it important?

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. Because high blood cholesterol does not produce obvious symptoms, experts recommend all adults aged 20 years and older have their cholesterol levels checked at least once every five years to help them take action to prevent or lower their risk of cardiovascular disease.[22]

How are we doing?

In 2017 and 2019, 81.0% of Utah adults had their cholesterol checked in the past five years (age-adjusted rate). There were no statistically significant differences in the rates by race and ethnicity.

Cholesterol Check within Past Five Years, 2017, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH Healthy Living through Environment, Policy, and Improved Clinical Care Program (EPICC) has four domains: epidemiology and surveillance, policy and environment, health systems, and community clinical linkages. Primary program strategies include increasing healthy nutrition and physical activity environments in K-12 schools, early care and education, and worksites as well as increasing awareness, improving the quality of medical care, and increasing access and availability of community health programs.

Percentage of Utah Adults Who Had a Cholesterol Screening in the Past Five Years, 2017, 2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# with screening	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	19,959	2,226,195	1,805,444	81.1% (80.3–81.8%)	81.0% (80.3–81.7%)	n/a
Am. Indian/AK Native	320	24,275	19,007	78.3% (71.7–83.7%)	77.5% (70.8–83.1%)	
Asian	223	61,475	48,565	79.0% (71.5–84.9%)	84.0% (76.0–89.7%)	
Black/ African Am.	146	24,748	18,041	72.9% (63.2–80.8%)	76.8% (68.1–83.7%)	
N. Hawaiian/Pac. Islander	106	19,984	15,028	75.2% (64.0–83.9%)	81.7% (72.7–88.1%)	
White, non-Hispanic	17,149	1,777,251	1,455,569	81.9% (81.1–82.6%)	80.4% (79.2–81.5%)	
Hispanic/Latino	1,672	282,991	217,903	77.0% (74.4–79.4%)	78.3% (74.7–81.6%)	

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017 and 2019 American Community Survey 1-Year Estimates.
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Influenza Immunization

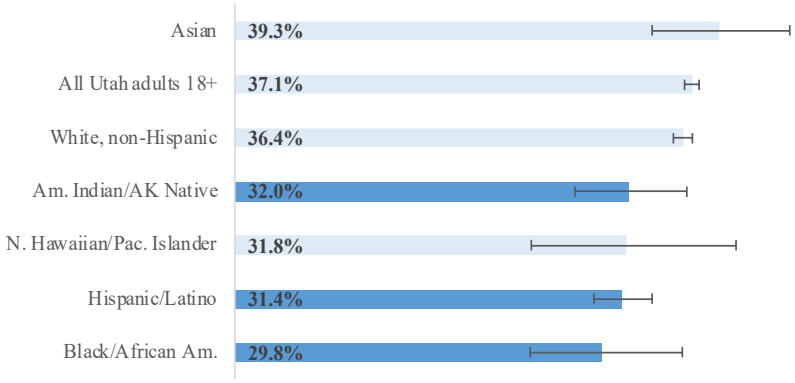
Why is it important?

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. During the 2019–2020 flu season, 38 million flu illnesses occurred in the US resulting in 400,000 hospitalizations and 22,000 deaths. The annual direct medical costs (hospitalizations, doctors office visits, medications, etc.) for influenza in adults are estimated at $8.7 billion including $4.5 billion for adult hospitalizations resulting from influenza-attributable illness. Influenza is also responsible for substantial indirect costs ($6.2 billion annually), mainly from lost productivity.[23]

How are we doing?

From 2016–2019, 37.1% of Utah adults reported receiving a flu shot within the past year (age-adjusted rate). Adults who identified as American Indian/Alaska Native (32.0%), Hispanic/Latino (31.4%), and Black/African American (29.8%) had significantly lower rates of flu vaccination than all Utah adults.

Adults with Flu Shot in Past Year, 2016–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Everyone six months of age and older should receive a flu vaccine every season with rare exceptions. Influenza and pneumococcal vaccinations are covered for seniors with Medicare Part B. Many community health clinics offer lower cost immunizations based on income level. A new long-term care facility licensing rule promotes consistent screening for influenza and pneumococcal vaccinations. It includes standing orders to give vaccines, keep immunization histories, offer of a one-time pneumococcal vaccination to residents, and offer an influenza vaccination annually for residents and employees. The UDOH Immunization Program and Office of Epidemiology (immunize.utah.gov) educate health care providers, clinic staff, and the public about flu vaccination.

Percentage of Adults Who Had a Flu Shot in the Past Year, 2016–2019

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+	41,645	2,202,758	812,818	36.9% (36.3–37.5%)	37.1% (36.5–37.7%)	n/a
Am. Indian/AK Native	685	23,576	7,379	31.3% (27.0–36.0%)	32.0% (27.6–36.7%)	↓
Asian	458	60,488	21,292	35.2% (30.2–40.6%)	39.3% (33.9–45.0%)	
Black/ African Am.	315	23,921	6,315	26.4% (21.1–32.4%)	29.8% (24.0–36.3%)	↓
N. Hawaiian/Pac. Islander	219	20,217	5,903	29.2% (22.1–37.6%)	31.8% (24.1–40.7%)	
White, non-Hispanic	35,988	1,762,488	678,558	38.5% (37.9–39.1%)	36.4% (35.6–37.1%)	
Hispanic/Latino	3,229	277,586	79,945	28.8% (27.0–30.7%)	31.4% (29.1–33.9%)	↓

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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Pneumonia Immunization

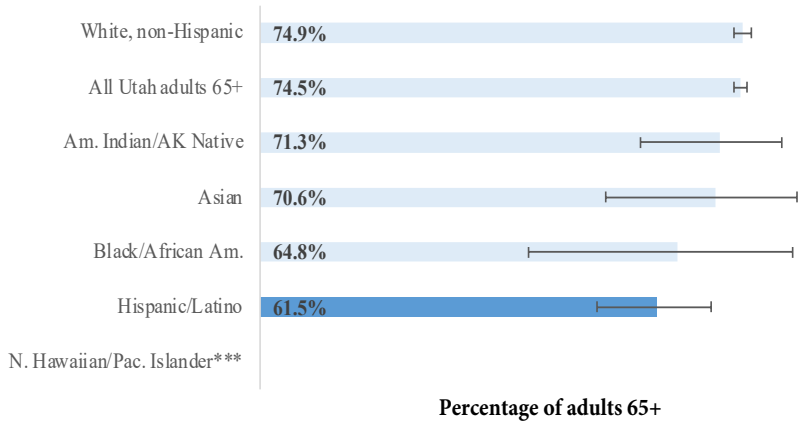
Why is it important?

Pneumococcal disease is caused by bacteria that can spread from person-to-person through loose contact. It can cause ear infections, and it can also lead to more serious infections of the lungs (pneumonia), blood (bacteremia), and covering of the brain and spinal cord (meningitis). Anyone can get pneumococcal disease, but children younger than two years of age and adults ages 65 years and older, people with certain medical conditions, and cigarette smokers are at the highest risk. Treatment of pneumococcal infections with penicillin and other drugs is not as effective as it used to be, because some pneumococcal strains are resistant to these drugs. This makes prevention through vaccines even more important.[24]

How are we doing

From 2016–2019, 74.5% of Utah adults aged 65 and older had received a pneumonia vaccination (crude rate). Adults 65 and older who identified as Hispanic/Latino had a significantly lower rate of pneumonia vaccination (61.5%) than all Utah adults 65 and older.

Adults 65+ with Pneumonia Vaccine, 2016–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The Utah Immunization Program (UIP) started the Senior Outreach Initiative to cover pneumococcal vaccines for adults aged 60+ without insurance or vaccine coverage under Medicare. Additionally, the UIP administers the Adult High Risk Initiative which provides the pneumococcal polysaccharide vaccine for adults without insurance who are at risk for contracting hepatitis B. Many community health clinics offer lower cost immunizations based on income level.Immunizations can also be given to the home-bound through many private providers and county services.

Percentage of Adults (Age 65+) with Pneumonia Vaccine, 2016–2019

Race/Ethnicity+	Sample Size	Average Annual 65+ Population	# with Vaccine	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah adults 65+	10,844	342,795	255,382	74.5%	73.5%	75.6%	n/a
Am. Indian/AK Native	110	2,230	1,590	71.3%	59.1%	81.0%	
Asian	51	6,582	4,647	70.6%	53.7%	83.3%	
Black/African Am.**	29	1,481	960	64.8%	41.7%	82.6%	
N. Hawaiian/Pac. Islander***	17	1,827	***	***	***	***	
White, non-Hispanic	7,324	309,655	231,931	74.9%	73.6%	76.2%	
Hispanic/Latino	178	19,818	12,188	61.5%	52.3%	69.9%	↓

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.
**Arrows indicate where rate was higher or lower than for all Utahns.*
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****Estimate has been suppressed because standard error is greater than 50% or undetermined.*

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Risk Factors for Illness and Injury

Utah Health Status by Race & Ethnicity 2021

Overweight or Obesity

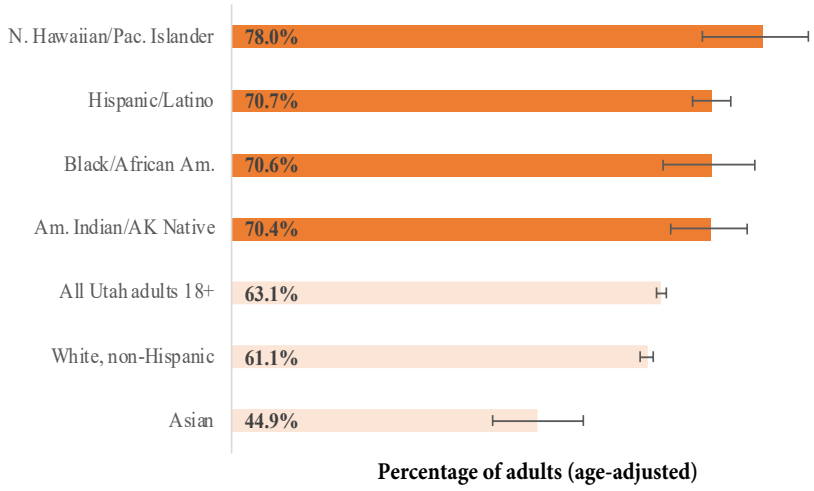
Why is it important?

Excess weight increases the risk for 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 In 2019, more than 60 percent of Utah adults experienced overweight or obesity.[25]

How are we doing?

From 2017–2019, almost two-thirds (60.2%) of Utah adults reported experiencing overweight or obesity (age-adjusted rate). Adults who identified as Native Hawaiian/ Pacific Islander (78.0%), Hispanic/Latino (70.7%), Black/African American (70.6%), and American Indian/Alaska Native (70.4%) had significantly higher rates of overweight or obesity than all Utahn adults. Adults who identified as White, non-Hispanic (61.1%) and Asian (44.9%) had significantly lower rates than all Utah adults.

Overweight or Obesity, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH EPICC Program focuses on environmental approaches that promote health, specifically promoting policies. The EPICC Program works in schools, worksites, communities, healthcare, and childcare. More information is available at choosehealth.utah.gov/.

Utah Percentage of Adults With Overweight or Obesity, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# with Overweight or Obesity	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	29,898	2,227,221	1,385,331	62.2% (61.4–62.9%)	63.1% (62.4–63.8%)	n/a
Am. Indian/AK Native	506	24,240	16,774	69.2% (63.4–74.4%)	70.4% (64.5–75.7%)	↑
Asian	323	62,151	27,222	43.8% (37.6–50.2%)	44.9% (38.4–51.7%)	↓
Black/ African Am.	231	25,121	16,831	67.0% (59.2–74.0%)	70.6% (63.4–76.9%)	↑
N. Hawaiian/Pac. Islander	167	20,411	15,676	76.8% (67.7–84.0%)	78.0% (69.2–84.8%)	↑
White, non-Hispanic	16,428	1,777,166	1,071,631	60.3% (59.3–61.3%)	61.1% (60.1–62.0%)	↓
Hispanic/Latino	1,496	283,231	195,996	69.2% (66.4–71.9%)	70.7% (67.8–73.3%)	↑

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
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Adolescent Obesity

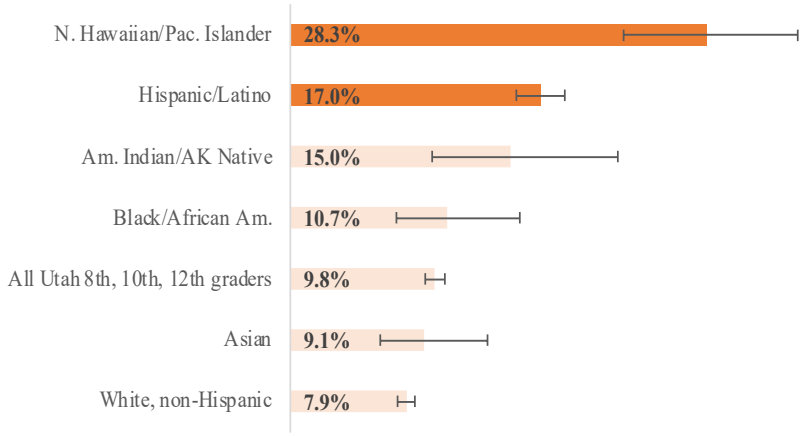
Why is it important?

The number of children and adolescents with overweight or obesity is increasing and diseases previously thought to affect mainly adults, such as type 2 diabetes, high blood pressure, and high cholesterol, are now being diagnosed in children and adolescents. The social and psychological impacts of childhood obesity include social isolation, increased rate of suicidal thoughts, low self-esteem, increased rate of anxiety disorders and depression, and an increased likelihood of being bullied.[26]

How are we doing?

In 2019, the obesity rate among Utah adolescents in grades 8, 10, and 12 was 9.8%. Adolescents who identified as Native Hawaiian/Pacific Islander (28.3%) and Hispanic/Latino (17.0%) had significantly higher rates of obesity than all Utah adolescents in grades 8, 10, and 12. Adolescents who identified as White, non-Hispanic had significantly lower rates of obesity (7.9%) than all Utah adolescents in grades 8, 10, and 12.

Adolescent Obesity, Utah, 2019



Percentage of 8th, 10th, and 12th graders

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH EPICC Program focuses on environmental approaches that promote health, specifically promoting policies. The EPICC Program works in schools, communities, healthcare, and childcare. More information is available at choosehealth.utah.gov/.

Utah Percentage of Adolescents With Obesity in Grades 8,10,12, 2019

Race/Ethnicity+	Sample Size	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah 8th, 10th, 12th graders	22,541	9.8%	9.2%	10.5%	n/a
Am. Indian/AK Native	277	15.0%	9.7%	22.3%	
Asian	413	9.1%	6.1%	13.4%	
Black/African Am.	298	10.7%	7.2%	15.6%	
N. Hawaiian/Pac. Islander	286	28.3%	22.7%	34.5%	↑
White, non-Hispanic	17,884	7.9%	7.3%	8.5%	↓
Hispanic/Latino	3,297	17.0%	15.4%	18.7%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Prevention Needs Assessment, 2019.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

No Physical Activity

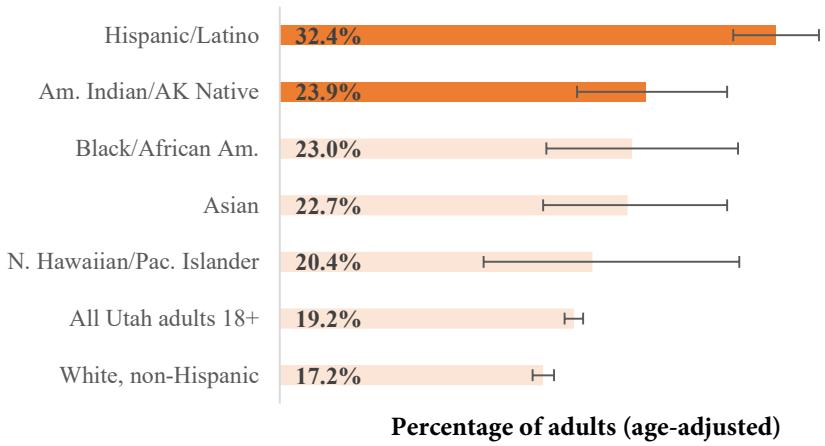
Why is it important?

Studies show physical activity protects independently against cardiovascular disease. It has also been shown to reduce the risk for some cancers, type 2 diabetes, stroke, and heart disease. Physical activity improves general physical and mental health and is known to improve effective disorders such as depression and anxiety. Among the elderly, regular physical activity helps relieve pain from osteoarthritis and increases quality of life and independent living. Physical inactivity is a leading cause of premature death and also results in greater occurrence of illness.[27]

How are we doing?

From 2017–2019, 19.2% of Utah adults reported they were physically inactive (age-adjusted rate). Adults who identified as Hispanic/Latino (31.1%) and American Indian/Alaska Native (23.9%) had significantly higher rates of no physical activity than all Utah adults. Adults who identified as White, non-Hispanic had significantly lower rates of no physical activity (17.3%) than all Utah adults.

No Physical Activity, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH EPICC Program was established to promote policies around healthy eating and active living. EPICC works in schools, worksites, communities, healthcare, and childcare. More information is available at choosehealth.utah.gov/.

Utah Percentage of Adults With No Physical Activity in the Past Month, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Without Physical Activity	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	31,776	2,227,221	423,172	19.0% (18.4–19.5%)	19.2% (18.6–19.8%)	n/a
Am. Indian/AK Native	536	24,240	5,769	23.8% (19.2–29.1%)	23.9% (19.4–29.2%)	↑
Asian	356	62,151	13,238	21.3% (16.5–27.2%)	22.7% (17.2–29.2%)	
Black/ African Am.	249	25,121	6,004	23.9% (18.0–31.1%)	23.0% (17.4–29.9%)	
N. Hawaiian/Pac. Islander	174	20,411	3,837	18.8% (12.6–27.1%)	20.4% (13.3–30.0%)	
White, non-Hispanic	17,376	1,777,166	307,450	17.3% (16.6–18.0%)	17.2% (16.5–17.9%)	↓
Hispanic/Latino	1,732	283,231	88,085	31.1% (28.5–33.8%)	32.4% (29.6–35.2%)	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

High Cholesterol

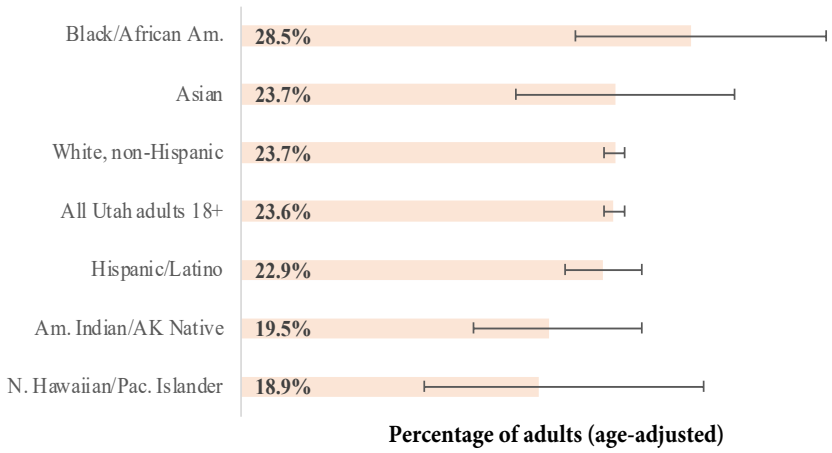
Why is it important?

High blood cholesterol is a major risk factor for heart disease and stroke. It is preventable. If identified early, it can be controlled with medication and lifestyle changes, such as following a diet low in saturated fat and cholesterol, increasing physical activity, and reducing excess weight. Experts recommend that all adults aged 20 years and older have their cholesterol levels checked at least once every five years to help them take action to prevent or lower their risk for cardiovascular disease.[28]

How are we doing?

In 2017 and 2019, 23.6% of Utah adults reported they had been told by a doctor their cholesterol was high (age-adjusted rate). There were no statistically significant differences in the rate of high cholesterol by race and ethnicity.

High Cholesterol, Utah, 2017, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH EPICC Program was established to reduce the incidence of diabetes, heart disease, and stroke by targeting risk factors including reducing obesity, increasing physical activity and nutritious food consumption, and improving diabetes and hypertension control. The program is organized around four domains: Epidemiology and Surveillance, Policy and Environment, Health Systems, and Community Clinical Linkages. The primary program strategies include increasing healthy environments in education and worksites, improving awareness, improving the quality of medical care, and improving access to community health programs. More information is available at choosehealth.utah.gov/.

Utah Percentage of Adults With High Cholesterol, 2017, 2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With High Cholest.	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	21,785	2,226,195	505,346	22.7% (22.0–23.4%)	23.6% (23.0–24.3%)	n/a
Am. Indian/AK Native	356	24,275	4,297	17.7% (13.2–23.2%)	19.5% (14.7–25.4%)	
Asian	244	61,475	10,082	16.4% (11.8–22.3%)	23.7% (17.4–31.3%)	
Black/ African Am.	163	24,748	5,049	20.4% (14.2–28.3%)	28.5% (21.2–37.1%)	
N. Hawaiian/Pac. Islander	123	19,984	2,358	11.8% (7.1–19.2%)	18.9% (11.6–29.3%)	
White, non-Hispanic	18,643	1,777,251	419,431	23.6% (22.9–24.4%)	23.7% (23.0–24.3%)	
Hispanic/Latino	1,863	282,991	55,466	19.6% (17.5–21.9%)	22.9% (20.5–25.4%)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017 and 2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
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High Blood Pressure

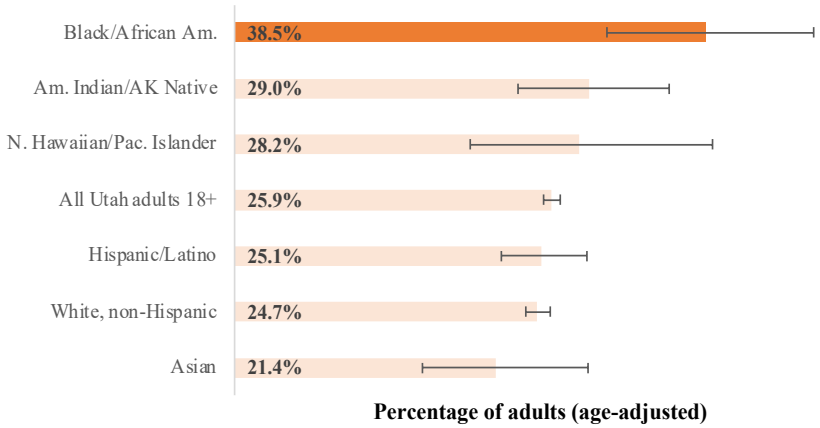
Why is it important?

High blood pressure (hypertension) is an important risk factor for heart disease and stroke. In most cases, it can be effectively managed with medication and lifestyle changes (such as diet, exercise, and abstaining from tobacco use). Treatment works best when high blood pressure is identified early. Because high blood pressure does not produce symptoms, regular screening is recommended.[29]

How are we doing?

In 2017 and 2019, 25.9% of Utah adults reported they had been told by a doctor their blood pressure was high (age-adjusted rate). Adults who identified as Black/African American had a significantly higher rate of high blood pressure (38.5%) than all Utah adults. Adults who identified as White, non-Hispanic had a significantly lower rate of high blood pressure (24.7%) than all Utah adults.

High Blood Pressure, Utah, 2017, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH EPICC Program was established to reduce the incidence of diabetes, heart disease, and stroke by targeting risk factors including reducing obesity, increasing physical activity and nutritious food consumption, and improving diabetes and hypertension control. EPICC is part of the Utah Million Hearts Coalition. Million Hearts 2022 is an initiative with the goal to reduce the number of heart attacks and strokes in the US by one million. The Utah Million Hearts Coalition has initiated efforts to educate staff in primary care clinics on the proper techniques for measuring high blood pressure.

Utah Percentage of Adults With High Blood Pressure, 2017, 2019

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+	21,961	2,226,195	558,775	25.1% (24.4–25.8%)	25.9% (25.3–26.6%)	n/a
Am. Indian/AK Native	357	24,275	6,554	27.0% (21.6–33.2%)	29.0% (23.2–35.5%)	
Asian	248	61,475	9,160	14.9% (10.6–20.6%)	21.4% (15.4–28.9%)	
Black/ African Am.	164	24,748	7,449	30.1% (22.5–38.9%)	38.5% (30.4–47.3%)	↑
N. Hawaiian/Pac. Islander	123	19,984	3,997	20.0% (13.4–28.6%)	28.2% (19.3–39.1%)	
White, non-Hispanic	8,727	1,777,251	447,867	25.2% (24.1–26.3%)	24.7% (23.8–25.8%)	↓
Hispanic/Latino	875	282,991	58,296	20.6% (17.6–24.1%)	25.1% (21.8–28.8%)	

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017 and 2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
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Cigarette Smoking

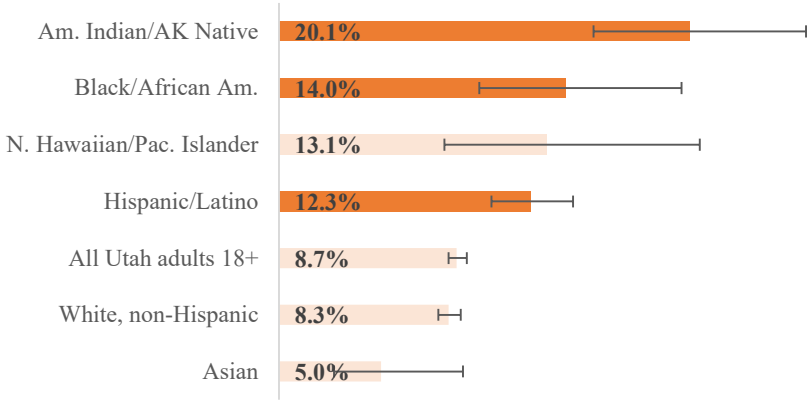
Why is it important?

Tobacco use remains the leading preventable cause of death and disease in the United States. In Utah, smoking claims more than 1,300 lives each year. It causes or worsens nearly every chronic condition and contributes to the primary causes of death in Utah 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. Exposure to secondhand smoke increases the risk for heart disease and lung cancer among nonsmokers.[30]

How are we doing?

From 2017–2019, 8.7% of Utah adults reported smoking (age-adjusted rate). Adults who identified as American Indian/Alaska Native (20.1%), Black/African American (14.0%), and Hispanic/Latino (12.3%) had significantly higher rates of adult smoking than all Utah adults.

Current Cigarette Smoking, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH Tobacco Prevention and Control Program (TPCP) and its partners use comprehensive programs to prevent young people from starting to use tobacco, help tobacco users quit, promote tobacco-free environments, and reduce tobacco-related disparities. These programs include an extensive anti-tobacco marketing campaign, free and confidential tobacco cessation services, school- and community-based prevention programs, and efforts to improve tobacco policies.

Utah Percentage of Adults Who Are Currently Smoking, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Currently Smoking	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	31,798	2,227,221	191,541	8.6% (8.2–9.0%)	8.7% (8.3–9.2%)	n/a
Am. Indian/AK Native	537	24,240	4,896	20.2% (15.7–25.6%)	20.1% (15.4–25.8%)	↑
Asian	360	62,151	3,729	6.0% (3.6–10.0%)	5.0% (2.7–9.0%)	
Black/ African Am.	251	25,121	3,291	13.1% (9.1–18.6%)	14.0% (9.8–19.7%)	↑
N. Hawaiian/Pac. Islander	175	20,411	2,776	13.6% (8.6–20.7%)	13.1% (8.1–20.6%)	
White, non-Hispanic	17,329	1,777,166	143,950	8.1% (7.6–8.7%)	8.3% (7.8–8.9%)	
Hispanic/Latino	1,720	283,231	33,704	11.9% (10.1–13.8%)	12.3% (10.4–14.4%)	↑

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
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UTAH DEPARTMENT OF HEALTH
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Exposure to Secondhand Smoke

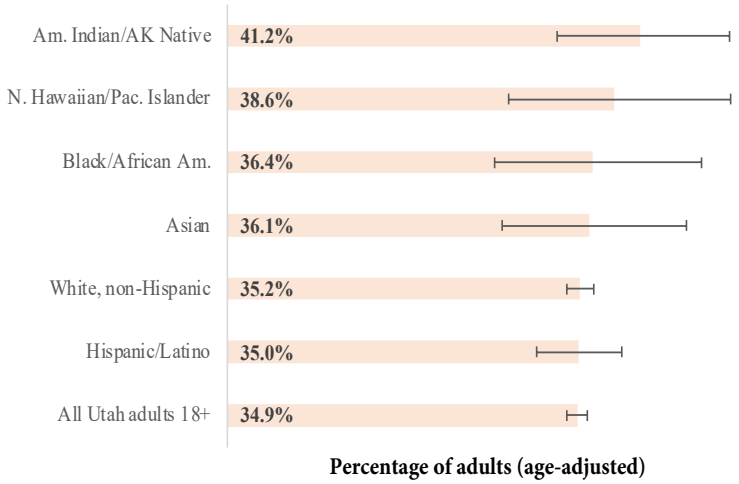
Why is it important?

The Centers for Disease Control and Prevention reports there is "no risk-free level of secondhand smoke exposure; even brief exposure can be harmful to health." Secondhand smoke alone increases the risk of developing heart disease by 25-30% and causes nearly 34,000 premature deaths among US adults who do not smoke. Exposure to secondhand smoke causes multiple health problems in infants and young children including respiratory symptoms (coughing, wheezing, shortness of breath), ear infections, and acute lower respiratory infections, such as bronchitis and pneumonia. Smoking during pregnancy results in more than 1,000 infant deaths annually in the US.[31]

How are we doing?

From 2017–2019, 34.9% (age-adjusted rate) of Utah adults reported being exposed to secondhand smoke within the past 30 days. There were no statistically significant differences in the rate of exposure to secondhand smoke by race and ethnicity.

Exposure to Secondhand Smoke, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. he UDOH Tobacco Prevention and Control Program (TPCP) and its partners use comprehensive programs to prevent young people from starting to use tobacco, help tobacco users quit, promote tobacco-free environments, and reduce tobacco-related disparities. These programs include an extensive anti-tobacco marketing campaign, free and confidential tobacco cessation services, school- and community-based prevention programs, and efforts to improve tobacco policies.

Utah Percentage of Adults Exposed to Secondhand Smoke in the Past 30 Days, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Exposed to SHS	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	14,317	2,227,221	783,982	35.2% (34.2–36.2%)	34.9% (33.9–35.9%)	n/a
Am. Indian/AK Native	227	24,240	10,035	41.4% (33.3–50.1%)	41.2% (32.9–50.1%)	
Asian	138	62,151	22,872	36.8% (28.3–46.3%)	36.1% (27.4–45.8%)	
Black/ African Am.	105	25,121	9,722	38.7% (28.8–49.7%)	36.4% (26.7–47.3%)	
N. Hawaiian/Pac. Islander	84	20,411	9,859	48.3% (36.0–60.8%)	38.6% (28.1–50.2%)	
White, non-Hispanic	7,824	1,777,166	620,231	34.9% (33.6–36.2%)	35.2% (33.9–36.5%)	
Hispanic/Latino	711	283,231	104,795	37.0 % (32.9–41.4%)	35.0% (30.8–39.4%)	

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Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
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UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

E-Cigarettes Use By Youth

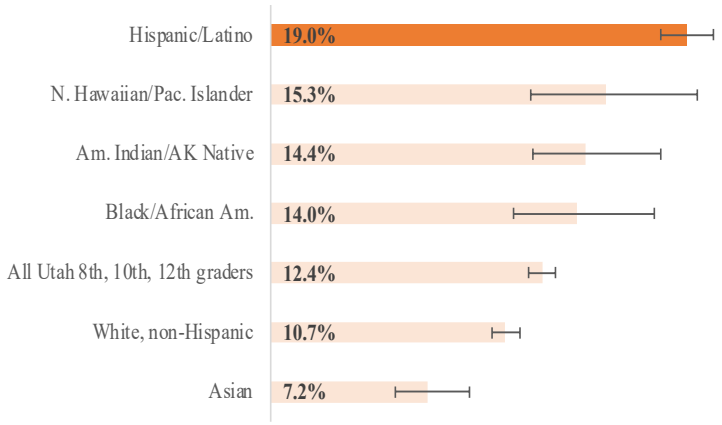
Why is it important?

Electronic cigarettes or vape products are battery-powered devices that turn liquids into an aerosol. They are marketed under a variety of names, but are most commonly referred to as electronic cigarettes, e-cigarettes, vape products, mods, or tanks. They may also be known as JUUL, Vuse, Suorin, MarkTen, and Blu. The liquids frequently contain nicotine and flavors.[32]

How are we doing?

Since 2011, Utah has seen a sharp increase in vape product experimentation and use among youth and young adults. From 2011–2019, the rate of vape product use among Utah youth increased from 1.9% to 12.4% (PNA 2011, 2019). In 2019, adolescents who identified as Hispanic/Latino had significantly higher rates of e-cigarette use (19.0%) than all Utah adolescents in grades 8,10, and 12. Adolescents who identified as White, non-Hispanic (10.7%) and Asian (7.2%) had significantly lower rates than all Utah adolescents in grades 8, 10, and 12.

Youth E-Cigarette Use, Utah, 2019



Percentage of 8th, 10th, and 12th graders

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Given the uncertain public health impact of vaping and the potential for increased nicotine addiction among young people, public health priorities in Utah include steps to monitor the use of vape products and enforce and strengthen policies that regulate youth access. Utah has developed a number of policies to regulate the safety of vape products and limit youth access. Retailers must be licensed through the Utah Tax Commission to sell electronic cigarettes and other vape products. The sale of vape products to those younger than 21 is prohibited. Since vape products are included in the Utah Indoor Clean Air Act, vaping in indoor public places is also prohibited. These measures are intended to reduce youth vaping and nicotine addiction.

Utah Percentage of Adolescents in Grades 8,10,12 Who Reported Using E-Cigarettes, 2019

Race/Ethnicity+	Sample Size	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah 8th, 10th, 12th graders	56,230	12.4%	11.8%	13.0%	n/a
Am. Indian/AK Native	824	14.7%	12.0%	17.8%	
Asian	1,058	7.2%	5.7%	9.1%	↓
Black/ African Am.	824	14.0%	11.1%	17.5%	
N. Hawaiian/Pac. Islander	732	15.3%	11.9%	19.5%	
White, non-Hispanic	43,408	10.7%	10.1%	11.4%	↓
Hispanic/Latino	9,163	19.0%	17.8%	20.2%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Prevention Needs Assessment, 2019.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

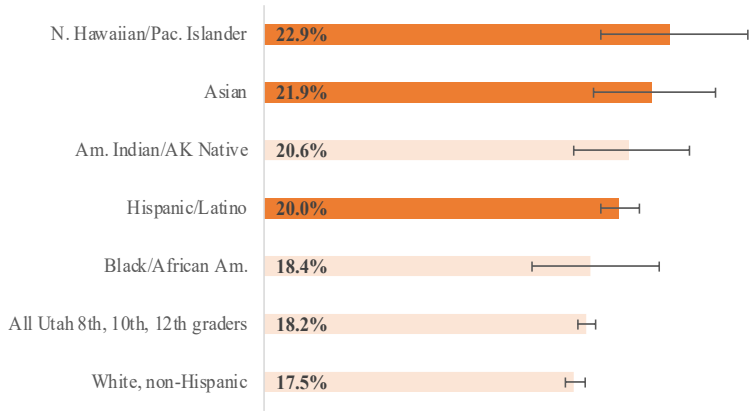
UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Adolescent Suicide Ideation

Why is it important?

Suicidal behavior is a serious and complex public health issue that takes an enormous toll on communities in both economic and human costs. All suicide attempts should be taken seriously. Suicide attempt survivors are often seriously injured, likely to have depression and/or another mental health disorder, and are at an increased risk for suicide. In 2019, suicide was the leading cause of death for Utahns ages 10 to 17 and 18-24. It is the second leading cause of death for ages 25 to 44 and the fifth leading cause of death for ages 45-64. Overall, suicide is the eighth leading cause of death for Utahns (age-adjusted rate). Deaths by suicide are only part of the problem. More people are hospitalized or treated in emergency rooms for suicide attempts than are fatally injured. In 2019, 70 Utahns were treated for self-inflicted injuries every day (15,875 treat-and-release emergency department visits plus 9,546 total hospitalizations).[33]

Adolescent Suicide Ideation, Utah, 2019



How are we doing?

Since 2019, 18.2% of Utah adolescents in grades 8, 10, and 12 reported suicide ideation. Adolescents who identified as Native Hawaiian/Pacific Islander (22.9%), Asian (21.9%), and Hispanic/Latino (20.0%) had significantly higher rates of suicide ideation than all Utah adolescents in grades 8, 10, and 12. Adolescents who identified as White, non-Hispanic had significantly lower rates (17.5%0 than all Utah adolescents in grades 8, 10, and 12.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH VIPP implements the Utah Violent Death Reporting System (UTVDRS) to help Utahns better understand the magnitude, trends, and characteristics of violent deaths such as suicide, and to evaluate and continue to improve state-based violence prevention policies and programs. The VIPP also works to improve the timeliness of syndromic surveillance data of nonfatal suicide-related outcomes. The VIPP partners with multiple state and local agencies to facilitate and build capacity for suicide prevention efforts across the state. VIPP also participates in the Utah Suicide Prevention Coalition, a state level multi-sectoral group, and its seven workgroups that focus on specific populations and topic areas.

Utah Percentage of Adolescents in Grades 8,10,12 Who Reported Suicide Ideation, 2019

Race/Ethnicity+	Sample Size	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah 8th, 10th, 12th graders	53,411	18.2%	17.7%	18.7%	n/a
Am. Indian/AK Native	768	20.6%	17.5%	24.0%	
Asian	1,023	21.9%	18.6%	25.5%	↑
Black/ African Am.	752	18.4%	15.1%	22.3%	
N. Hawaiian/Pac. Islander	688	22.9%	19.0%	27.3%	↑
White, non-Hispanic	41,494	17.5%	17.0%	18.1%	↓
Hispanic/Latino	8,503	20.0%	19.0%	21.2%	↑

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Utah Prevention Needs Assessment, 2019.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Heavy Drinking of Alcohol

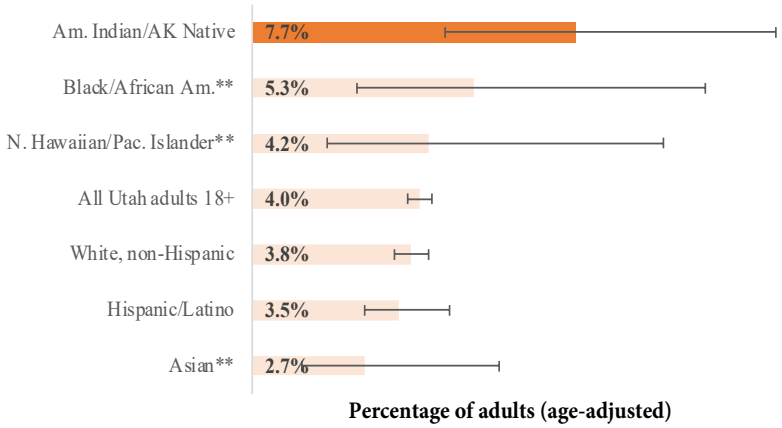
Why is it important?

Heavy drinking is defined as consuming eight (8) or more alcoholic beverages per week for women and 15 or more alcoholic beverages per week for men. Excessive alcohol use is responsible for 88,000 deaths in the US each year. Estimates also suggest more than 500 Utahns die from alcohol-attributable causes each year. Utah is ranked seven in the nation for alcohol poisoning deaths. Excessive alcohol use is also associated with many health and social harms, including liver cirrhosis, certain cancers, fetal alcohol spectrum disorder, violence, and unintentional injuries. Excessive drinking cost the US $249 billion in 2010, which calculates to $2.05 per drink. In 2014, the cost of excessive alcohol use in Utah was estimated to be $1.2 billion.[34]

How are we doing?

From 2017–2019, 4.0% of Utah adults reported heavy drinking of alcohol within the past 30 days (age-adjusted rate). Adults who identified as American Indian/Alaska Native had significantly higher rates of heavy drinking of alcohol (7.7%) than all Utah adults.

Heavy Drinking of Alcohol, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH VIPP receives funding from the Alcohol Program at the Centers for Disease Control (CDC) for a full-time epidemiologist to conduct more monitoring and surveillance of excessive alcohol use and related harms. The Utah Division of Substance Abuse and Mental Health is the agency responsible for ensuring substance abuse and mental health prevention and treatment services are available statewide. The Division also provides general information, research, and statistics to the public regarding substance abuse and mental health services.

Utah Percentage of Adults Who Reported Heavy Drinking of Alcohol in the Past 30 Days, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Heavy Drinking	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	31,262	2,227,221	86,862	3.9% (3.6–4.2%)	4.0% (3.7–4.3%)	n/a
Am. Indian/AK Native	514	24,240	1,794	7.4% (4.4–12.2%)	7.7% (4.6–12.5%)	↑
Asian**	348	62,151	1,429	2.3% (1.0–5.1%)	2.7% (1.2–5.9%)	
Black/African Am.**	236	25,121	1,206	4.8% (2.4–9.4%)	5.3% (2.5–10.8%)	
N. Hawaiian/Pac. Islander**	167	20,411	796	3.9% (1.6–8.9%)	4.2% (1.8–9.8%)	
White, non-Hispanic	17,113	1,777,166	65,755	3.7% (3.3–4.0%)	3.8% (3.4–4.2%)	
Hispanic/Latino	1,632	283,231	10,763	3.8% (2.9–5.1%)	3.5% (2.7–4.7%)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

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Binge Drinking of Alcohol

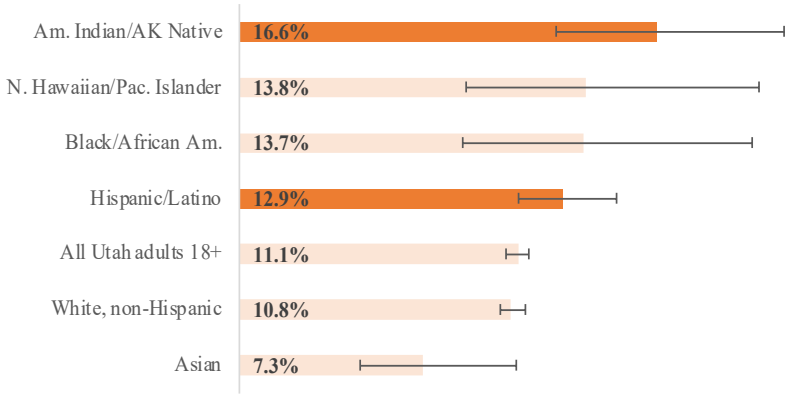
Why is it important?

Binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08% or above. This typically happens when men consume five (5) or more drinks, and when women consume four (4) or more drinks, in about two hours. Binge drinking is the most common pattern of excessive alcohol use in the US and those who binge drink tend to do so frequently and with high intensity. Excessive alcohol use is responsible for 88,000 deaths in the US each year. It's also associated with many health and social harms, including liver cirrhosis, certain cancers, unintentional injuries, violence, and fetal alcohol spectrum disorder. In 2014, the cost of excessive alcohol use in Utah was estimated to be $1.2 billion.[35]

How are we doing?

From 2017–2019, 11.1% of Utah adults reported binge drinking alcohol within the past 30 days (age-adjusted rate). Adults who identified as American Indian/Alaska Native (16.6%) and Hispanic/Latino (12.9%) had significantly higher rates of binge drinking alcohol than all Utah adults. Adults who identified as Asian had a significantly lower rate (7.3%) than all Utah adults.

Binge Drinking of Alcohol, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH VIPP receives funding from the Alcohol Program at the CDC to conduct more monitoring and surveillance of excessive alcohol use and related harms. The Utah Division of Substance Abuse and Mental Health is responsible for ensuring substance abuse and mental health prevention and treatment services are available statewide. The Division provides general information, research, and statistics to the public regarding substance abuse and mental health services.

Utah Percentage of Adults Who Reported Binge Drinking of Alcohol in the Past 30 Days, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Binge Drinking	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	31,336	2,227,221	247,222	11.1% (10.7–11.6%)	11.1% (10.6–11.5%)	n/a
Am. Indian/AK Native	512	24,240	4,315	17.8% (13.4–23.2%)	16.6% (12.6–21.7%)	↑
Asian	346	62,151	5,159	8.3% (5.5–12.5%)	7.3% (4.8–11.0%)	↓
Black/African Am.	233	25,121	3,693	14.7% (9.6–22.0%)	13.7% (8.9–20.4%)	
N. Hawaiian/Pac. Islander	170	20,411	2,837	13.9% (9.0–20.8%)	13.8% (9.0–20.7%)	
White, non-Hispanic	17,133	1,777,166	186,602	10.5% (9.9–11.2%)	10.8% (10.1–11.4%)	
Hispanic/Latino	1,666	283,231	40,219	14.2% (12.3–16.3%)	12.9% (11.1–15.0%)	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

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Protective Factors for Health

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Utah Health Status by Race & Ethnicity 2021

Daily Fruit Consumption

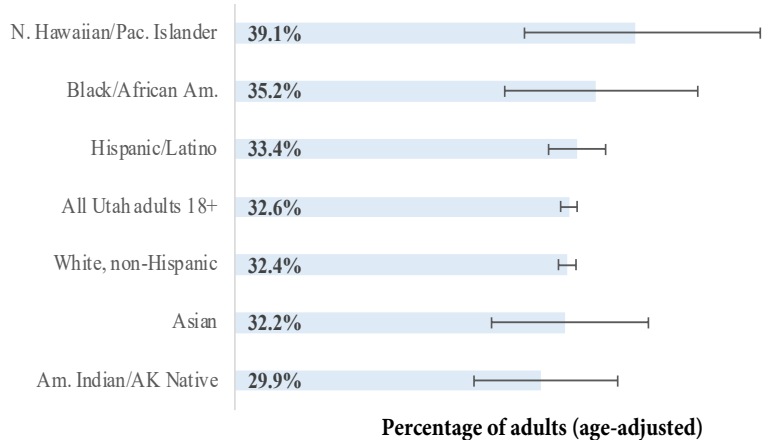
Why is it important?

Fruit contains essential vitamins, minerals, fiber, and other compounds that may help prevent many chronic diseases. Compared with people who consume small amounts of fruit, those who eat more generous amounts are likely to have reduced risk for chronic diseases, including cardiovascular diseases and certain cancers. The 2020–2025 Dietary Guidelines for Americans recommend two cups of fruit per day for a standard 2,000 calorie diet.[36,37]

How are we doing?

In 2017 and 2019, only one in three (32.6%) Utah adults reported eating two or more servings of fruit each day (age-adjusted rate). There were no statistically significant differences in the rate of fruit consumption by race and ethnicity.

Daily Fruit Consumption, Utah, 2017, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH EPICC Program was established to promote policies around healthy eating and active living. EPICC works in schools, worksites, communities, healthcare, and childcare. For example, Action for Healthy Kids brings partners together to improve nutrition environments and develop policies in Utah's schools. Local health departments (LHDs) receive federal funding to partner with schools, worksites, and community-based organizations to increase access to fresh fruits and vegetables. Ten LHDs have implemented the TOP (Teaching Obesity Prevention in Early Child Care Settings) Star program to improve the nutrition in child care centers and homes.

Percentage of Adults Who Reported Eating Two+ Fruits Daily, 2017, 2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Eating Fruit	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	20,386	2,226,195	721,287	32.4% (31.6–33.2%)	32.6% (31.8–33.4%)	n/a
Am. Indian/AK Native	305	24,275	6,943	28.6% (22.5–35.7%)	29.9% (23.3–37.3%)	
Asian	220	61,475	19,733	32.1% (25.5–39.6%)	32.2% (25.0–40.3%)	
Black/African Am.	146	24,748	8,984	36.3% (27.4–46.2%)	35.2% (26.3–45.2%)	
N. Hawaiian/Pac. Islander	110	19,984	7,574	37.9% (26.8–50.4%)	39.1% (28.2–51.2%)	
White, non-Hispanic	17,608	1,777,251	574,052	32.3% (31.4–33.1%)	32.4% (31.6–33.3%)	
Hispanic/Latino	1,656	282,991	91,972	32.5% (29.9–35.3%)	33.4% (30.6–36.2%)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017 and 2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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Daily Vegetable Consumption

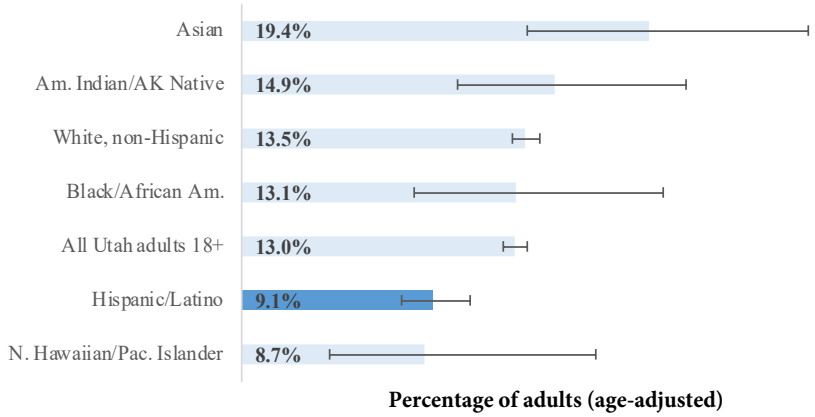
Why is this important?

Vegetables contain essential vitamins, minerals, fiber, and other compounds that may help prevent many chronic diseases. Compared with people who consume small amounts of vegetables, those who eat more generous amounts are likely to have reduced risk for chronic diseases, including cardiovascular diseases and certain cancers. The 2020-2025 Dietary Guidelines for Americans recommend two and one half cups of vegetables per day for a standard 2,000 calorie diet.[38,39]

How are we doing?

In 2017 and 2019, 13.0% of Utah adults reported eating three servings of vegetables per day. People who identified as Asian had significantly higher rates of vegetable consumption (19.4%) than all Utah adults. People who identified as Hispanic/Latino had significantly lower rates (9.1%) than all Utah adults.

Daily Vegetable Consumption, Utah, 2017, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH EPICC Program was established to promote policies around healthy eating and active living. EPICC works in schools, worksites, communities, healthcare, and childcare. For example, Action for Healthy Kids brings partners together to improve nutrition environments and develop policies in Utah's schools. LHDs receive federal funding to partner with schools, worksites, and community-based organizations to increase access to fresh fruits and vegetables. Ten LHDs have implemented the TOP Star program, to improve the nutrition in child care centers and homes.

Percentage of Adults Who Reported Eating Three+ Vegetables Daily, 2017, 2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Eating Vegetables	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	20,104	2,226,195	289,405	13.0% (12.4–13.6%)	13.0% (12.5–13.6%)	n/a
Am. Indian/AK Native	308	24,275	3,326	13.7% (9.5–19.4%)	14.9% (10.3–21.2%)	
Asian	218	61,475	10,943	17.8% (12.7–24.4%)	19.4% (13.6–27.0%)	↑
Black/African Am.	145	24,748	3,044	12.3% (7.5–18.9%)	13.1% (8.2–20.1%)	
N. Hawaiian/Pac. Islander	107	19,984	2,438	12.2% (5.4–25.1%)	8.7% (4.2–16.9%)	
White, non-Hispanic	17,384	1,777,251	236,374	13.3% (12.7–14.0%)	13.5% (12.9–14.2%)	
Hispanic/Latino	1,619	282,991	27,167	9.6% (8.0–11.4%)	9.1% (7.6–10.9%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017 and 2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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Recommended Aerobic Physical Activity

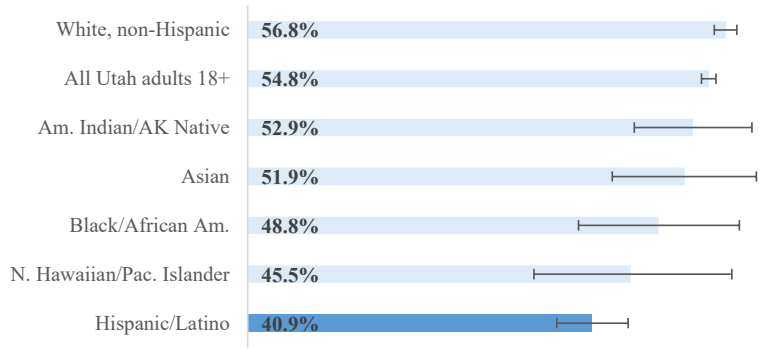
Why is this important?

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 and has been known to improve disorders such as depression and anxiety. Regular physical activity helps relieve pain from osteoarthritis 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.[40]

How are we doing?

In 2017 and 2019, 54.8% of Utah adults reported getting the recommended amount of aerobic activity (age-adjusted rate). People who identified as Hispanic/Latino had significantly lower rates of recommended aerobic physical activity (40.9%) than all Utah adults. People who identified as White, non-Hispanic/Latino had significantly higher rates of recommended aerobic physical activity (56.8%) than all Utah adults.

Recommended Aerobic Activity, Utah, 2017, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH EPICC Program promotes policies around healthy eating and active living in schools, worksites, communities, healthcare, and childcare. For example, the Action for Healthy Kids brings partners together to improve physical activity environments in Utah's schools. The Utah Council for Worksite Health Promotion recognizes businesses that offer employee fitness and health promotion programs. LHDs also work with cities within their jurisdictions to create a built environment that encourages physical activity. Ten LHDs implemented the TOP Star program, which aims to improve physical activity environments and achieve best practice in child care centers and homes.

Percentage of Adults Getting the Recommended Amount of Aerobic Activity, 2017, 2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# Getting Activity	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	20,244	2,226,195	1,211,050	54.4% (53.5–55.3)	54.8% (53.9–55.6%)	n/a
Am. Indian/AK Native	309	24,275	12,138	50.0% (42.7–57.3%)	52.9% (45.9–59.9%)	
Asian	218	61,475	30,123	49.0% (41.2–56.9%)	51.9% (43.3–60.4%)	
Black/African Am.	146	24,748	11,384	46.0% (36.8–55.5%)	48.8% (39.3–58.4%)	
N. Hawaiian/Pac. Islander	112	19,984	8,993	45.0% (33.4–57.2%)	45.5% (34.0–57.5%)	
White, non-Hispanic	8,116	1,777,251	1,002,370	56.4% (55.0–57.8%)	56.8% (55.4–58.1%)	↑
Hispanic/Latino	764	282,991	114,611	40.5% (36.4–44.7%)	40.9% (36.7–45.2%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017 and 2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

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Health of Mothers and Infants

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Utah Health Status by Race & Ethnicity 2021

The title of this section "Health of Mothers and Infants" is consistent with past reports and current programming at the Utah Department of Health.

The language in this section of the report aims to center language around people and use gender-inclusive language when possible. Many of the data sources in the section of the report are collected or analyzed based on whether an individual gave birth and not on gender identification. As data collection and analysis changes, future reports will reflect these changes.

Infant Mortality

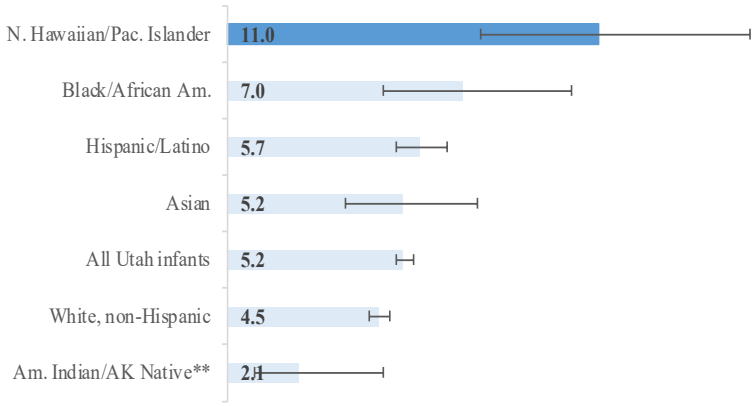
Why is this important?

The infant death rate is an important measure of a nation's health and a worldwide indicator of health status and social well-being. The number of infants who died before their first birthday (less than 365 days) per 1,000 live births gives insight into the health of a community or population. The top four causes of infant mortality in Utah are perinatal conditions (includes preterm birth and can reflect the overall state of maternal health as well as the quality and accessibility of health care for pregnant people, birth defects, medical conditions of the infant, and sudden unexpected infant death (SUID).[41]

How are we doing?

From 2014–2018, the infant mortality rate for all Utah infants was 5.2 per 1,000 live births. Native Hawaiian/ Pacific Islander populations had significantly higher infant mortality rates (11.0 per 1,000) when compared with all Utahn infants. White, non-Hispanic (4.5 per 1,000) and American Indian/Alaska Native (2.1 per 1,000) populations had significantly lower infant mortality rates when compared with all Utahn infants.

Infant Mortality, Utah, 2014–2018



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Infant mortality is complex. A comprehensive approach to address racial and ethnic health disparities early on and through different stages of life must include individual, community, and place-based, and system-based interventions that are culturally and linguistically responsive. The UDOH Maternal and Infant Health Program (mihp.utah.gov) can provide resources for parents and their families before, during, and after pregnancy to promote healthy pregnancies and births. The UDOH Baby Your Baby program offers information about healthy pregnancy at babyyourbaby.org and 1-800-826-9662.

Utah Infant Mortality Rate, 2014–2018

Race/Ethnicity+	Average Annual # of Deaths	Average Annual # of Live Births	Crude Rate / 1,000 Live Births	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	260	49,643	5.2	5.0	5.5	n/a
Am. Indian/AK Native**	1	573	2.1	0.8	4.6	↓
Asian	6	1,198	5.2	3.5	7.4	
Black/African Am.	5	745	7.0	4.6	10.2	
N. Hawaiian/Pac. Islander	6	582	11.0	7.5	15.5	↑
White, non-Hispanic	166	37,268	4.5	4.2	4.8	↓
Hispanic/Latino	45	7,838	5.7	5.0	6.5	

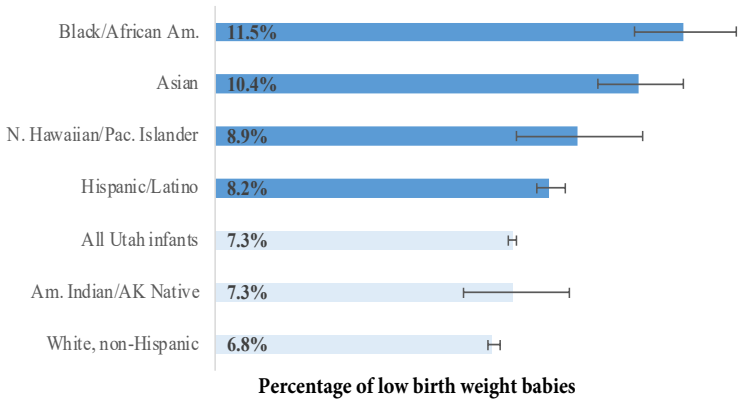
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Linked Birth and Death Certificate Database (Birth Cohort), Office of Vital Records and Statistics, UDOH
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

Low Birth Weight

Why is it important?

As birth weight decreases, the risk for death increases. Low birth weight (LBW) infants or infants weighing less than 2,500 grams who survive often require intensive care at birth and are at risk for many health problems including delayed motor and social development or learning disabilities. Utah inpatient hospital discharge data (2019) indicate average hospital charges for a premature infant was $99,267 (DRG 790, 791, 792) compared with $4,128 for a full-term newborn infant (DRG 795). Utah inpatient hospital discharge data (2019) indicate the average length of stay for a premature infant was 17 days (DRG 790, 791, 792) compared with two days for a full-term newborn infant (DRG 795).

Low Birth Weight, Utah, 2018–2019



How are we doing?

From 2017–2019, 7.3% of live born Utah infants weighed less than 2,500 grams. Black/African American (11.5%), Asian (10.4%), Native Hawaiian/ Pacific Islander (8.9%), and Hispanic/Latino (8.2%) populations had significantly higher rates of low birth weight infants when compared with all Utah infants. White, non-Hispanic populations had a significantly lower rate (6.8%) when compared with all Utah infants.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. To reduce the low birth weight rate, efforts emphasize promotion of preconception health to support people who could become pregnant to be at optimal health at the time of conception as chronic health conditions, physical, emotional, and behavioral health issues can have a strong impact on the developing fetus. The UDOH Maternal and Infant Health Program "Power Your Life" campaign promotes preconception health at poweryourlife.org. The UDOH Baby Your Baby program offers information about healthy pregnancy at babyyourbaby.org and 1-800-826-9662.

Percentage of Live Born Infants with Low Birth Weight, 2014–2018

Race/Ethnicity+	Total Infants <2500 g	Total Live Births	% of Infants <2500 g	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	10,401	142,621	7.3%	7.2%	7.4%	n/a
Am. Indian/AK Native	117	1,614	7.3%	6.1%	8.7%	
Asian	373	3,582	10.4%	9.4%	11.5%	↑
Black/African Am.	285	2,485	11.5%	10.3%	12.8%	↑
N. Hawaiian/Pac. Islander	119	1,345	8.9%	7.4%	10.5%	↑
White, non-Hispanic	7,156	105,022	6.8%	6.7%	7.0%	↓
Hispanic/Latino	1,963	23,938	8.2%	7.9%	8.6%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Preterm Birth

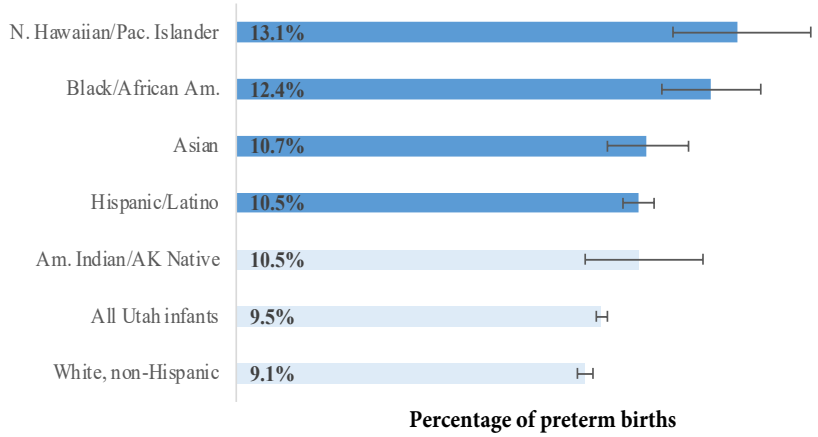
Why is this important?

Preterm birth or birth before 37 weeks gestation is the leading cause of perinatal death in otherwise normal newborns and is a leading cause of long-term neurological disabilities in children. Babies born preterm also have increased risks for long term morbidities and often require intensive care after birth. Utah inpatient hospital discharge data (2017) indicate average hospital charges for a premature infant was $83,177 (DRG 790, 791, 792) compared with $3,574 for a full-term newborn infant (DRG 795). Utah inpatient hospital discharge data (2017) indicate the average length of stay for a premature infant was 16 days (DRG 790, 791, 792) compared with 1.8 days for a full-term newborn infant (DRG 795).[42]

How are we doing?

In 2017–2019, 9.5% of all Utah live births were preterm. Native Hawaiian/Pacific Islander (13.1%), Black/African American (12.4%), Asian (10.7%), and Hispanic/Latino (10.5%) populations had higher preterm birth rates than all Utah infants. White, non-Hispanic populations had a significantly lower rate (9.1%) when compared with all Utah infants.

Preterm Birth, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Approximately half of preterm births in Utah are due to complications of the pregnancy or maternal health factors. The remaining preterm births have unexplained causes. The maternal committee of the Utah Women and Newborns Quality Collaborative (UWNQC) developed videos on preterm birth prevention available at mihp.utah.gov/uwnqc/. The UDOH Maternal and Infant Health Program can provide resources for parents and their families before, during, and after pregnancy to promote healthy pregnancies and births. The UDOH Baby Your Baby program offers information about healthy pregnancy at babyyourbaby.org and 1-800-826-9662.

Percentage of Live Infants Born at Less Than 37 Weeks, 2017–2019

Race/Ethnicity+	Total Births <37 weeks	Total Live Births	% of Births <37 weeks	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	13,568	142,621	9.5%	9.4%	9.7%	n/a
Am. Indian/AK Native	170	1,614	10.5%	9.1%	12.2%	
Asian	384	3,582	10.7%	9.7%	11.8%	↑
Black/African Am.	307	2,485	12.4%	11.1%	13.7%	↑
N. Hawaiian/Pac. Islander	176	1,345	13.1%	11.4%	15.0%	↑
White, non-Hispanic	9,528	105,022	9.1%	8.9%	9.3%	↓
Hispanic/Latino	2,502	23,938	10.5%	10.1%	10.9%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Obesity in Pregnancy

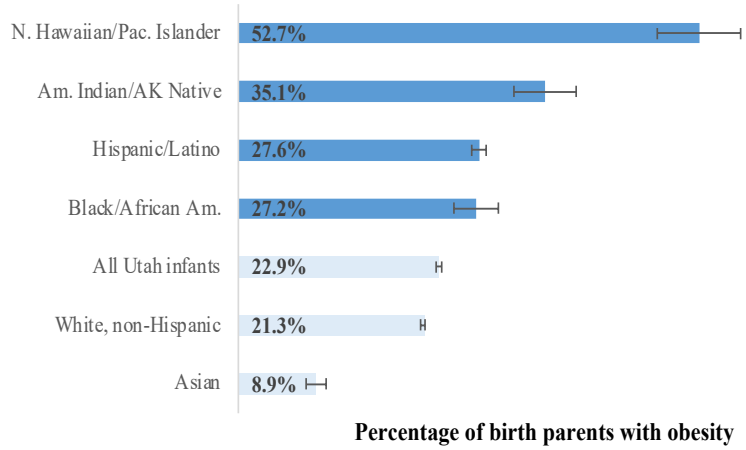
Why is this important?

People who are not at a healthy weight prior to pregnancy are at increased risk of adverse maternal and infant outcomes. People who experience obesity, a body mass index (BMI) >30, prior to pregnancy have longer hospital stays and higher utilization of medical care during pregnancy.[43]

How are we doing?

In 2018–2019, 22.9% of Utah people experienced obesity prior to pregnancy. People who identified as Native Hawaiian/Pacific Islander (52.7%), American Indian/Alaska Native (35.1%), Hispanic/Latino (27.6%), and Black/African American (27.2%) had significantly higher rates of obesity in pregnancy than all Utah mothers. People who identified as Asian (8.9%) and White, non-Hispanic (21.3%) had significantly lower rates of obesity in pregnancy than all Utah mothers.

Obesity in Pregnancy, Utah, 2018–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. In an effort to reduce the rate of obesity in people who could become pregnant, emphasis is being placed on preconception health to help achieve optimal weight and health prior to pregnancy. The UDOH Maternal and Infant Health Program "Power Your Life" campaign promotes preconception health at poweryourlife.org. The UDOH Maternal and Infant Health Program (mihp.utah.gov) can provide resources for parents and their families before, during, and after pregnancy to promote healthy pregnancies and births. The UDOH EPICC programs can provide information on healthy eating and physical activity at choosehealth.utah.gov/.

Percentage of Live Births to Utah People With BMI >30 Prior to Pregnancy, 2018–2019

Race/Ethnicity+	Average Annual # Born to Birth Parent With Obesity	Average Annual # Live Births	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	10,753	47,022	22.9%	22.6%	23.2%	n/a
Am. Indian/AK Native	183	521	35.1%	31.5%	38.7%	↑
Asian	104	1,165	8.9%	7.7%	10.1%	↓
Black/African Am.	227	836	27.2%	24.7%	29.7%	↑
N. Hawaiian/Pac. Islander	238	452	52.7%	47.9%	57.4%	↑
White, non-Hispanic	7,272	34,138	21.3%	20.8%	21.3%	↓
Hispanic/Latino	2,227	8,081	27.6%	26.7%	28.4%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Smoking During Pregnancy

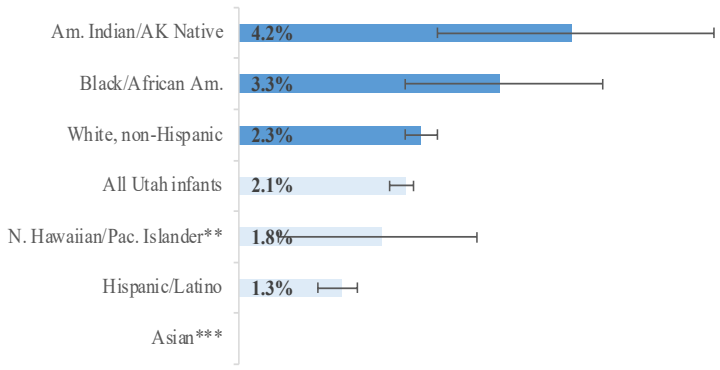
Why is this important?

During pregnancy, people who smoke cigarettes have a higher risk of delivering their infant too early and with a low birth weight, making it more likely their infant will be sick and have to stay in the hospital longer. These infants also have a higher risk of having some kind of birth defect such as a cleft lip and palate. Infants whose mothers smoked during pregnancy or were exposed to secondhand smoke after delivery have a higher risk of sudden infant death syndrome (SIDS). According to the 2014 Surgeon General's Report[44], there is no safe level of tobacco use or exposure for women and their infants.[45]

How are we doing?

In 2018–2019, 2.1% of all Utah people smoked during the third trimester of their pregnancies. People who identified as American Indian/Alaska Native (4.2%), Black/African American (3.3%), and White, non-Hispanic (2.3%) had a significantly higher rate of smoking during the third trimester than Utah overall. People who identified as Hispanic/Latina had a significantly lower rate (1.3%) than Utah overall.

Smoking in Pregnancy, Utah, 2018–2019



Percentage of infants born to people who smoked during the third trimester

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. In Utah, all LHDs screen pregnant clients for smoking and provide resources and referrals to promote cessation. The UDOH Medicaid Program and Department of Workforce Services workers screen all pregnant applicants for tobacco use at the time of enrollment. People who smoke are provided cessation information and followed-up every six weeks throughout their pregnancies. The UDOH TPCP funds statewide and local tobacco-use cessation services, including the Utah comprehensive tobacco cessation website, waytoquit.org, which offers help and tips for quitting tobacco, as well as information about the Utah Tobacco Quit Line at 1-800-QUIT-NOW and the Utah online quit coaching program at quitnow.net.

Percentage of Utah People Who Smoked During the Third Trimester, 2018–2019

Race/Ethnicity+	Average Annual # Born to Birth Parent Who Smoked	Average Annual # Live Births	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	973	47,021	2.1%	1.9%	2.2%	n/a
Am. Indian/AK Native	22	521	4.2%	2.5%	6.0%	↑
Asian***	***	1,165	***	***	***	
Black/African Am.	28	836	3.3%	2.1%	4.6%	↑
N. Hawaiian/Pac. Islander**	8	452	1.8%	0.5%	3.0%	
White, non-Hispanic	789	34,138	2.3%	2.1%	2.5%	↑
Hispanic/Latino	102	8,081	1.3%	1.0%	1.5%	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether 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 the standard error is greater than 50% or undetermined.*

Gestational Diabetes

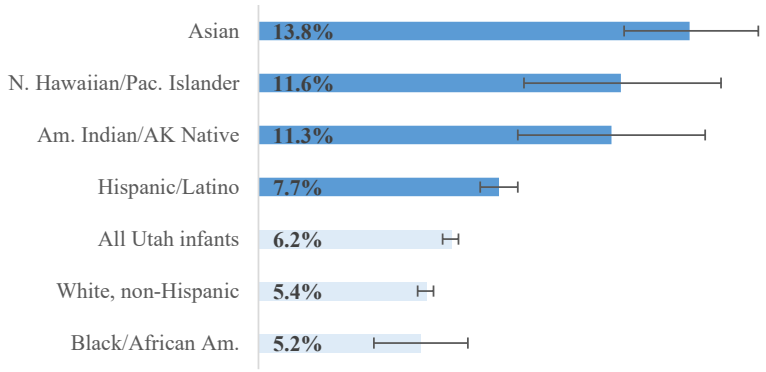
Why is this important?

Gestational diabetes mellitus (GDM) is defined as having abnormally high blood glucose levels during pregnancy. This abnormality usually disappears after pregnancy, although as many as 5 to 10 percent of people with gestational diabetes may actually have had undiagnosed type 2 diabetes. People with gestational diabetes tend to have a higher risk of developing diabetes later in life. At least 40 percent of people with gestational diabetes will develop diabetes within 20 years. People with gestational diabetes are more likely to have large babies (more than 4,000 grams), a risk factor for non-elective cesarean section delivery and adverse birth outcomes. Infants born to women with gestational diabetes have a higher risk of developing diabetes and obesity themselves.[46]

How are we doing?

In 2019, 6.2% of Utah births were to people who experienced GDM. People who identified as Asian (13.8%), Native Hawaiian/Pacific Islander (11.6%), American Indian/Alaska Native (11.3%), and Hispanic/Latino (7.7%) had significantly higher rates of gestational diabetes than all Utah people who experienced GDM. People who identified as White, non-Hispanic had significantly lower rates (5.4%) than Utah overall.

Gestational Diabetes (GDM), Utah, 2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH EPICC Program supports participation in diabetes education for people with gestational diabetes. Instructors, who are generally certified diabetes educators or registered dietitians, can help people with gestational diabetes control their blood glucose levels with diet and exercise and thereby reduce their likelihood of needing oral medications or insulin. The UDOH Maternal and Infant Health Program "Power Your Life" campaign encourages people who could become pregnant to be healthy before pregnancy, including being at a healthy weight at poweryourlife.org.

Percentage of Utah Births to People Who Had Gestational Diabetes (GDM), 2019

Race/Ethnicity+	# Births to People With GDM	Total # Live Births	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	2,870	46,832	6.2%	5.9%	6.4%	n/a
Am. Indian/AK Native	55	486	11.3%	8.3%	14.3%	↑
Asian	160	1,156	13.8%	11.7%	16.0%	↑
Black/African Am.	46	886	5.2%	3.7%	6.7%	
N. Hawaiian/Pac. Islander	53	455	11.6%	8.5%	14.8%	↑
White, non-Hispanic	1,806	33,640	5.4%	5.1%	5.6%	↓
Hispanic/Latina	622	8,061	7.7%	7.1%	8.3%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
interpret with caution.

Folic Acid Consumption

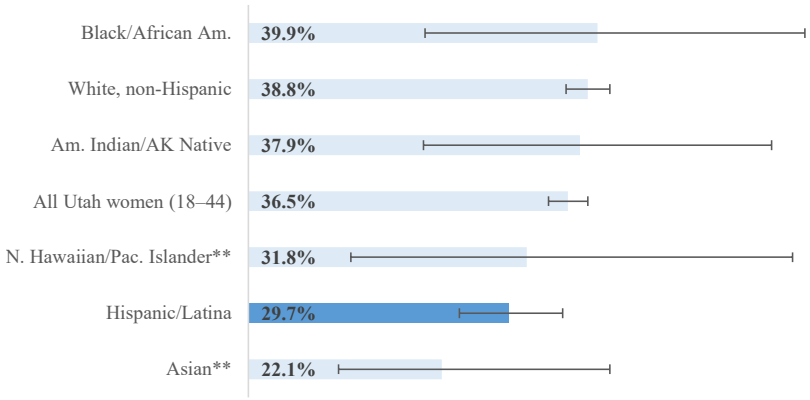
Why is this important?

Consuming a multivitamin with folic acid daily beginning 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 increased risk for illness, long term disability, and premature death. These children often need lifelong health and rehabilitation services to improve outcomes and reduce complications.

How are we doing?

In 2016 and 2018, 36.5% of Utah women aged 18–44 reported taking folic acid daily (age-adjusted using two age groups: 18–34 and 35–44 years). Women aged 18–44 who identified as Hispanic/Latina had significantly lower rates (29.7%) of folic acid consumption than all Utah women aged 18–44. Women aged 18–44 who identified as White, non-Hispanic had significantly higher rates (38.8%) than all Utah overall.

Daily Folic Acid Consumption, 2016, 2018



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. All people who could become pregnant 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. 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 at health.utah.gov/cshcn.

Percentage of Utah Women (18–44 Years) Taking Folic Acid, 2016, 2018

Race/Ethnicity+	Sample Size	2010, 2012 Annual Female 18-44 Pop.	# Reporting Daily Consumption	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah women (18–44)	3,131	603,259	212,347	35.2% (33.0–37.4%)	36.5% (34.3–38.8%)	n/a
Am. Indian/AK Native	65	7,064	2,706	38.3% (20.0–60.6%)	37.9% (20.0–59.8%)	
Asian**	54	18,878	4,587	24.3% (12.6–41.7%)	22.1% (10.3–41.3%)	
Black/African Am.	30	6,631	2,507	37.8% (19.7–60.1%)	39.9% (20.2–63.6%)	
N. Hawaiian/Pac. Islander**	18	6,357	1,557	24.5% (8.3–53.8%)	31.8% (11.7–62.2%)	
White, non-Hispanic	2,529	463,492	173,810	37.5% (35.0–40.0%)	38.8% (36.3–41.3%)	↑
Hispanic/Latina	392	87,553	24,777	28.3% (23.0–34.4%)	29.7% (24.1–35.9%)	↓

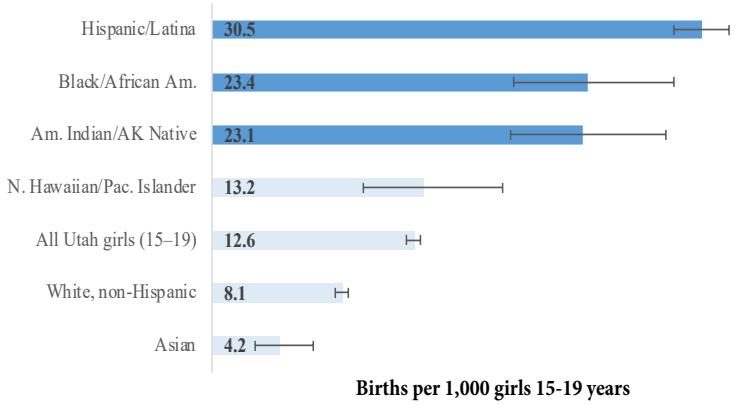
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2016 and 2018 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

Births to Adolescents

Why is this important?

Research indicates bearing a child during adolescence is associated with long-term difficulties for the birth parents, their children, and society. These consequences are often attributable to poverty and other adverse socioeconomic circumstances that frequently accompany early childbearing. Compared to babies born to older birth parents, babies born to adolescent birth parents, particularly young adolescent birth parents, are at higher risk for low birth weight and infant mortality. These babies are more likely to grow up in homes that offer lower levels of emotional support and cognitive stimulation, and are less likely to earn a high school diploma. For the birth parents, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce future employment prospects and earning potential.[47]

Births to Adolescents, Utah, 2018–2019



How are we doing?

In 2018–2019, the rate of Utah adolescent girls (15–19 years) who gave birth was 12.6 per 1,000. Adolescent girls who identified as Hispanic/Latina (30.5 per 1,000), Black/African American (23.4 per 1,000), and American Indian/Alaska Native (23.1 per 1,000) populations had a significantly higher rate of adolescent births than all Utah overall. Adolescent girls who identified as White, non-Hispanic (8.1 per 1,000) and Asian (4.2 per 1,000) populations had a significantly lower rate than Utah overall.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH receives federal funding from the US Department of Health and Human Services, Administration for Children and Families, Family & Youth Services Bureau to provide two programs to address teen pregnancy prevention in Utah. The UDOH sub-contracts these federal funds to local health departments, community agencies, and tribal entities or governments.

Utah Adolescent Birth Rate, 2018–2019

Race/Ethnicity+	# of Births to Girls 15-19 Years	Total Population of Girls 15-19 Years	Crude Rate / 1,000	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah girls (15–19)	3,094	246,295	12.6	12.1	13.0	n/a
Am. Indian/AK Native	91	3,942	23.1	18.6	28.3	↑
Asian	23	5,447	4.2	2.7	6.3	↓
Black/African Am.	88	3,759	23.4	18.8	28.8	↑
N. Hawaiian/Pac. Islander	39	2,950	13.2	9.4	18.1	
White, non-Hispanic	1,482	183,712	8.1	7.7	8.5	↓
Hispanic/Latina	1,277	41,939	30.5	28.8	32.2	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Unintended Pregnancy

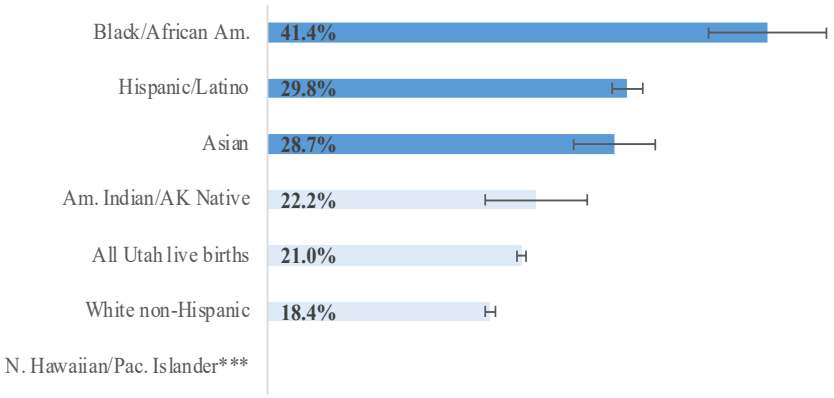
Why is this important?

In the US, unintended pregnancy is a major public health problem. Unintended pregnancy is a general term that includes pregnancies a person reports were either mistimed or unwanted at the time of conception. People with unintended pregnancies are less likely to seek early prenatal care or receive adequate prenatal care, more likely to smoke or drink during pregnancy, and less likely to initiate or maintain breastfeeding.[48]

How are we doing?

From 2017–2019, the crude rate of Utah people with a live birth who reported having an unintended pregnancy was 21.0%, or almost one-fourth of all pregnancies. Unintended pregnancy rates among people with a live birth who identified as Black/African American (41.4%), Hispanic/Latino (29.8%), and Asian (28.7%) were significantly higher than all Utah people with a live birth. People with a live birth who identified as White, non-Hispanic had a significantly lower rate (18.4%) when compared with all Utahns.

Unintended Pregnancy, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. To reduce unplanned pregnancies, public health efforts may include education to increase knowledge of human reproduction, conception, proper use of available contraceptive methods, and optimal spacing of pregnancies. A 2018 Utah law allows pharmacists to dispense three contraception types through a standing order signed by the UDOH's executive director. As of August 1, 2012, non-grandfathered plans must provide coverage for preventive health care, including contraception and counseling without cost-sharing. Medicaid provides family planning counseling and FDA-approved contraceptive methods without cost-sharing. The UDOH Maternal and Infant Health Program provides information on family planning, contraception, and birth spacing.[49]

Utah Births from Unintended Pregnancies, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual # of People with Live Birth	Est. Annual # Unintended	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah people with a live birth	4,329	45,719	9,605	21.0%	20.6%	21.4%	n/a
Am. Indian/AK Native	54	486	108	22.2%	18.0%	26.4%	
Asian	108	937	269	28.7%	25.3%	32.1%	↑
Black/African Am.	83	677	280	41.4%	36.5%	46.2%	↑
N. Hawaiian/Pac. Islander***	32	318	***	***	***	***	
White, non-Hispanic	3,124	35,179	6,479	18.4%	18.0%	18.9%	↓
Hispanic/Latina	824	7,278	2,166	29.8%	28.5%	31.0%	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Pregnancy Risk Assessment Monitoring System. See Methodology section for details on PRAMS data.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
****Estimate has been suppressed because the standard error is greater than 50% or undetermined.*

Ever Breastfed

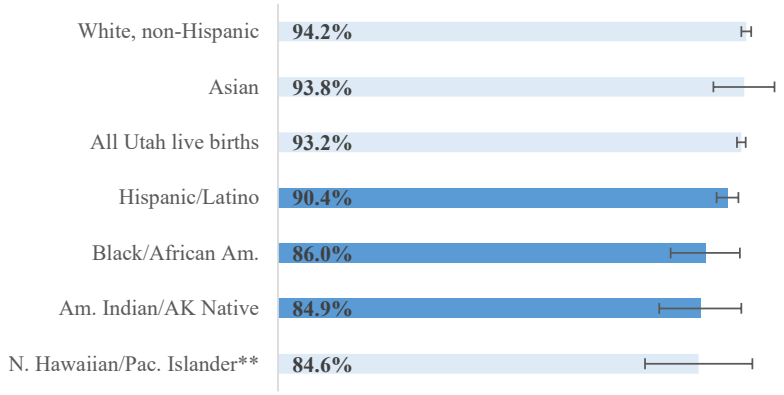
Why is this important?

Suboptimal breastfeeding practices are unequivocally associated with a greater risk for infant morbidity and mortality and poorer developmental outcomes, particularly in premature infants. Increased breastfeeding rates is one of the most important behaviors to decrease infant death and illness worldwide. When breastfeeding does not occur, the important benefits are not enjoyed by infants, parents, families, society, and the environment. It is the normal, preferred feeding for infants, including premature and sick babies.[50]

How are we doing?

From 2017–2019, 93.2% of Utah people with a live birth reported having ever breastfed. People with a live birth who identified as American Indian/Alaska Native (84.9%), Black/African American (86.0%), and Hispanic/Latina (90.4%) had a significantly lower rate than all Utahns.

People Who Have Ever Breastfed, Utah, 2017–2019



Percentage of women who have ever breastfed

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The Utah Women's Infants, and Children Program (WIC), through LHD WIC Clinics, provides breastfeeding education and support, community resources, breastfeeding classes, individualized consultation with an International Board Certified Lactation Consultant or Breastfeeding Peer Counselor, nutritious food for breastfeeding parents (up to 1 year postpartum), and manual and electric breast pumps and supplies. Lactation professionals are available in every local health district in Utah (1-877-WIC-KIDS) wic.utah.gov. WIC also works closely with local agency hospitals to support evidence-based policy and practices such as the Baby Friendly Hospital Initiative of Ten Steps to Successful Breastfeeding and to support the transition of parents and baby from hospital to home to ensure breastfeeding success. WIC also supported the first Human Milk Bank Collection site in Utah and is facilitating the establishment of a Human Milk Donor Bank, as a member of the Human Milk Banking Association of North America.[51]

Percentage of Utahns Who Have Ever Breastfed, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual # of People with Live Birth	Est. Annual # Ever Breastfed	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah women with a live birth	4,277	45,564	42,471	93.2%	92.3%	94.1%	n/a
Am. Indian/AK Native	54	485	412	84.9%	76.7%	93.2%	↓
Asian	106	948	889	93.8%	87.6%	99.9%	
Black/African Am.	85	691	594	86.0%	79.0%	92.9%	↓
N. Hawaiian/Pac. Islander**	28	279	236	84.6%	73.8%	95.4%	
White, non-Hispanic	3,093	35,206	33,166	94.2%	93.2%	95.2%	
Hispanic/Latina	811	7,150	6,463	90.4%	88.2%	92.6%	↓

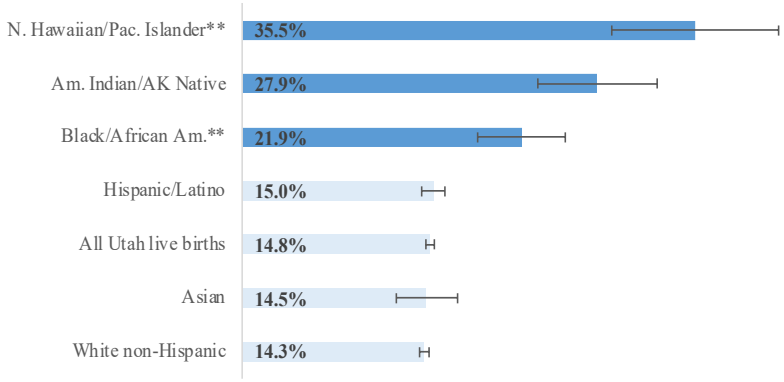
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
*Utah Pregnancy Risk Assessment Monitoring System. See Methodology section for details on PRAMS data.*Arrows indicate whether the rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

Postpartum Depression

Why is this important?

Postpartum depression is the most common complication related to childbirth. While postpartum depression is treatable, many people who suffer from it remain undiagnosed. Untreated postpartum depression can last as long as one to two years and may affect the ability of a person to function in normal daily tasks. Further, untreated postpartum depression may impact family relationships, a parent's ability to bond with their baby, and the cognitive development of their baby as well as other children in the home. There may be a variety of reasons a person does not receive treatment for postpartum depression including the inability to recognize the signs and symptoms as well as the uncertainty of knowing who to ask for help.[52]

Postpartum Depression, Utah, 2017–2019



Women with Postpartum Depressive Symptoms (PDS)

How are we doing?

From 2017–2019, 14.8% of Utah people with a live birth reported having postpartum depressive symptoms (PDS). People with a live birth who identified as Native Hawaiian/Pacific Islander (35.5%), American Indian/Alaska Native (27.9%), and Black/African American (21.9%) had a significantly higher rate of PDS than all Utah people with a live birth. People with a live birth who identified as White, non-Hispanic had a significantly lower rate (14.3%) when compared to Utah overall.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH MIHP works to increasing awareness of postpartum depression (PPD) and screening among health providers. MIHP staff participate in Utah's Maternal Mental Health Collaborative. MIHP worked with Medicaid to include information on PPD in a "termination of coverage" notice people receive prior to losing Medicaid coverage 60 days postpartum. It encourages people to seek help for PPD if needed before their coverage ends.[53]

Percentage of Utah People With a Live Birth With Postpartum Depressive Symptoms (PDS), 2017–2019

Race/Ethnicity+	Sample Size	Average Annual # of People with Live Birth	Est. Annual # With PDS	Crude Rate	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah people with a live birth	3,705	46,498	6,863	14.8%	14.4%	15.1%	n/a
Am. Indian/AK Native	55	488	136	27.9%	23.2%	32.6%	↑
Asian	109	961	139	14.5%	12.1%	16.9%	
Black/African Am.**	87	702	154	21.9%	18.5%	25.4%	↑
N. Hawaiian/Pac. Islander**	32	318	113	35.5%	29.0%	42.1%	↑
White, non-Hispanic	2,681	35,726	5,104	14.3%	13.9%	14.7%	↓
Hispanic/Latina	847	7,441	1,118	15.0%	14.1%	15.9%	

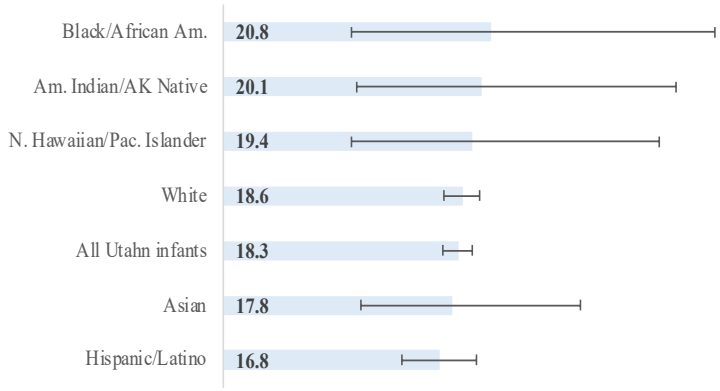
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Birth Certificates Database, Office of Vital Records and Statistics, UDOH.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

Major Structural Birth Defects

Why is this important?

The Utah Birth Defect Network (UBDN) collects data on 47 major structural malformations and chromosomal birth defects. These birth defects are associated with significant mortality, illness, and disability throughout the lifespan. In the United States, birth defects are the leading cause of infant death and a major contributor to lifelong disabilities. Utah reported one of the highest prevalence rates for Down syndrome between 2012–2016, compared with other states.[54] This may be explained by the slightly higher proportion of Utah pregnancies that occur in the maternal age group 35 years and older compared with the same maternal age group nationwide.[55,56]

Major Structural Birth Defects, Utah, 1999–2017



Number of birth defect cases per 1,000 births

How are we doing?

From 1999–2017, an average of 929 birth defect cases per year have been reported in Utah, with a prevalence rate of 18.3 per 1,000 live births.[57] There were no statistically significant differences in the rates by race and ethnicity.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. To reduce the occurrence of birth defects among infants in Utah, primary prevention activities must be targeted at people who could become pregnant 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 400mcg of folic acid prior to pregnancy, maintaining a healthy pre-pregnancy weight, controlling blood sugar if diabetic, eating a healthy diet, avoiding alcohol consumption, and smoking. People planning a pregnancy should always consult an obstetric care provider about any medications they may be taking or chronic diseases (e.g., diabetes) they may have. Information on the Utah Birth Defect Network and birth defects can be found at health.utah.gov/ubdn/.

Utah Major Structural Birth Defect Rate*, 1999–2017

Race/Ethnicity+	Average Annual # of Birth Defects	Average Annual # of Live Births	Crude Rate / 10,000 Live Births	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	929	50,909	18.3	17.1	19.4	n/a
Am. Indian/AK Native	12	596	20.1	10.4	35.2	
Asian	19	1,069	17.8	10.7	27.8	
Black/African Am.**	10	482	20.8	10.0	38.2	
N. Hawaiian/Pac. Islander**	12	619	19.4	10.0	33.9	
White	743	40,036	18.6	17.2	19.9	
Hispanic/Latina	218	7,604	16.8	13.9	19.7	

+Individuals were classified into only one racial/ethnic category.
Utah Birth Defect Network. Average Annual Live Births Data: Utah Birth Certificate Database.
**This analysis does not include clubfoot.*
***Arrows indicate whether the rate was higher or lower than for all Utahns.*

Orofacial Clefts

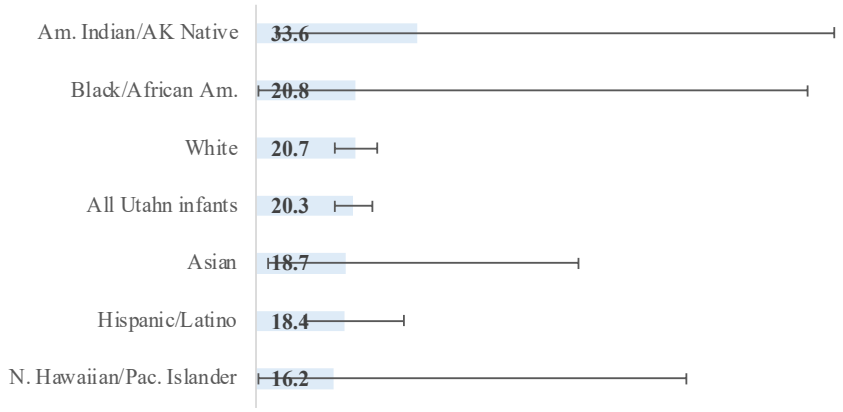
Why is this important?

Orofacial clefts (cleft lip and/or cleft palate) are among the most common birth defects. Surgery is required to repair cleft lip and/or palate and cases often require follow up procedures as children get older. Treatment of orofacial clefts helps improve breathing, hearing, and speech and language development. Delay in addressing orofacial clefts can impede learning and language development in children.

How are we doing?

From 1999–2017, the prevalence rate of orofacial clefts in Utah was 20.3 per 10,000 births.[58] Utah has one of the highest rates of orofacial clefts in the United States; the reason is unclear. There were no statistically significant differences in the rates by race and ethnicity.

Orofacial Clefts, Utah, 1999–2017



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity at every stage of life. To reduce the occurrence of birth defects among infants in Utah, primary prevention activities must be targeted at people who could become pregnant 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 400mcg of folic acid prior to pregnancy, maintaining a healthy pre-pregnancy weight, controlling blood sugar if diabetic, eating a healthy diet, avoiding alcohol consumption, and smoking. People planning a pregnancy should always consult an obstetric care provider about any medications they may be taking or chronic diseases (e.g., diabetes) they may have. Information on the Utah Birth Defect Network and birth defects can be found at health.utah.gov/ubdn/.

Utah Orofacial Cleft Rate, 1999–2017

Race/Ethnicity+	Average Annual # Orofacial Clefts	Average Annual # of Live Births	Crude Rate / 10,000 Live Births	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	104	50,909	20.3	16.5	24.4	n/a
Am. Indian/AK Native	2	596	33.6	4.1	121.2	
Asian	2	1,069	18.7	2.3	67.6	
Black/African Am.	1	482	20.8	0.5	115.6	
N. Hawaiian/Pac. Islander	1	619	16.2	0.4	90.0	
White	83	40,036	20.7	16.3	25.2	
Hispanic/Latina	14	7,604	18.4	10.1	30.9	

+Individuals were classified into only one racial/ethnic category.
Utah Birth Defect Network. Average Annual Live Births Data: Utah Birth Certificate Database.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Critical Congenital Heart Defects

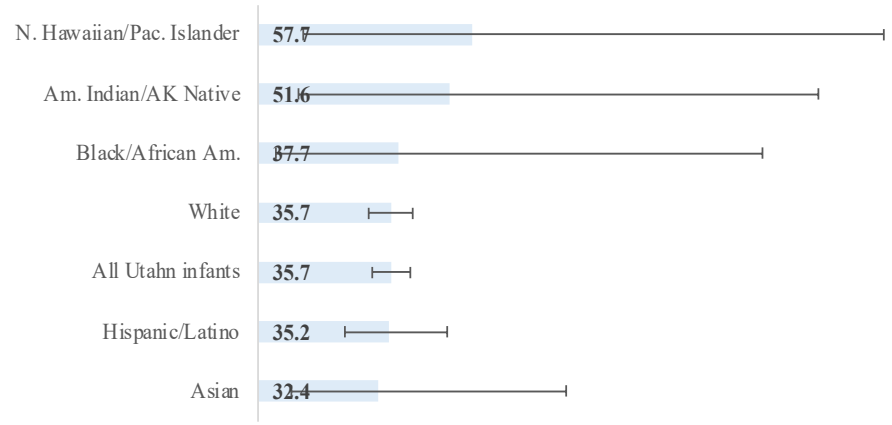
Why is this important?

Critical congenital heart defects (CCHD) affect about 7,200 babies in the United States every year. While many of these babies may be identified by either a prenatal ultrasound or the newborn exam, some of these babies will appear perfectly healthy. Babies diagnosed with CCHDs will require surgery or other treatments within the first year of life. Heart defects that are not immediately detected can lead to serious complications in the first days and weeks of life, often leading to emergency care and increased mortality/poorer outcomes.

How are we doing?

From 2003–2017, the prevalence rate of children diagnosed with a critical congenital heart defect in Utah was 35.7 per 10,000 births.[59] There were no statistically significant differences in the rates by race and ethnicity.

Critical Congenital Heart Defects, Utah, 2003–2017



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. To reduce the occurrence of congenital heart defects among infants in Utah, primary prevention activities must be targeted at people who could become pregnant who are not yet pregnant. These strategies include taking a daily multivitamin with 400mcg of folic acid prior to pregnancy, maintaining a healthy pre-pregnancy weight, controlling blood sugar if diabetic, eating a healthy diet, avoiding alcohol consumption, and smoking. People planning a pregnancy should always consult an obstetric care provider about any medications they may be taking or chronic diseases (e.g., diabetes) they may have. Information on the Utah Birth Defect Network and birth defects can be found at health.utah.gov/ubdn/. Usually, the cause of a congenital heart defect is unknown. Since October 2014, all babies born in Utah are mandated to be screened for Critical Congenital Heart Defects between 24 and 48 hours of birth. More information can be found at health.utah.gov/cchd/.

Utah Critical Congenital Heart Defect Rate, 2003–2017

Race/Ethnicity+	Average Annual # Heart Defects	Average Annual # of Live Births	Crude Rate / 10,000 Live Births	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	185	51,777	35.7	30.6	40.9	n/a
Am. Indian/AK Native	3	581	51.6	10.7	150.9	
Asian	4	1,234	32.4	8.8	83.0	
Black/African Am.	3	520	57.7	11.9	168.6	
N. Hawaiian/Pac. Islander	2	531	37.7	4.6	136.1	
White	114	40,386	35.7	29.8	41.5	
Hispanic/Latina	28	7,965	35.2	23.4	50.8	

+Individuals were classified into only one racial/ethnic category.
Utah Birth Defect Network. Average Annual Live Births Data: Utah Birth Certificate Database.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Down Syndrome

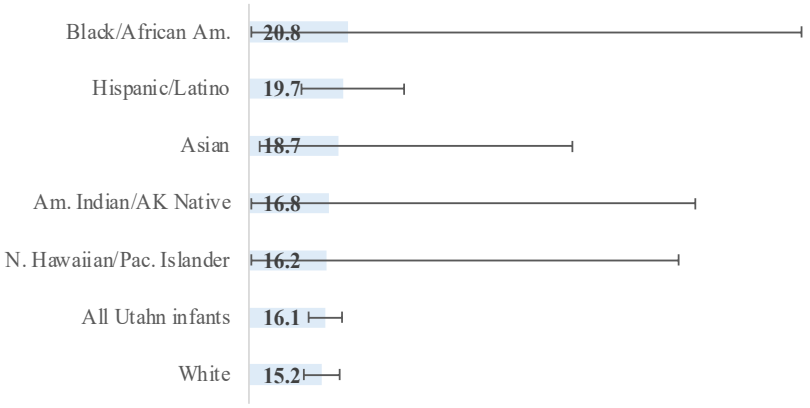
Why is this important?

Down syndrome (Trisomy 21) is the most common chromosomal condition diagnosed in the United States and occurs in one in every 700 infants. The chromosomal change in a Down syndrome diagnosis affects the body and brain development of an infant, which can cause cognitive and physical challenges. A number of health problems can occur in tandem with Down syndrome including; hearing loss, obstructive sleep apnea, ear infections, eye diseases, and heart defects. It is important that infants diagnosed with Down syndrome are provided services early in life to help improve physical and cognitive abilities.

How are we doing?

From 1995–2017, the prevalence rate of Down syndrome was 16.1 per 10,000 births or one in every 660 births. This is higher than the national prevalence rate of 14.0 per 10,000 births. The prevalence rate has remained stable since the UBDN began tracking Down syndrome in 1995. There were no statistically significant differences in the rates by race and ethnicity.

Down Syndrome, Utah, 1999–2017



Number with Down syndrome per 10,000 births

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The American Academy of Pediatrics (AAP) 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 early identification of associated conditions and risk factors for morbidity. With better clinical care and social support, people with Down syndrome are living longer. With appropriate care, people with Down syndrome can expect to live long lives, with varying degrees of independence in the community. Children born with Down syndrome meet the medical eligibility for Early Intervention Services. Information on this program can be found at utahbabywatch.org.

Utah Down Syndrome Rate, 1999–2017

Race/Ethnicity+	Average Annual # With Down Synd.	Average Annual # of Live Births	Crude Rate / 10,000 Live Births	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	82	50,909	16.1	12.6	19.6	n/a
Am. Indian/AK Native	1	596	16.8	0.4	93.5	
Asian	2	1,067	18.7	2.3	67.7	
Black/African Am.	1	482	20.8	0.5	115.6	
N. Hawaiian/Pac. Islander	1	619	16.2	0.4	90.0	
White	61	40,037	15.2	11.4	19.1	
Hispanic/Latina	15	7,604	19.7	11.0	32.5	

+Individuals were classified into only one racial/ethnic category.
Utah Birth Defect Network. Average Annual Live Births Data: Utah Birth Certificate Database.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Neural Tube Defects

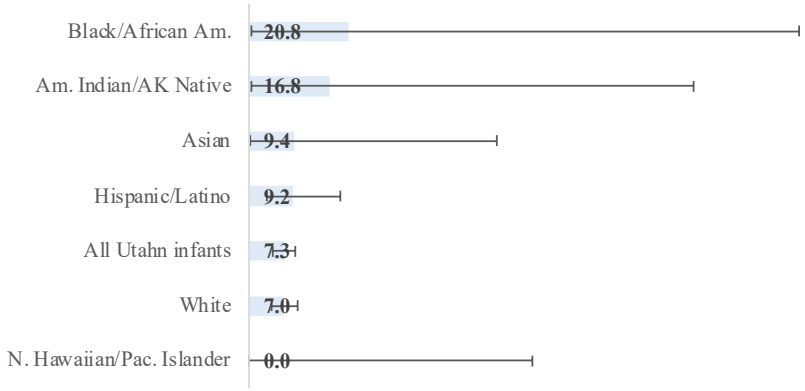
Why is this important?

The neural tube develops the brain and spine and defects occur when the neural tube does not close properly. Because many of these defects develop very early in the pregnancy, people who could become pregnant are encouraged to take 400 mcg of folic acid every day that can help prevent neural tube defects. The Utah Birth Defect Network (UBDN) monitors three neural tube defects: anencephaly, spina bifida without anencephaly, and encephalocele.

How are we doing?

From 1999–2017, the prevalence rate of neural tube defects in Utah was 7.3 per 10,000 live births. There were no statistically significant differences in the rates by race and ethnicity.

Utah Neural Tube Defect (NTD) Rate, 1999–2017



Number of neural tube defects per 10,000 births

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity at every stage of life. To reduce the occurrence of birth defects among infants in Utah, primary prevention activities must be targeted at people who could become pregnant who are not yet pregnant. Improving one's health before becoming pregnant improves the odds of having a healthy baby. Some strategies include taking a daily multivitamin with 400mcg of folic acid prior to pregnancy, maintaining a healthy pre-pregnancy weight, controlling blood sugar if diabetic, eating a healthy diet, avoiding alcohol consumption, and smoking. People planning a pregnancy should always consult an obstetric care provider about any medications they may be taking or chronic diseases (e.g., diabetes) they may have. Information on the UBDN and birth defects can be found at health.utah.gov/ubdn/.

Utah Neural Tube Defect (NTD) Rate, 1999–2017

Race/Ethnicity+	Average Annual # With NTDs	Average Annual # of Live Births	Crude Rate / 10,000 Live Births	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utah infants	37	50,909	7.3	4.9	9.6	n/a
Am. Indian/AK Native	1	596	16.8	0.4	93.5	
Asian	1	1,069	9.4	0.2	52.1	
Black/African Am.	1	482	20.8	0.5	115.6	
N. Hawaiian/Pac. Islander	<1	619	0.0	0.0	59.6	
White	28	40,037	7.0	4.7	10.1	
Hispanic/Latina	7	7,604	9.2	3.7	19.0	

+Individuals were classified into only one racial/ethnic category.
Utah Birth Defect Network. Average Annual Live Births Data: Utah Birth Certificate Database.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Infectious Diseases

UTAH DEPARTMENT OF HEALTH
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Utah Health Status by Race & Ethnicity 2021

Tuberculosis

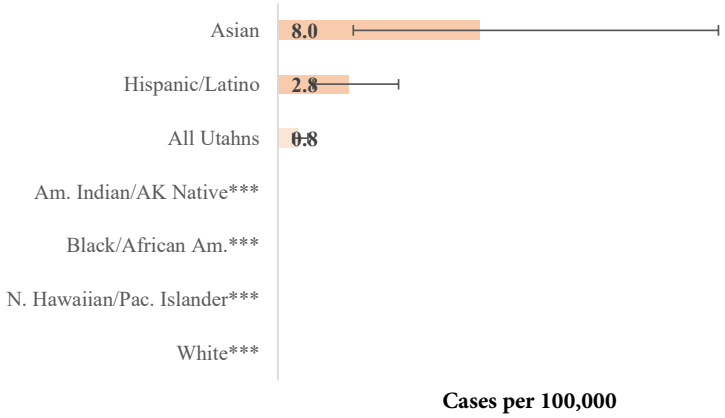
Why is it important?

Tuberculosis (TB) is caused by a type of bacteria called Mycobacterium tuberculosis. TB is typically spread through the air when a person with active TB disease in their lungs coughs or sneezes and someone inhales the tiny airborne particles (droplet nuclei). The bacteria usually attack the lungs but may attack any part of the body. The United States 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 prevent outbreaks.[60]

How are we doing?

From 2015–2019, the rate of tuberculosis cases in Utah was 0.8 per 100,000 Utahns. People who identified as Asian (8.0 per 100,000) and Hispanic/Latino (2.8 per 100,000) had rates significantly higher than all Utahns. People who identified as White, non-Hispanic had a significantly lower (0.1 per 100,000) rate than all Utahns.

Tuberculosis, Utah, 2015–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The UDOH TB Control Program is charged with reducing the incidence of TB disease through timely reporting and treatment. The program also provides screening and preventive therapy for those with TB infection. Utah's 13 local health departments are the front line of TB case management for the state. Their responsibilities include diagnosis of TB infection and active TB disease; treatment of TB infection and active TB disease; ensuring patient adherence to treatment; screening high-risk populations; coordination/referral; and providing culturally-appropriate client education.

Utah Tuberculosis Incidence Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Cases	Average Annual Population	Crude Rate / 100,000	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utahns	26	3,096,850	0.8	0.6	9.6	n/a
Am. Indian/AK Native***	***	29,465	***	***	93.5	
Asian**	6	74,707	8.0	3.0	52.1	↑
Black/African Am.***	***	34,600	***	***	115.6	
N. Hawaiian/Pac. Islander***	***	29,528	***	***	59.6	
White***	***	2,430,802	***	***	10.1	
Hispanic/Latino	12	434,838	2.8	1.4	19.0	↑

+Individuals were classified into only one racial/ethnic category.
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 2019.
**Arrows indicate whether 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 the standard error is greater than 50% or undetermined.*

Chlamydia

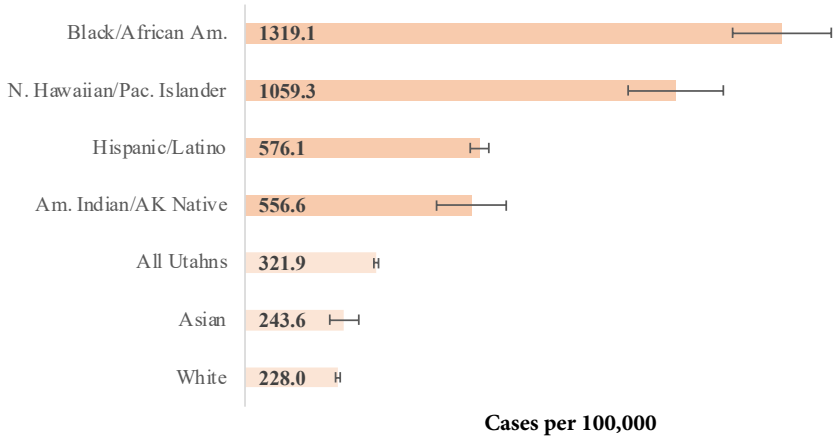
Why is it important?

Infections caused by the bacterium Chlamydia trachomatis are the most frequently reported notifiable disease in Utah, with 11,073 cases reported in 2019. Almost 60 percent of the reported cases were among persons between 15 and 24 years of age. The overall rate for chlamydia in Utah in 2019 was 345.4 cases per 100,000 persons. 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.[61]

How are we doing?

From 2015–2019, there were 321.9 cases of chlamydia per 100,000 Utahns. People who identified as Black/African American (1319.1 per 100,000), Native Hawaiian/Pacific Islander (1059.3 per 100,000), Hispanic/Latino (576.1 per 100,000), and American Indian/Alaska Native (556.6 per 100,000) had rates significantly higher than all Utahns. People who identified as Asian (243.6 per 100,000) and White, non-Hispanic (228.0 per 100,000) had significantly lower rates than all Utahns.

Chlamydia, Utah, 2015–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Persons who test positive for chlamydia are confidentially interviewed by a disease intervention specialist from their LHD to educate the patient, ensure proper treatment, and to obtain sexual partner information for follow up. This process helps prevent diagnosed individuals from spreading the infection and keeps the patient from becoming reinfected. The UDOH HIV and STD Prevention and Surveillance Program, along with LHDs, currently provide STD presentations upon request to a variety of organizations, agencies, and facilities.

Utah Chlamydia Incidence Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Cases	Average Annual Population	Crude Rate / 100,000	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utahns	9,967	3,096,850	321.9	315.5	328.2	n/a
Am. Indian/AK Native	164	29,465	556.6	471.4	641.8	↑
Asian	182	74,707	243.6	208.2	279.0	↓
Black/African Am.	456	34,600	1319.1	1198.1	1440.1	↑
N. Hawaiian/Pac. Islander	313	29,528	1059.3	941.9	1176.7	↑
White	5,543	2,430,802	228.0	222.0	234.0	↓
Hispanic/Latino	2,505	434,838	576.1	553.5	598.6	↑

+Individuals were classified into only one racial/ethnic category.
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 2019.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Gonorrhea

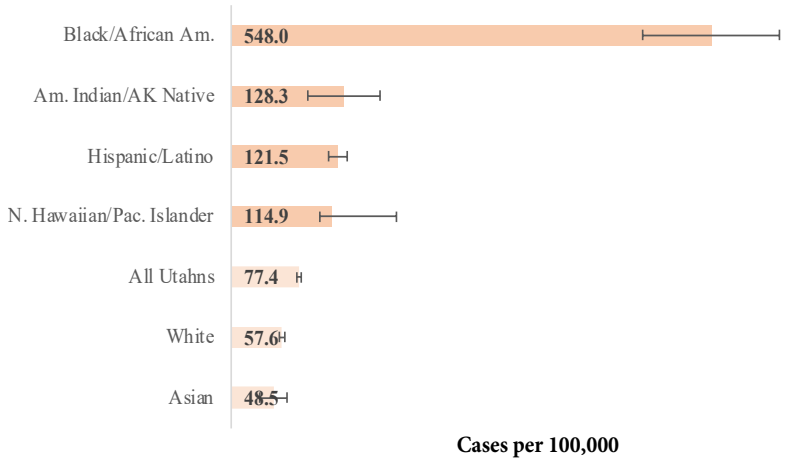
Why is it important?

Gonorrhea, caused by the bacterium Neisseria gonorrhoeae, is a priority public health concern in Utah. Untreated gonorrhea infections can damage reproductive systems. Females with gonorrhea infection are at risk for developing pelvic inflammatory disease (PID), and both men and women may become infertile as a result of untreated gonorrhea infections. 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, potentially resulting in ophthalmia neonatorum. Gonorrhea can spread to joints and become systemic (disseminated gonorrhea). In addition to the cervix and urethra, the rectum and pharynx are also possible sites of gonococcal infection.[62]

How are we doing?

From 2015–2019, there were 77.4 cases of gonorrhea per 100,000 Utahns. People who identified as Black/African American (548.0 per 100,000), Native Hawaiian/Pacific Islander (144.9 per 100,000), Hispanic/Latino (121.5 per 100,000), and American Indian/Alaska Native (128.3 per 100,000) had rates significantly higher than all Utahns. People who identified as White, non-Hispanic (57.6 per 100,000) and Asian (48.5 per 100,000) had significantly lower rates than all Utahns.

Gonorrhea, Utah, 2015–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Persons who test positive for gonorrhea are interviewed by a LHD disease intervention specialist to educate the patient, ensure proper treatment, and to obtain sexual partner information for follow up. This process potentially prevents the spread of infection and reduces the likelihood of the patient becoming reinfected. The CDC currently recommends patients with gonococcal infections be treated a dual antibiotic therapy effective against chlamydia. The UDOH and LHDs, provide STD presentations upon request.

Utah Gonorrhea Incidence Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Cases	Average Annual Population	Crude Rate / 100,000	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utahns	2,396	3,096,850	77.4	74.3	80.5	n/a
Am. Indian/AK Native	38	29,465	128.3	87.4	169.2	↑
Asian	36	74,707	48.5	32.7	64.2	↓
Black/African Am.	190	34,600	548.0	470.0	626.0	↑
N. Hawaiian/Pac. Islander	43	29,528	144.9	101.5	188.4	↑
White	1,399	2,430,802	57.6	54.5	60.6	↓
Hispanic/Latino	528	434,838	121.5	111.1	131.8	↑

+Individuals were classified into only one racial/ethnic category.
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 2019.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Human Immunodeficiency Virus (HIV)

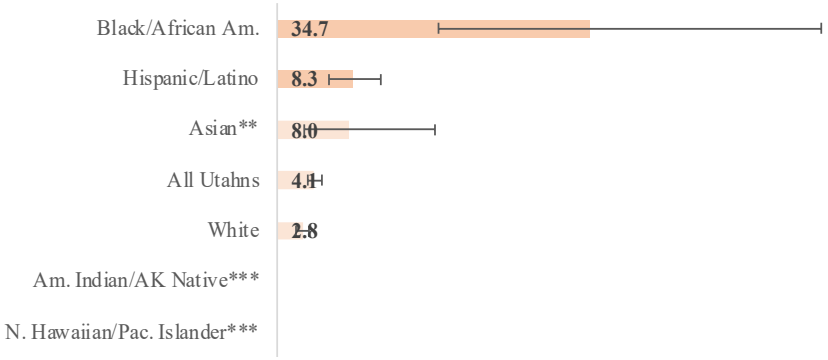
Why is it important?

Human immunodeficiency virus (HIV) is a blood-borne virus. Transmission occurs primarily through sexual contact with an infected person, sharing needles for the injection of drugs, or before, during, or after the birth of children to HIV-infected mothers. No treatment is available to cure HIV, although antiretroviral treatments are available to extend survival among those who are infected with HIV.[63]

How are we doing?

From 2015–2019, there were 4.1 cases of HIV per 100,000 Utahns. People who identified as Black/African American (34.7 per 100,000) and Hispanic/Latino (8.3 per 100,000) had rates significantly higher than all Utahns. People who identified as White, non-Hispanic had significantly lower rates (2.8 per 100,000) than all Utahns.

Human Immunodeficiency Virus (HIV), Utah, 2015–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The UDOH Bureau of Epidemiology has the responsibility of investigating cases of HIV in order to monitor trends in the disease and, whenever possible, interrupt the transmission of HIV. This is done by collecting pertinent demographic information on reported HIV-positive individuals and by conducting follow-up on newly-diagnosed individuals and their partners. Community-based prevention efforts include HIV testing as a part of routine medical care; targeting high-risk populations to get tested; encouraging safer sexual practices; encouraging drug users to get treatment and increase harm reduction practices; and encouraging pregnant women or women considering pregnancy to be tested for HIV.

Utah Human Immunodeficiency Virus (HIV) Incidence Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Cases	Average Annual Population	Crude Rate / 100,000	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utahns	127	3,096,850	4.1	3.4	4.9	n/a
Am. Indian/AK Native***	***	29,465	***	***	***	
Asian**	6	74,707	8.0	3.0	17.5	
Black/African Am.	12	34,600	34.7	17.9	60.6	↑
N. Hawaiian/Pac. Islander***	***	29,528	***	***	***	
White	67	2,430,802	2.8	2.1	3.5	↓
Hispanic/Latino	36	434,838	8.3	5.8	11.5	↑

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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 2019.
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
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Hepatitis C

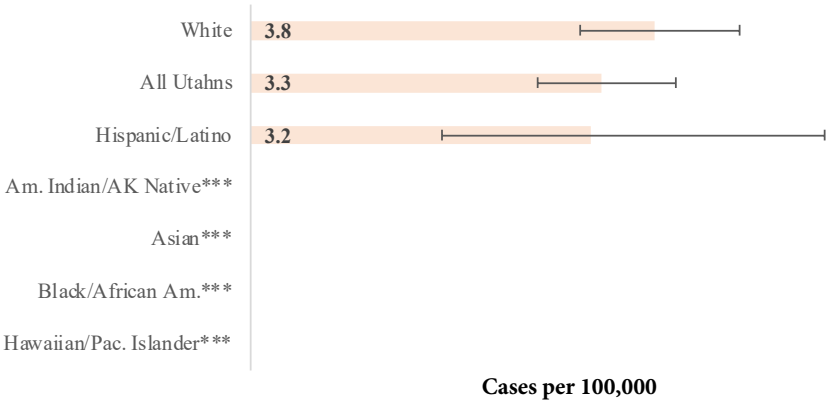
Why is it important?

Hepatitis C virus (HCV) is a bloodborne infectious disease that can cause substantial liver-related morbidity and an increased risk for liver cancer and liver-related death. HCV is predominantly spread via exposure to contaminated blood.[64] The highest risk of HCV transmission is sharing syringes to inject drugs and HCV can be spread by people who have no symptoms.[65] In Utah, acute HCV infections are increasing most rapidly among young people 20–39 years of age, most likely a result of an increase in injection drug use associated with the opioid epidemic.[66]

How are we doing?

From 2015–2020, there were 3.3 cases of acute HVC per 100,000 Utahns. There were no significant differences in acute HVC rates by race or ethnicity.

Acute Hepatitis C, Utah, 2015–2020



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. HCV elimination is possible in Utah and can be achieved through increased harm reduction services, prevention services, and increased access to HCV treatment services. Ongoing efforts are needed to screen and link newly-diagnosed individuals to treatment and harm reduction services, as well as linking previously diagnosed patients to services. Goals of the UDOH Bureau of Epidemiology include data collection and reporting expansion, improved access to clinical and community resources for HCV, better access to HCV screening and linkage to care services, and increased HCV education/awareness. More information can be found at health.utah.gov/epi/diseases/hepatitisC.

Utah Acute Hepatitis C Incidence Rate, 2015-2020

Race/Ethnicity+	Average Annual # of Cases	Average Annual Population	Crude Rate / 100,000	95% CI (Lower)	95% CI (Upper)	Sig. *
All Utahns	103	3,096,850	3.3	2.7	4.0	n/a
Am. Indian/AK Native***	***	29,465	***	***	***	
Asian***	***	74,707	***	***	***	
Black/African Am.***	***	34,600	***	***	***	
N. Hawaiian/Pac. Islander***	***	29,528	***	***	***	
White	92	2,430,802	3.8	3.1	4.6	
Hispanic/Latino	14	434,838	3.2	1.8	5.4	

+Individuals were classified into only one racial/ethnic category.
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 2019.
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UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Injury and Violence

UTAH DEPARTMENT OF HEALTH

Office of Health Disparities

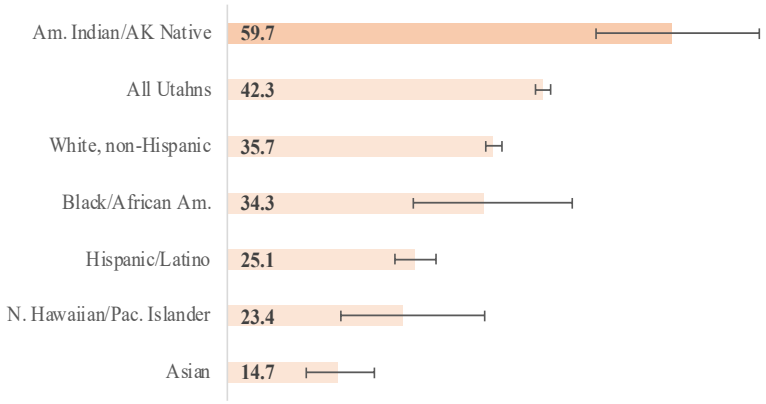
Utah Health Status by Race & Ethnicity 2021

Unintentional Injury Deaths

Why is it important?

In Utah, unintentional injuries are a leading cause of death and disability. They accounted for 1,301 deaths in 2019. Thousands of other injuries are treated in hospitals, doctor's offices, clinics, emergency departments, homes, schools, and work sites. In 2019, the leading causes of unintentional injury death for all ages in Utah were poisoning, falls, motor vehicle traffic crashes, suffocation, and drowning/submersion.[67]

Unintentional Injury Death, Utah, 2015–2019



How are we doing?

From 2015–2019, the age-adjusted rate of death by unintentional injury in Utah was 42.3 per 100,000. People who identified as American Indian/Alaska Native had a significantly higher (59.7 per 100,000) unintentional injury death rate than all Utahns. People who identified as White, non-Hispanic (35.7 per 100,000), Hispanic/Latino (25.1 per 100,000), Native Hawaiian/Pacific Islander (23.4 per 100,000), and Asian (14.7 per 100,000) had significantly lower rates than all Utahns.

How can we improve?

TThe UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. he UDOH VIPP works with several agencies, such as the Utah Department of Public Safety, Primary Children's Medical Center, and the 13 local health departments to further reduce unintentional injury deaths. Most injuries can be prevented by safe behavior choices, safety equipment use, and obeying safety laws. High-priority prevention areas include: poisoning, fall-related injury, motor vehicle crash injury, suffocation, pedestrian injury, and drowning/submersion.[68]

Utah Unintentional Injury Death Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	1,237	3,096,851	39.9 (39.0–41.0)	42.3 (41.3–43.4)	n/a
Am. Indian/AK Native	27	47,758	56.1 (47.0–66.5)	59.7 (49.5–71.4)	↑
Asian	9	78,494	11.5 (8.4–15.3)	14.7 (10.6–19.7)	↓
Black/ African Am.	12	43,489	27.1 (20.7–35.0)	34.3 (24.9–46.2)	
N. Hawaiian/Pac. Islander	6	31,979	20.0 (13.7–28.3)	23.4 (15.2–34.5)	↓
White, non-Hispanic	855	2,430,802	35.2 (34.1–36.2)	35.7 (34.6–36.8)	↓
Hispanic/Latino	90	434,838	20.7 (18.8–22.7)	25.1 (22.5–27.9)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
ICD-10 codes: V01–X59, Y85–86.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Motor Vehicle Traffic Crash Deaths

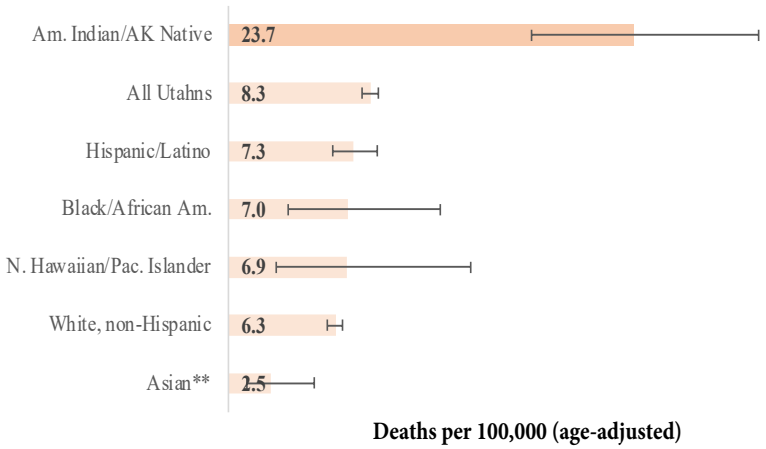
Why is it important?

In Utah during 2019, motor vehicle traffic crashes (MVTCs) accounted for 231 deaths. This was a decrease from 238 deaths in 2018. MVTCs were one of the main injury causes of death.[69]

How are we doing?

The age-adjusted rate of motor vehicle crash deaths in Utah from 2015–2019 was 8.3 deaths per 100,000. People who identified as American Indian/Alaska Native had a significantly higher death rate (23.7 per 100,000) from motor vehicle crashes than all Utahns. People who identified as White, non-Hispanic (6.3 per 100,000), and Asian (2.5 per 100,000) had significantly lower rates than all Utahns.

Motor Vehicle Traffic Crash Death, Utah, 2015–2019



How can we improve?

The VIPP provides funding to the 13 local health departments in Utah to implement motor vehicle safety programs and Safe Kids coalitions/ chapters activities. These programs focus on child 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 state and local agencies to prevent MVTC deaths. Many other partners play a role in the prevention of motor vehicle traffic crash deaths including the Utah Department of Public Safety, Utah Department of Transportation, Utah State Legislature, law enforcement, media, vehicle manufacturers, emergency response, and medical treatment. Further information can be accessed at vipp.health.utah.gov/motor-vehicle-crashes/ and zerofatalities.com/.[70]

Utah Motor Vehicle Traffic Crash Death Rate, 2015-2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	251	3,096,851	8.1 (7.7–8.6)	8.3 (7.8–8.8)	n/a
Am. Indian/AK Native	11	47,758	23.9 (18.1–30.9)	23.7 (17.7–31.0)	↑
Asian**	2	78,494	2.0 (0.9–4.0)	2.5 (1.1–5.0)	↓
Black/ African Am.	3	43,489	6.9 (3.9–11.4)	7.0 (3.5–12.4)	
N. Hawaiian/Pac. Islander**	2	31,979	5.6 (2.6–107)	6.9 (2.8–14.2)	
White, non-Hispanic	150	2,430,802	6.2 (5.8–6.7)	6.3 (5.8–6.7)	↓
Hispanic/Latino	31	434,838	7.2 (6.1–8.4)	7.3 (6.1–8.7)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
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 whether the rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Unintentional Poisoning Deaths

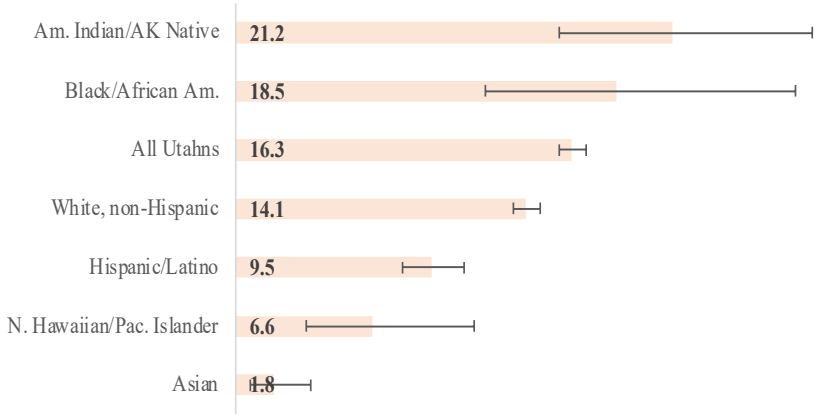
Why is it important?

Drug poisoning deaths are a preventable public health problem. They are the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes. Ten Utah adults die each week from a drug overdose; eight of which are a result of opioids; and four of those eight are due to prescription opioids. Utah is particularly affected by prescription opioids, which are responsible for 41% of the unintentional and undetermined drug poisoning deaths in the state.[71]

How are we doing?

From 2015–2019, the age-adjusted rate of death by unintentional poisoning in Utah was 16.3 per 100,000. People who identify as White, non-Hispanic (14.1 per 100,000), Hispanic/Latino (9.5 per 100,000), Native Hawaiian/Pacific Islander (6.6 per 100,000), and Asian (1.8 per 100,000) had significantly lower rates than all Utahns.

Unintentional Poisoning Deaths, Utah, 2015–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH received funding to address prescription drug abuse, misuse, and overdose deaths by continuing data collection efforts to help target interventions, develop provider materials, increase naloxone awareness, expand public awareness efforts, and develop provider tools and resources to address prescription drug abuse. To address the opioid epidemic in Utah, the UDOH VIPP oversees academic detailing; leads opioid dashboard development; manages Stop the Opidemic, an awareness campaign on opioid abuse and misuse; organizes naloxone dissemination and tracks overdose reversals; and provides funding to LHDs, 2-1-1, and other community partners.[72]

Utah Unintentional Poisoning Death Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	497	3,096,851	16.0 (15.4–16.7)	16.3 (15.7–17.0)	n/a
Am. Indian/AK Native	10	47,758	21.4 (15.9–28.1)	21.2 (15.7–28.0)	
Asian**	1	78,494	1.8 (0.7–3.7)	1.8 (0.7–3.6)	↓
Black/ African Am.	7	43,489	15.2 (10.5–21.3)	18.5 (12.1–27.2)	
N. Hawaiian/Pac. Islander	2	31,979	7.5 (3.9–13.1)	6.6 (3.4–11.6)	↓
White, non-Hispanic	339	2,430,802	13.9 (13.3–14.6)	14.1 (13.5–14.8)	↓
Hispanic/Latino	38	434,838	8.8 (7.6–10.1)	9.5 (8.1–11.1)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
ICD-10 codes: X40–X49
**Arrows indicate whether the rate was higher or lower than for all Utahns.*
*** Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution.*

Deaths by Suicide

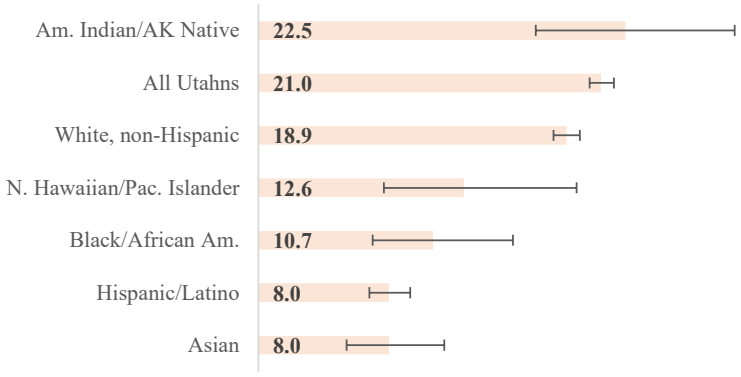
Why is it important?

In 2019, death by suicide was the leading cause of death for Utahns ages 10–17 and 18–24. It is the second leading cause of death for ages 25–44 and the fifth leading cause of death for ages 45–64. Overall, death by suicide is the eighth leading cause of death for Utahns (age-adjusted rate). More people are hospitalized or treated in emergency departments for suicide attempts than are fatally injured. In 2019, 70 Utahns were treated for self-inflicted injuries every day (15,875 treat-and-release emergency department visits plus 9,546 total hospitalizations). Suicidal behavior is a serious and complex public health issue that takes an enormous toll on communities in both economic and human costs.[73]

How are we doing?

From 2015–2019, the age-adjusted death by suicide rate in Utah was 21.0 per 100,000 persons. People who identified as White, non-Hispanic (18.9 per 100,000), Native Hawaiian/Pacific Islander (12.6 per 100,000), Black/African American (10.7 per 100,000), Asian (8.0 per 100,000), and Hispanic/Latino (8.0 per 100,000) had significantly lower rates of death by suicide than all Utahns.

Deaths by Suicide, Utah, 2015–2019



Deaths per 100,000 (age-adjusted)

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH VIPP is funded by the CDC to implement the UTVDRS. UTVDRS is a data collection and monitoring system to help Utahns better understand the public health problem of violence by informing decision-makers about the magnitude, trends, and characteristics of violent deaths such as death by suicide, and to evaluate and continue to improve state-based violence prevention policies and programs. The CDC also provides funding for VIPP to improve the timeliness of syndromic surveillance data of nonfatal suicide-related outcomes, including nonfatal self-directed violence, and suicidal ideation. The VIPP also participates in the Utah Suicide Prevention Coalition, a state level multi-sectoral group, and its seven workgroups that focus on specific populations and topic areas.[74]

Utah Death by Suicide Rate, 2015–2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	641	3,096,851	20.7 (20.0–21.4)	21.0 (20.3–21.8)	n/a
Am. Indian/AK Native	12	47,758	24.7 (18.8–31.9)	22.5 (17.0–29.2)	
Asian	6	78,494	7.9 (5.4–11.2)	8.0 (5.4–11.4)	↓
Black/ African Am.	5	43,489	12.4 (8.2–18.1)	10.7 (7.0–15.6)	↓
N. Hawaiian/Pac. Islander	4	31,979	13.1 (8.1–20.1)	12.6 (7.7–19.5)	↓
White, non-Hispanic	455	2,430,802	18.7 (17.9–19.5)	18.9 (18.1–19.7)	↓
Hispanic/Latino	36	434,838	8.2 (7.1–9.5)	8.0 (6.8–9.3)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
*ICD-10 codes X60–X84, Y87.0, *U03*
**Arrows indicate whether the rate was higher or lower than for all Utahns.*

Chronic Diseases and Conditions

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Utah Health Status by Race & Ethnicity 2021

Fair or Poor Health

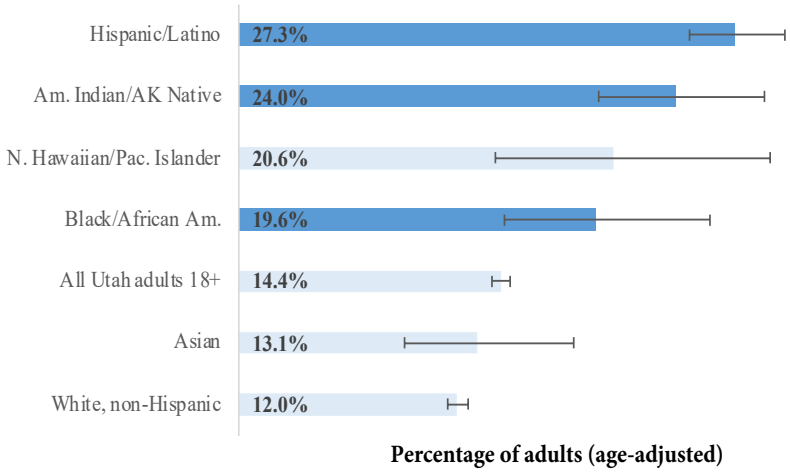
Why is it important?

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.[75]

How are we doing?

From 2017–2019, the age-adjusted rate of Utah adults who reported fair or poor general health status was 14.4%. Adults who identified as Hispanic/Latino (27.3%), American Indian/ Alaska Native (24.0%), and Black/African American (19.6%) had significantly higher rates of fair or poor health than all Utah adults. Adults who identified as White, non-Hispanic had significantly lower rates of self-reported fair or poor health (12.0%) than all Utah adults.

Fair or Poor Health, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. A comprehensive approach to address racial and ethnic health disparities must include individual, community, and place-based, and system-based interventions that are culturally and linguistically responsive. As the Utah State Office of Minority Health, the UDOH OHD works with programs across the department to address racial and ethnic health disparities and advance health equity in Utah. OHD reports and resources are available at health.utah.gov/dispairites.

Percentage of Utah Adults Reporting Fair or Poor Health, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With Fair/ Poor Health	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,505	2,227,221	316,265	14.2% (13.7–14.7%)	14.4% (13.9–14.9%)	n/a
Am. Indian/AK Native	558	24,240	5,793	23.9% (19.6–28.8%)	24.0% (19.8–28.9%)	↑
Asian	373	62,151	7,272	11.7% (8.2–16.3%)	13.1% (9.1–18.4%)	
Black/ African Am.	260	25,121	4,748	18.9% (14.0–25.1%)	19.6% (14.6–25.9%)	↑
N. Hawaiian/Pac. Islander	180	20,411	3,368	16.5% (11.1–23.7%)	20.6% (14.1–29.2%)	
White, non-Hispanic	17,658	1,777,166	216,814	12.2% (11.6–12.8%)	12.0% (11.5–12.6%)	↓
Hispanic/Latino	1,791	283,231	68,542	24.2% (21.9–26.7%)	27.3% (24.8–30.0%)	↑

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Poor Physical Health Status

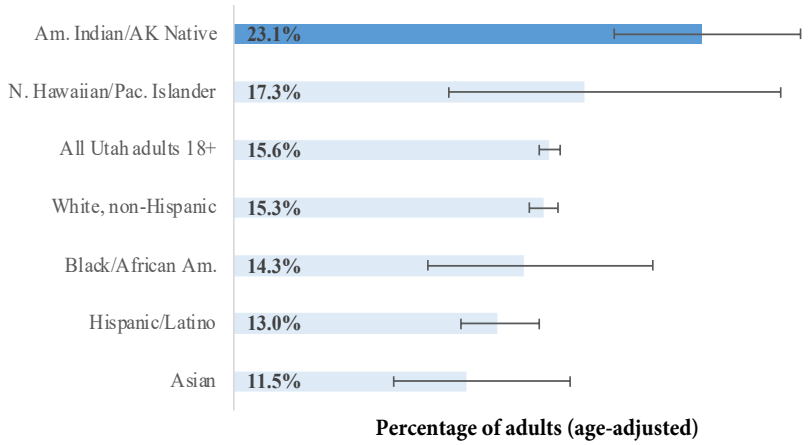
Why is it important?

General physical health status is the culmination of all the things that affect a person's health. A person may have had poor health because of an injury, an acute infection such as a cold or flu, or a chronic health problem. This measure can be used to identify health disparities, track population trends, plan public health programs, and measure progress toward several Healthy People 2030 goals.[76]

How are we doing?

From 2017–2019, 15.6% of Utah adults reported poor physical health status (age-adjusted rate). Adults who identified as American Indian/Alaska Native had a significantly higher rate of self-reported poor physical health (23.1%) than all Utah adults. Adults who identified as Hispanic/Latino had a significantly lower rate of self-reported poor physical health (13.0%) than all Utah adults.

Poor Physical Health Status, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. A comprehensive approach to address racial and ethnic health disparities must include individual, community, and place-based and system-based interventions that are culturally and linguistically responsive. As the Utah State Office of Minority Health, the UDOH OHD works with programs across the department to address racial and ethnic health disparities and advance health equity in Utah. OHD reports and resources are available at health.utah.gov/dispairites.

Percentage of Utah Adults Reporting 7+ Days When Physical Health Was Not Good in the Past Month, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With Fair/ Poor Physical Health	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	31,996	2,227,221	345,219	15.5% (15.0–16.0%)	15.6% (15.1–16.1%)	n/a
Am. Indian/AK Native	537	24,240	5,527	22.8% (18.5–27.7%)	23.1% (18.8–28.0%)	↑
Asian	370	62,151	7,147	11.5% (8.1–16.0%)	11.5% (7.9–16.6%)	
Black/ African Am.	255	25,121	2,964	11.8% (7.9–17.3%)	14.3% (9.6–20.7%)	
N. Hawaiian/Pac. Islander	178	20,411	2,755	13.5% (8.6–20.6%)	17.3% (10.6–27.0%)	
White, non-Hispanic	17,404	1,777,166	271,906	15.3% (14.7–16.0%)	15.3% (14.6–16.0%)	
Hispanic/Latino	1,752	283,231	32,855	11.6% (9.9–13.5%)	13.0% (11.2–15.1%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Poor Mental Health Status

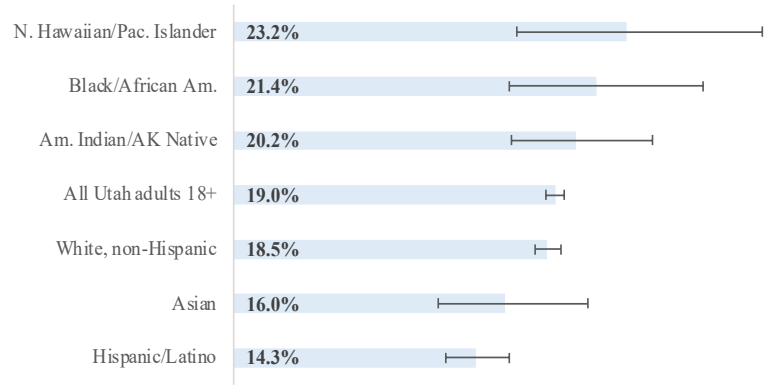
Why is it important?

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 US 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.[77]

How are we doing?

From 2017–2019, 19.0% of Utah adults reported seven or more days in the past 30 days when their mental health was not good (age-adjusted rate). Adults who identified as Hispanic/Latino had a significantly lower rate (14.3%) than all Utah adults.

Poor Mental Health Status, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The Utah DSAMH is the state agency responsible for ensuring mental health services are available statewide. The Division also provides general information, research results, and statistics to the public regarding substance abuse and mental health services. The Division contracts with community mental health centers (CMHC) to provide these services and monitors these centers through site visits, a year-end review process, and a peer review process. The UDOH VIPP has partnered with the DSAMH to facilitate the Suicide Prevention Coalition and Suicide Fatality Reviews. In addition, six LHDs (Bear River, Davis, Summit, Tooele, Utah, Weber-Morgan) have been funded to do suicide prevention activities.

Percentage of Utah Adults Reporting 7+ Days When Mental Health Was Not Good in the Past Month, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With Fair/ Poor Mental Health	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,104	2,227,221	434,308	19.5% (18.9–20.1%)	19.0% (18.4–19.5%)	n/a
Am. Indian/AK Native	548	24,240	5,090	21.0% (16.9–25.8%)	20.2% (16.4–24.7%)	
Asian	370	62,151	12,182	19.6% (15.0–25.3%)	16.0% (12.1–20.9%)	
Black/ African Am.	256	25,121	5,878	23.4% (17.8–30.2%)	21.4% (16.3–27.7%)	
N. Hawaiian/Pac. Islander	177	20,411	6,082	29.8% (21.4–39.7%)	23.2% (16.7–31.2%)	
White, non-Hispanic	17,469	1,777,166	330,553	18.6% (17.8–19.4%)	18.5% (17.8–19.3%)	
Hispanic/Latino	1,764	283,231	43,051	15.2% (13.4–17.2%)	14.3% (12.5–16.3%)	↓

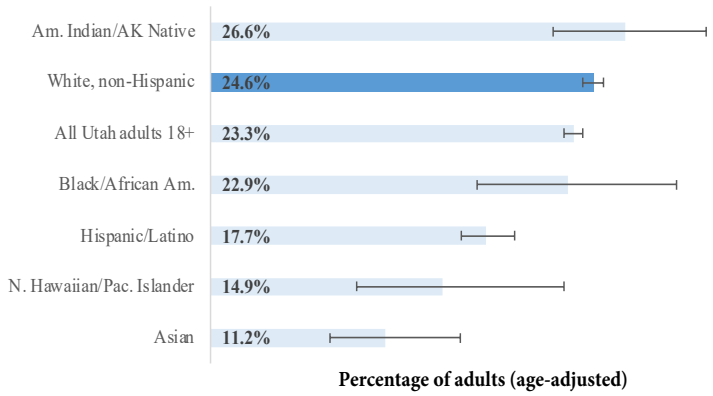
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Major Depression

Why is it important?

Approximately 20.6% of adults in the US experienced some kind of mental illness during 2019. Of all mental illnesses, depression is the most common disorder, with 7.1% of adults suffering from at least one episode of major depression in 2017. 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.[78]

Major Depression, Utah, 2017–2019



How are we doing?

From 2017–2019, the age-adjusted rate of major depression among Utah adults was 23.3%. Adults who identified as Hispanic/Latino (17.7%), Native Hawaiian/Pacific Islander (14.9%), and Asian (11.2%) had significantly lower rates of major depression than all Utah adults. Adults who identified as White, non-Hispanic had a significantly higher rate (24.6%) than all Utah adults.

How can we improve?

TThe UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life.The Utah DSAMH is the state agency responsible for ensuring mental health services are available statewide. DSAMH provides general information, research results, and statistics to the public on substance abuse and mental health services. DSAMH contracts with community mental health centers (CMHC) to provide these services and monitors these centers through site visits, a year-end review process, and a peer review process. The UDOH VIPP partnered with DSAMH for the Suicide Prevention Coalition and Suicide Fatality Reviews. In addition, six funded LHDs do suicide prevention activities.

Percentage of Utah Adults Who Have Ever Reported Having Depression, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With Depression	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,429	2,227,221	518,942	23.3% (22.7–23.9%)	23.3% (22.7–23.9%)	n/a
Am. Indian/AK Native	556	24,240	6,424	26.5% (21.9–31.6%)	26.6% (22.0–31.8%)	
Asian	372	62,151	8,266	13.3% (9.6–18.2%)	11.2% (7.7–16.0%)	↓
Black/ African Am.	258	25,121	5,602	22.3% (16.7–29.0%)	22.9% (17.1–29.9%)	
N. Hawaiian/Pac. Islander	180	20,411	3,511	17.2% (10.9–26.2%)	14.9% (9.4–22.7%)	↓
White, non-Hispanic	27,680	1,777,166	435,406	24.5% (23.8–25.1%)	24.6% (23.9–25.2%)	↑
Hispanic/Latino	2,789	283,231	51,265	18.1% (16.5–19.9%)	17.7% (16.1–19.5%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Arthritis Prevalence

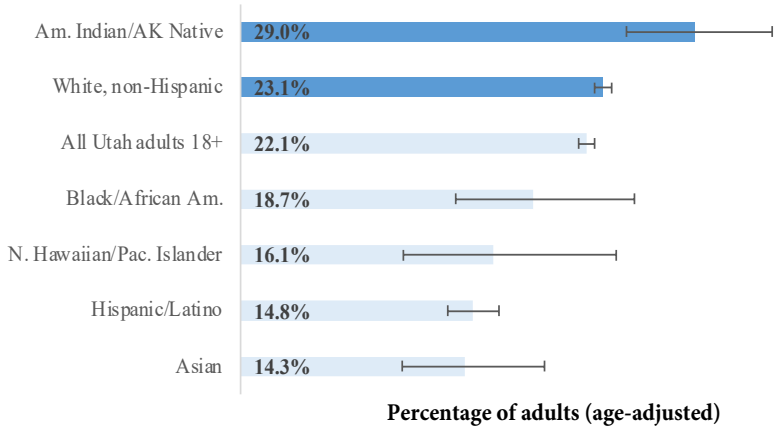
Why is it important?

Arthritis affects 54 million adults (one in every four) in the US and is projected to increase. Arthritis is a leading cause of disability and is associated with substantial activity limitation, work disability, and reduced quality of life. In 2019, the percentage of Utah adults aged 18 and older with arthritis was 23.1 percent (crude rate). This represents approximately 525,473 individuals based on the estimated Utah population 18 and older for 2019.[79]

How are we doing?

From 2017–2019, the age-adjusted percentage of Utah adults who reported their doctor or other health care professional had told them they had arthritis was 22.1%. Adults who identified as American Indian/Alaska Native (29.0%) and White, non-Hispanic (23.1%) had significantly higher rates of arthritis than all Utah adults. Adults who identified as Hispanic/Latino (14.8%) and Asian (14.3%) had significantly lower rates of arthritis than all Utah adults.

Arthritis Prevalence, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH Arthritis Program measures the occurrence of arthritis in Utah, works to increase arthritis awareness and educational opportunities, and promotes participation in programs proven to help persons with arthritis, pain, and other chronic conditions.

Percentage of Utah Adults with Arthritis, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With Arthritis	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,409	2,227,221	476,625	21.4% (20.9–21.9%)	22.1% (21.6–22.6%)	n/a
Am. Indian/AK Native	554	24,240	6,787	28.0% (23.3–33.2%)	29.0% (24.6–33.9%)	↑
Asian	373	62,151	5,159	8.3% (5.9–11.7%)	14.3% (10.3–19.4%)	↓
Black/ African Am.	260	25,121	3,366	13.4% (9.5–18.6%)	18.7% (13.7–25.1%)	
N. Hawaiian/Pac. Islander	178	20,411	1,939	9.5% (6.0–14.6%)	16.1% (10.4–24.0%)	
White, non-Hispanic	27,655	1,777,166	415,857	23.4% (22.8–24.0%)	23.1% (22.6–23.7%)	↑
Hispanic/Latino	2,791	283,231	32,572	11.5% (10.2–12.9%)	14.8% (13.2–16.5%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
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Asthma Prevalence

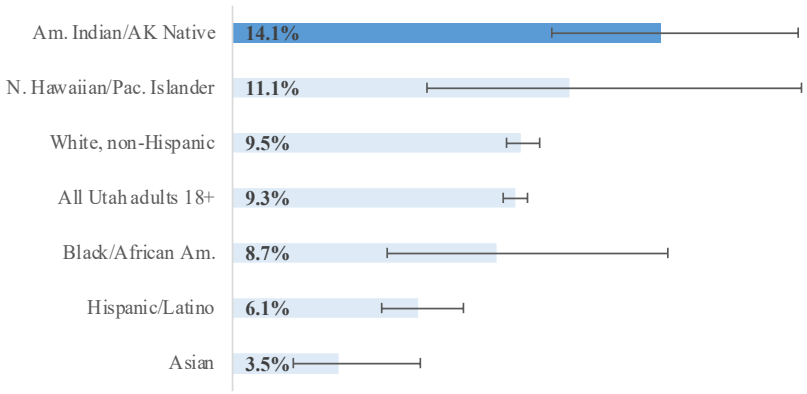
Why is it important?

Asthma is a serious personal and public health issue with 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.[80]

How are we doing?

From 2017–2019, 9.3% of Utah adults reported currently having asthma (age-adjusted rate). Adults who identified as American/Indian/Alaska Native had significantly higher rates of current asthma (14.1%) than all Utah adults. Adults who identified as Asian (3.5%) and Hispanic/Latino (6.1%) had significantly lower rates of current asthma than all Utah adults.

Asthma Prevalence, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible for all Utahns of every race and ethnicity. The UDOH Utah Asthma Program (UAP) works with the Utah Asthma Task Force and other partners to maximize the reach, impact, efficiency, and sustainability of comprehensive asthma control services in Utah. The UAP builds program infrastructure and implements strategies to improve asthma control, reduce asthma-related emergency department visits and hospitalizations, and reduce health care costs. More information can be found at health.utah.gov/asthma.

Percentage of Utah Adults Who Reported Having Asthma, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With Asthma	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,297	2,227,221	209,359	9.4% (9.0–9.8%)	9.3% (8.9–9.7%)	n/a
Am. Indian/AK Native	555	24,240	3,418	14.1% (10.5–18.8%)	14.1% (10.5–18.6%)	↑
Asian	374	62,151	2,300	3.7% (2.1–6.6%)	3.5% (2.0–6.2%)	↓
Black/ African Am.	258	25,121	1,784	7.1% (4.3–11.5%)	8.7% (5.1–14.3%)	
N. Hawaiian/Pac. Islander	178	20,411	2,204	10.8% (5.8–19.1%)	11.1% (6.4–18.7%)	
White, non-Hispanic	17,560	1,777,166	170,608	9.6% (9.1–10.2%)	9.5% (9.0–10.1%)	
Hispanic/Latino	1,784	283,231	17,277	6.1% (4.9–7.5%)	6.1% (4.9–7.6%)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Chronic Obstructive Pulmonary Disease (COPD)

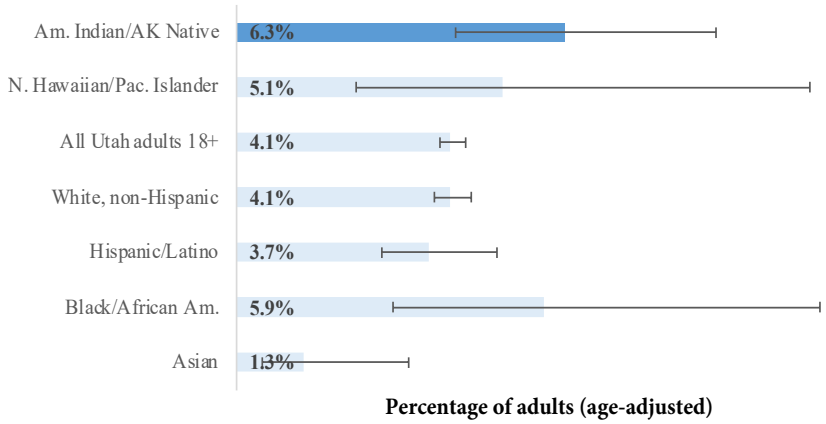
Why is it important?

Chronic Obstructive Pulmonary Disease (COPD) is a large group of lung diseases characterized by airflow obstruction and often associated with symptoms related to difficulty in breathing, but can be present without any symptoms. The most important and frequent conditions in COPD are chronic bronchitis and emphysema, but it also includes other diagnoses. Chronic lower respiratory disease, primarily COPD, was the third leading cause of death in the United States in 2014. Almost 15.7 million in the US (6.4%) reported they have been diagnosed with COPD. However, it is commonly accepted that COPD is frequently underdiagnosed, so the actual number may be higher.[81]

How are we doing?

From 2017–2019, 4.1% of Utah adults reported having COPD (age-adjusted rate). Adults who identified as American Indian/Alaska Native (6.3%) had significantly higher rates of COPD than all Utah adults. Adults who identified as Asian had significantly lower rates (1.3%) than all Utah adults.

COPD Prevalence, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. While smoking is the primary cause of COPD, air pollution can play a substantial role in causing the disease and in worsening the symptoms. The UDOH TPCP and its partners use comprehensive programs to prevent young people from starting to use tobacco, help tobacco users quit, promote tobacco-free environments, and reduce tobacco-related disparities. The UDOH Environmental Epidemiology Program provides data and support on how health and the environment are connected. The Utah Division of Air Quality (DAQ), works to safeguard and improve Utah's air, land, and water through balanced regulation.[82]

Percentage of Utah Adults Who Reported Having COPD, 2017–2019

Race/Ethnicity+	Sample Size	Average Annual 18+ Population	# With COPD	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,448	2,227,221	91,316	4.1% (3.8–4.3%)	4.1% (3.9–4.4%)	n/a
Am. Indian/AK Native	557	24,240	1,479	6.1% (4.1–9.1%)	6.3% (4.2–9.2%)	↑
Asian**	371	62,151	497	0.8% (0.3–2.1%)	1.3% (0.5–3.3%)	↓
Black/ African Am.**	260	25,121	1,181	4.7% (2.5–8.6%)	5.9% (3.0–11.2%)	
N. Hawaiian/Pac. Islander**	179	20,411	592	2.9% (1.4–5.9%)	5.1% (2.3–11.0%)	
White, non-Hispanic	17,642	1,777,166	72,864	4.1% (3.8–4.5%)	4.1% (3.8–4.5%)	
Hispanic/Latino	1,794	283,231	9,630	3.4% (2.5–4.6%)	3.7% (2.8–5.0%)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether 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.*

Diabetes Prevalence

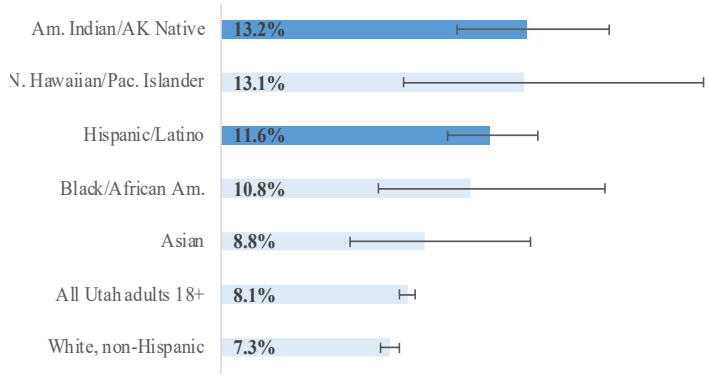
Why is it important?

More than 180,000 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. It is also the leading cause of blindness among adults younger than 75. It is one of the leading causes of heart disease. Diabetes places an enormous burden on health care resources. Nationally, approximately $245 billion is spent annually: $176 billion in direct medical costs and $69 billion in indirect medical costs (disability, work loss, and premature death). In Utah, more than a billion dollars each year is spent on direct and indirect medical costs of diabetes. Currently, about 80 million people in the US aged 20 and older have prediabetes, a condition that puts them at high risk for developing diabetes. For many individuals, taking small steps, such as losing 5-7 percent of their weight or increasing physical activity, can help them delay or prevent developing diabetes.[83]

How are we doing?

From 2017–2019, 8.1% of Utah adults reported they had been diagnosed with diabetes by a doctor (age-adjusted rate). Adults who identified as American Indian/ Alaska Native (13.2%) and Hispanic/Latino (11.6%) had significantly higher rates of diabetes than all Utah adults. Adults who identified as White, non-Hispanic had significantly lower rates (7.3%) than all Utahns.

Diabetes Prevalence, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH EPICC is organized around four domains: epidemiology and surveillance, policy and environment, health systems, and community clinical linkages. It's primary program strategies include increased healthy nutrition and physical activity environments in K-12 schools, early care and education, and worksites as well as increased awareness, improved quality of medical care, and increased access and availability of community health programs. The EPICC Program promotes diabetes education throughout the state and encourages people with diabetes to enroll in a diabetes self-management education class.

Percentage of Utah Adults Who Reported Having Diabetes, 2017–2019

Race/Ethnicity	Sample Size	Average Annual 18+ Population	# With Diabetes	Crude Rate (95% CI)	Age-adjusted Rate (95% CI)	Sig. *
All Utah adults 18+	32,554	2,227,221	173,723	7.8% (7.5–8.2%)	8.1% (7.7–8.4%)	n/a
Am. Indian/AK Native	557	24,240	2,982	12.3% (9.6–15.7%)	13.2% (10.2–16.8%)	↑
Asian	375	62,151	2,735	4.4% (2.7–7.0%)	8.8% (5.6–13.4%)	
Black/ African Am.	260	25,121	1,859	7.4% (4.5–11.8%)	10.8% (6.8–16.6%)	
N. Hawaiian/Pac. Islander	181	20,411	1,490	7.3% (4.1–12.8%)	13.1% (7.9–20.9%)	
White, non-Hispanic	17,686	1,777,166	133,287	7.5% (7.1–8.0%)	7.3% (6.9–7.7%)	↓
Hispanic/Latino	1,798	283,231	24,641	8.7% (7.3–10.5%)	11.6% (9.8–13.7%)	↑

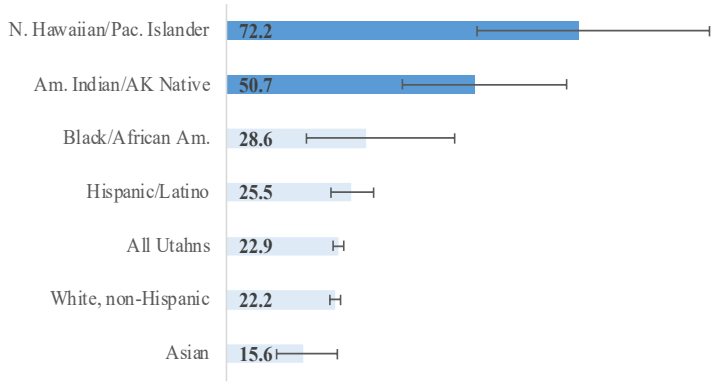
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah BRFSS, Office of Public Health Assessment, UDOH.
Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Diabetes Death

Why is it important?

Diabetes is a leading cause of disability and death and the seventh leading cause of death in the US.[84] More than 180,000 Utahns have been diagnosed with diabetes. Diabetes can have devastating consequences. It is the leading cause of non-traumatic lower-extremity amputation and renal failure. It is the leading cause of blindness among adults younger than 75 and is one of the leading causes of heart disease. Diabetes places an enormous burden on health care resources. In Utah, more than a billion dollars each year is spent on direct and indirect medical costs for diabetes. Currently, about 80 million people in the US aged 20 and older have prediabetes, a condition that puts them at high risk for developing diabetes. For many individuals, taking small steps, such as losing five to seven percent of their weight or increasing physical activity, can help them delay or prevent developing diabetes.[85]

Diabetes Death, Utah, 2017–2019



How are we doing?

From 2017–2019, the age-adjusted diabetes death rate was 22.9 per 100,000 population. Adults who identified as American Indian/Alaska Native (50.7 per 100,000) and Native Hawaiian/Pacific Islander (72.2 per 100,000) had significantly higher diabetes death rates than all Utah adults. Adults who identified as Asian had significantly lower rates (15.6 per 100,00) than all Utah adults.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH EPICC is organized around four domains: epidemiology and surveillance, policy and environment, health systems, and community clinical linkages. It's primary program strategies include increased healthy nutrition and physical activity environments in K-12 schools, early care and education, and worksites as well as increased awareness, improved quality of medical care, and increased access and availability of community health programs. The EPICC Program promotes diabetes education throughout the state and encourages people with diabetes to enroll in a diabetes self-management education class.

Utah Diabetes Death Rate, 2017–2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	639	3,153,517	20.3 (19.4–21.2)	22.9 (21.9–23.9)	n/a
Am. Indian/AK Native	14	48,739	28.0 (20.1–38.0)	50.7 (35.9–69.5)	↑
Asian	9	82,244	11.4 (7.5–16.4)	15.6 (10.3–22.6)	↓
Black/ African Am.	6	45,575	13.9 (8.4–21.7)	28.6 (16.3–46.7)	
N. Hawaiian/Pac. Islander	14	32,968	42.5 (30.6–57.4)	72.2 (51.3–98.8)	↑
White, non-Hispanic	544	2,463,707	22.1 (21.0–23.2)	22.2 (21.1–23.3)	
Hispanic/Latino	51	449,018	11.4 (9.6–13.3)	25.5 (21.4–30.1)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Coronary Heart Disease Death

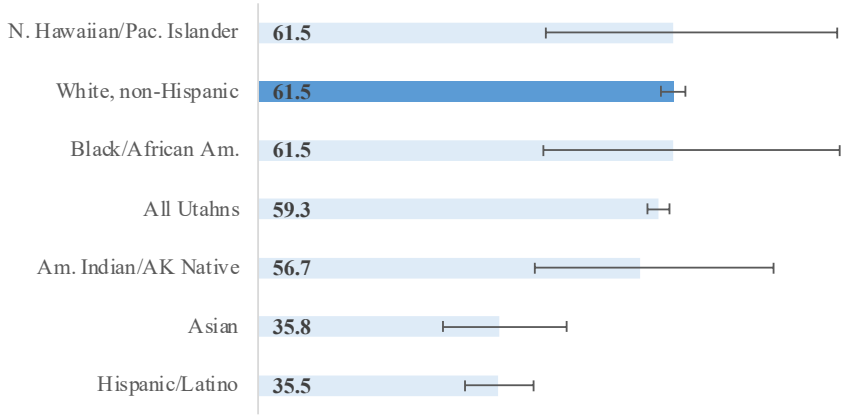
Why is it important?

Coronary heart disease (CHD) is a condition that reduces blood flow to the heart. When the coronary arteries become narrowed or clogged, an inadequate amount of blood oxygen reaches the heart tissue. Prevention of CHD is key to reducing mortality from heart disease.[86]

How are we doing?

From 2017–2019, the age-adjusted Utah coronary heart disease death rate was 59.3 per 100,000 population. People who identified as Asian (35.8 per 100,000) and Hispanic/Latino (35.5 per 100,000) had significantly lower rates of coronary heart disease death than all Utahns. People who identified as White, non-Hispanic had significantly higher rates of CHD than all Utahns.

Coronary Heart Disease Death, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The UDOH EPICC has four domains: epidemiology and surveillance, policy and environment, health systems, and community clinical linkages. It's primary program strategies include increased healthy nutrition and physical activity environments in K-12 schools, early care and education, and worksites as well as increased awareness, improved quality of medical care, and increased access and availability of community health programs. EPICC to reduce the incidence of stroke by targeting risk factors including obesity reduction, increased physical activity and nutritious food consumption, and improved hypertension control. Million Hearts is an initiative to prevent one million cardiovascular events in the US in five years. More information is available at millionhearts.hhs.gov.

Utah Coronary Heart Disease Death Rate, 2017–2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	1,649	3,153,517	52.3 (50.9–53.8)	59.3 (57.7–61.0)	n/a
Am. Indian/AK Native	15	48,739	31.5 (23.0–42.0)	56.7 (41.0–76.4)	
Asian	22	82,244	26.3 (20.3–33.4)	35.8 (27.5–45.8)	↓
Black/ African Am.	13	45,575	28.5 (20.3–39.0)	61.5 (42.3–86.3)	
N. Hawaiian/Pac. Islander	13	32,968	38.4 (27.2–52.7)	61.5 (42.7–85.9)	
White, non-Hispanic	1,511	2,463,707	61.3 (59.6–63.1)	61.5 (59.7–63.3)	↑
Hispanic/Latino	73	449,018	16.2 (14.1–18.5)	35.5 (30.7–40.8)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Stroke Deaths

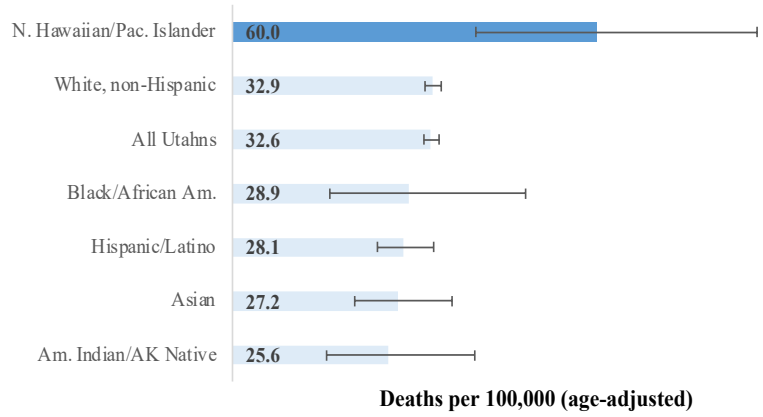
Why is it important?

In the US there are more than 140,000 deaths due to stroke each year. Stroke, the death of brain tissue usually resulting from artery blockage, was the fifth leading cause of death in Utah in 2018. There were 919 deaths with stroke as the underlying cause of death in the state. [87]

How are we doing?

From 2017–2019, Utah's age-adjusted stroke death rate was 32.6 per 100,000. People who identified as Native Hawaiian/Pacific Islander had a significantly higher rate of stroke death (60.0 per 100,000) than all Utahns.

Stroke Deaths, Utah, 2017–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The UDOH EPICC Program is organized around four domains: epidemiology and surveillance, policy and environment, health systems, and community clinical linkages. It's primary program strategies include increased healthy nutrition and physical activity environments in K-12 schools, early care and education, and worksites as well as increased awareness, improved quality of medical care, and increased access and availability of community health programs. The EPICC Program aims to reduce the incidence of stroke by targeting risk factors including obesity reduction, increased physical activity and nutritious food consumption, and improved hypertension control. At a national level, the US Department of Health and Human Services (HHS) established Million Hearts. Million Hearts is an initiative to prevent one million cardiovascular events in the US in five years. This initiative is co-led by the CDC and the Centers for Medicare & Medicaid Services (CMS). More information is available at millionhearts.hhs.gov.

Utah Stroke Death Rate, 2017–2019

Race/Ethnicity+	Average Annual # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	906	3,153,517	28.7 (27.7–29.8)	32.6 (31.4–33.9)	n/a
Am. Indian/AK Native	7	48,739	14.4 (8.9–22.0)	25.6 (15.5–39.9)	
Asian	16	82,244	19.5 (14.3–25.8)	27.2 (20.0–36.2)	
Black/ African Am.	5	45,575	11.7 (6.7–19.0)	28.9 (16.0–48.3)	
N. Hawaiian/Pac. Islander	10	32,968	30.3 (20.5–43.3)	60.0 (40.0–86.4)	↑
White, non-Hispanic	814	2,463,707	33.0 (31.7–34.4)	32.9 (31.6–34.3)	
Hispanic/Latino	53	449,018	28.7 (27.7–29.8)	28.1 (23.8–33.1)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Cancer

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

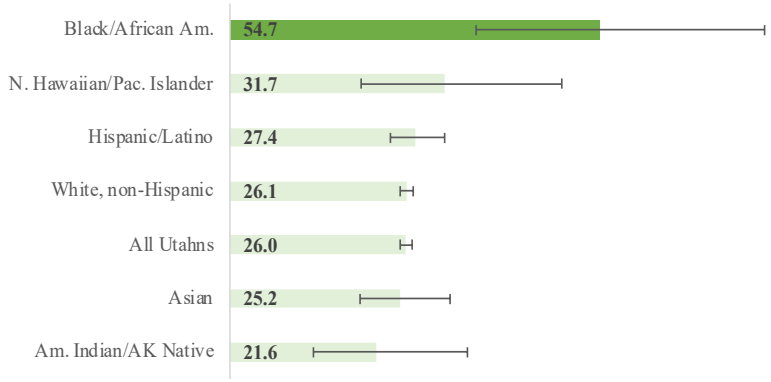
Utah Health Status by Race & Ethnicity 2021

Invasive Lung Cancer Incidence

Why is it important?

Lung cancer is the leading cause of cancer-related death in Utah and the US Because symptoms often do not appear until the disease is advanced, early detection of this cancer is difficult. Cigarette smoking is the single most important risk factor for lung cancer. There are more than 80 carcinogens in cigarette smoke. 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 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.[88]

Invasive Lung Cancer Incidence, Utah, 2014–2018



How are we doing?

From 2014–2018, the overall lung cancer incidence rate (age-adjusted) in Utah was 26.0 per 100,000 persons. People who identified as Black/African American had a significantly higher rate (54.7 per 100,000) than all Utahns.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Since nearly 90% of lung cancer deaths can be attributed to smoking, public health programs to reduce lung cancer focus on tobacco prevention and control. UDOH TPCP coordinates efforts to accomplish the following four goals: prevent youth from starting to use tobacco, help tobacco users quit, eliminate exposure to secondhand smoke, and reduce tobacco-related disparities. The UDOH also initiated the UCAN whose mission is to lower cancer incidence and mortality in Utah through collaborative efforts directed toward cancer prevention and control. As a result of this planning process, objectives and strategies have been developed by community partners regarding the early detection of cervical, breast, and colorectal cancers as well as the promotion of physical activity, healthy eating habits, melanoma cancer prevention, and cancer survivorship advocacy.[89]

Utah Invasive Lung Cancer Incidence Rate, 2014–2018

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	675	3,043,035	22.2 (21.4–22.9)	26.0 (25.1–26.9)	n/a
Am. Indian/AK Native**	4	29,050	12.4 (7.3–19.6	21.6 (12.3–35.1)	
Asian	13	71,424	18.2 (14.1–23.2)	25.2 (19.2–32.5)	
Black/ African Am.	7	32,999	20.6 (14.3–28.8)	54.7 (36.3–79.1)	↑
N. Hawaiian/Pac. Islander	5	28,596	17.5 (11.3–25.8)	31.7 (19.4–49.0)	
White, non-Hispanic	602	2,399,354	25.1 (24.2–26.0)	26.1 (25.1–27.0)	
Hispanic/Latino	43	421,408	10.3 (9.0–11.8)	27.4 (23.6–31.7)	

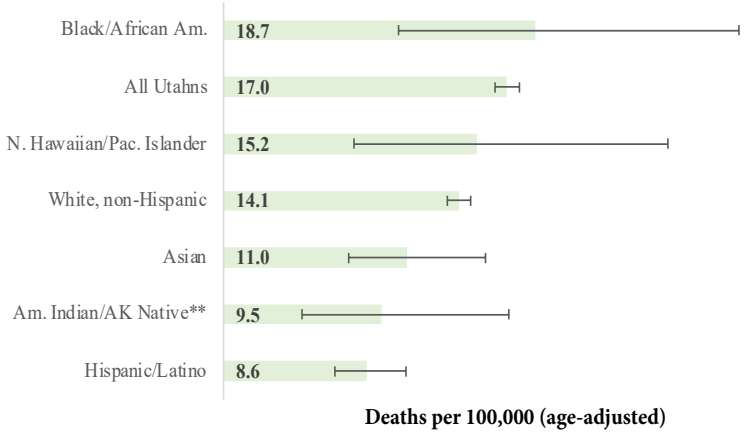
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Cancer Registry, contract HHSN261201800016I, National Cancer Institute's SEER Program with support from the University of Utah and Huntsman Cancer Foundation. Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2019
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Lung Cancer Death

Why is it important?

Lung cancer is the leading cause of cancer-related death in Utah. Because lung cancer symptoms often do not appear until the disease is advanced, early detection of this cancer is difficult. Cigarette smoking is the single most important risk factor for lung cancer. There are more than 80 carcinogens in cigarette smoke. Other risk factors include occupational or environmental exposure to secondhand smoke, radon, asbestos (particularly among smokers), certain metals, some organic chemicals, radiation, air pollution, and 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.[90]

Lung Cancer Death, Utah, 2015–2019



How are we doing?

From 2015–2019, the age-adjusted lung cancer death rate in Utah was 17.0 per 100,000 population. People who identified as White, non-Hispanic (14.1 per 100,000), Asian (11.0 per 100,000), and Hispanic/Latino (8.6 per 100,000) had significantly lower lung cancer death rates when compared with all Utahns.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Since nearly 90% of lung cancer deaths can be attributed to smoking, public health programs to reduce lung cancer focus on tobacco prevention and control. UDOH TPCP coordinates efforts to prevent youth from starting to use tobacco, help tobacco users quit, eliminate exposure to secondhand smoke, and reduce tobacco-related disparities. The UDOH initiated UCAN whose mission is to lower cancer incidence and mortality in Utah through collaborative efforts. Objectives and strategies have been developed by partners on the early detection of cervical, breast, and colorectal cancers as well as promoting physical activity, healthy eating habits, melanoma cancer prevention, and cancer survivorship advocacy.[91]

Utah Lung Cancer Death Rate, 2015–2019

Race/Ethnicity+	Annual Average # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	456	3,096,851	14.7 (14.1–15.3)	17.0 (16.3–17.7)	n/a
Am. Indian/AK Native**	2	47,758	4.6 (2.3–8.2)	9.5 (4.7–17.1)	
Asian	6	78,494	7.9 (5.4–11.2)	11.0 (7.5–15.7)	↓
Black/ African Am.	3	43,489	7.8 (4.6–12.5)	18.7 (10.5–30.9)	
N. Hawaiian/Pac. Islander	3	31,979	8.1 (4.3–13.9)	15.2 (7.8–26.6)	
White, non-Hispanic	333	2,430,802	13.7 (13.1–14.4)	14.1 (13.4–14.8)	↓
Hispanic/Latino	15	434,838	3.5 (2.8–4.4)	8.6 (6.7–10.9)	↓

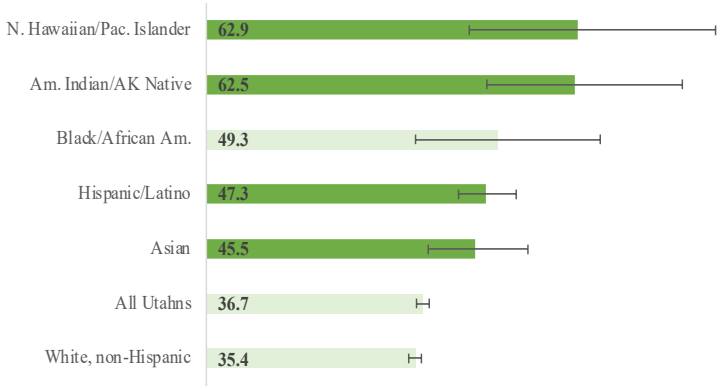
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH
Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2019
ICD-10 codes: C33–C34.
**Arrows indicate whether 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 a cancer that starts in the colon or the rectum. These cancers can also be called colon cancer or rectal cancer, depending on where they start. Colon cancer and rectal cancer are often grouped together because they have many features in common. Colorectal cancer is the fourth most common cancer found in men and women in the US It is also the fourth leading cause of cancer death. According to American Cancer Society Surveillance Research, it is estimated there will be 147,950 new cases of colorectal cancer diagnosed in the US during 2020, resulting in an estimated 53,200 deaths.[92]

Invasive Colorectal Cancer Incidence, Utah, 2014–2018



How are we doing?

From 2014–2018, the incidence rate for invasive colorectal cancer for all Utahns was 36.7 per 100,000 population (age-adjusted rate). People who identified as Native Hawaiian/Pacific Islander (62.9 per 100,000), American Indian/Alaska Native (62.5 per 100,000), Hispanic/Latino (47.3 per 100,000), and Asian (45.5 per 100,000), had significantly higher rates than all Utahns. People who identified as White, non-Hispanic (35.4 per 100,000) had significantly lower rates than all Utahns.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Most colorectal cancers start as a growth on the inner lining of the colon or rectum, called polyps. Polyps can be found early and removed before they turn into cancer. Screening for colorectal cancer has been identified by the CDC as a priority public health issue. The UDOH initiated the UCAN whose mission is to lower cancer incidence and mortality in Utah through collaborative efforts. Objectives and strategies have been developed by partners regarding the early detection of cervical, breast, and colorectal cancers as well as the promotion of physical activity, healthy eating habits, skin cancer prevention, and cancer survivorship advocacy.[93]

Utah Invasive Colorectal Cancer Incidence Rate, 2014–2018

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	958	3,043,035	25.1 (24.3–25.9)	36.7 (35.6–37.7)	n/a
Am. Indian/AK Native	13	29,050	33.1 (24.4–43.8)	62.5 (47.5–80.7)	↑
Asian	25	71,424	24.6 (19.8–30.4)	45.5 (37.6–54.5)	↑
Black/ African Am.	10	32,999	19.4 (13.3–27.4)	49.3 (35.4–66.8)	
N. Hawaiian/Pac. Islander	10	28,596	25.2 (17.6–34.9)	62.9 (44.5–86.3)	↑
White, non-Hispanic	799	2,399,354	27.0 (26.0–27.9)	35.4 (34.3–36.5)	↓
Hispanic/Latino	98	421,408	17.5 (15.7–19.3)	47.3 (42.7–52.5)	↑

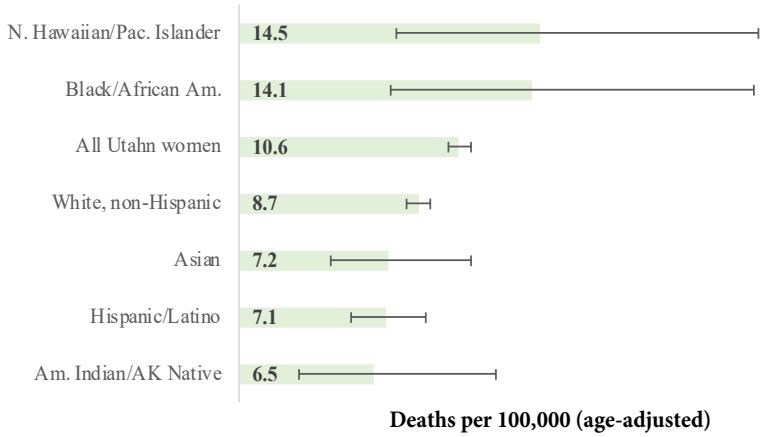
+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Cancer Registry, contract HHSN261201800016I, National Cancer Institute's SEER Program with support from the University of Utah and Huntsman Cancer Foundation. Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2019
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Colorectal Cancer Death

Why is it important?

Colorectal cancer is one of the leading causes of cancer-related deaths in Utah. 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. Several scientific organizations recommend routine screening for colorectal cancer should begin at age 50 for adults at average risk. Persons at high risk may need to begin screening at a younger age. The National Cancer Institute advises each individual to discuss risk factors and screening options with their health care provider. Medicare and many insurance plans now help pay for colorectal cancer screening.

Colorectal Cancer Death, Utah, 2015–2019



How are we doing?

From 2015–2019, the age-adjusted rate of colorectal cancer death in Utah was 10.6 per 100,000 population. People who identified as White, non-Hispanic (8.7 per 100,000) and Hispanic/Latino (7.1 per 100,000) had significantly lower rates of colorectal cancer death than all Utahns.

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Most colorectal cancers start as a growth on the inner lining of the colon or rectum, called polyps. Polyps can be found early and removed before they turn into cancer. Screening for colorectal cancer has recently been identified by the CDC as a priority public health issue. The UDOH initiated the UCAN whose mission is to lower cancer incidence and mortality in Utah through collaborative efforts. Objectives and strategies have been developed by partners regarding the early detection of cervical, breast, and colorectal cancers as well as the promotion of physical activity, healthy eating habits, skin cancer prevention, and cancer survivorship advocacy.[94]

Utah Colorectal Cancer Death Rate, 2015–2019

Race/Ethnicity+	Annual Average # of Deaths	Average Annual Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utahns	288	3,096,851	9.3 (8.8–9.8)	10.6 (10.1–11.2)	n/a
Am. Indian/AK Native**	2	47,758	4.2 (2.0–7.7)	6.5 (2.9–12.4)	
Asian	4	78,494	5.1 (3.1–7.9)	7.2 (4.4–11.2)	
Black/ African Am.	3	43,489	6.4 (3.5–10.8)	14.1 (7.3–24.8)	
N. Hawaiian/Pac. Islander	3	31,979	8.8 (4.8–14.7)	14.5 (7.6–25.0)	
White, non-Hispanic	205	2,430,802	8.4 (7.9–9.0)	8.7 (8.1–9.2)	↓
Hispanic/Latino	14	434,838	3.3 (2.6–4.2)	7.1 (5.4–9.0)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
ICD-10 codes: C18–C21.
**Arrows indicate whether 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

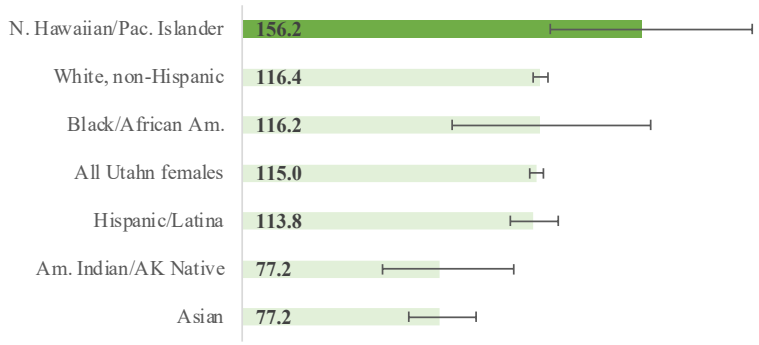
Why is it important?

Breast cancer is the most commonly occurring cancer in US women (except for basal and squamous cell skin cancers) and the leading cause of female cancer-related deaths in Utah. If the tumor is found early enough, the risk of death can be lowered. Clinical trials and observational studies have demonstrated that routine screening with mammography can reduce breast cancer mortality by about 20% for women of average risk.[95]

How are we doing?

During 2014–2018, the breast cancer incidence rate (age-adjusted) was 115.0 cases per 100,000 females. Women who identified as Native Hawaiian/Pacific Islander had significantly higher rates (156.2 per 100,000) than all Utah women. Women who identified as American Indian/ Alaska Native (77.2 per 100,000) and Asian (77.2 per 100,000) had significantly lower rates than all Utah women.

Invasive Female Breast Cancer Incidence, Utah, 2014–2018



Cases per 100,000 females (age-adjusted)

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH UCCP provides free breast cancer screening to uninsured or under-insured women ages 40-64 years whose income is at or below the 250% federal poverty level. Women in need of cancer treatment are enrolled into Medicaid as per the Breast and Cervical Cancer Treatment Act. Visit cancerutah.org or call 1-800-717-1811 for more information or to see who qualifies for free mammography services. The UCCP also works with health-systems to implement evidence-based practices to improve cancer screening rates. In addition, the UCCP initiated UCAN whose mission is to lower cancer incidence and mortality in Utah through collaborative efforts. Objectives and strategies regarding the early detection of cervical, testicular, prostate, skin, breast, and colorectal cancers as well as the promotion of physical activity, healthy eating habits, and smoking cessation.[96]

Utah Invasive Female Breast Cancer Incidence Rate, 2014–2018

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 Utah females	1,579	1,511,341	104.5 (102.2–106.8)	115.0 (112.4–117.6)	n/a
Am. Indian/AK Native	8	14,784	55.5 (39.8–75.3)	77.2 (54.7–105.9)	↓
Asian	28	37,916	74.9 (63.1–88.3)	77.2 (64.9–91.2)	↓
Black/ African Am.	9	13,976	61.5 (44.5–82.9)	116.2 (82.2–159.5)	
N. Hawaiian/Pac. Islander	14	13,718	103.5 (80.8–130.6)	156.2 (120.4–199.4)	↑
White, non-Hispanic	1,377	1,195,952	115.2 (112.5–117.9)	116.4 (113.6–119.3)	
Hispanic/Latino	139	205,278	67.5 (62.6–72.7)	113.8 (104.8–123.3)	

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
ICD-10 codes: C18–C21.
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Female Breast Cancer Death

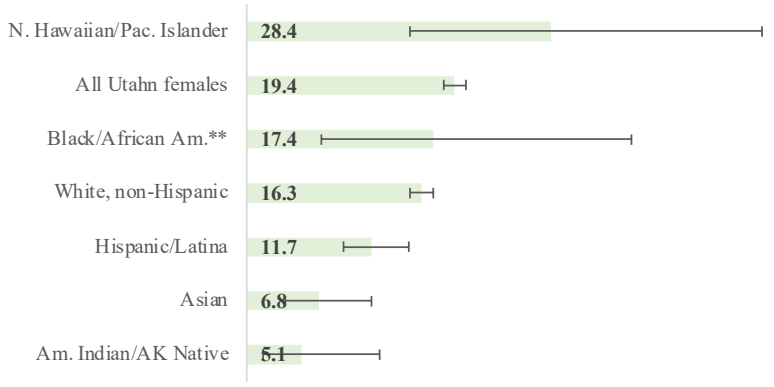
Why is it important?

Breast cancer is the most commonly occurring cancer in US women (except for basal and squamous cell skin cancers) and the leading cause of female cancer-related deaths in Utah. If the tumor is found early enough, the risk of death can be lowered. Clinical trials and observational studies have demonstrated that routine screening with mammography can reduce breast cancer mortality by about 20% for women of average risk.[97]

How are we doing?

From 2015–2019, the age-adjusted breast cancer death rate in Utah was 19.4 per 100,000 females. Women who identified as White, non-Hispanic (16.3 per 100,000), Hispanic/Latina (11.7per 100,000), Asian (6.8 per 100,000), and American Indian/Alaska Native (5.1 per 100,000) had significantly lower rates of breast cancer death than all Utah women.

Female Breast Cancer Death, Utah, 2015–2019



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. The UDOH UCCP provides free breast cancer screening to uninsured or under-insured women ages 40-64 years whose income is at or below the 250% federal poverty level. Women in need of cancer treatment are enrolled into Medicaid as per the Breast and Cervical Cancer Treatment Act. Visit cancerutah.org or call 1-800-717-1811 for more information or to see who qualifies for free mammography services. The UCCP also works with health-systems to implement evidence-based practices to improve cancer screening rates. In addition, the UCCP initiated UCAN whose mission is to lower cancer incidence and mortality in Utah through collaborative efforts. Objectives and strategies regarding the early detection of cervical, testicular, prostate, skin, breast, and colorectal cancers as well as the promotion of physical activity, healthy eating habits, and smoking cessation.[98]

Utah Female Breast Cancer Death Rate, 2015–2019

Race/Ethnicity+	Annual Average # of Deaths	Average Annual Female Population	Crude Rate per 100,000 (95% CI)	Age-adjusted Rate per 100,000 (95% CI)	Sig. *
All Utah females	275	1,537,576	17.9 (17.0–18.9)	19.4 (18.4–20.5)	n/a
Am. Indian/AK Native**	1	23,650	4.2 (1.4–9.9)	5.1 (1.5–12.4)	↓
Asian	3	41,491	6.3 (3.3–10.7)	6.8 (3.6–11.7)	↓
Black/ African Am.**	2	18,875	8.5 (3.7–16.7)	17.4 (7.0–35.9)	
N. Hawaiian/Pac. Islander	3	15,363	19.5 (10.9–32.2)	28.4 (15.3–48.2)	
White, non-Hispanic	201	1,211,235	16.6 (15.6–17.6)	16.3 (15.3–17.4)	↓
Hispanic/Latino	14	211,868	6.7 (5.2–8.5)	11.7 (9.0–15.1)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
ICD-10 code: C50.
**Arrows indicate whether 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

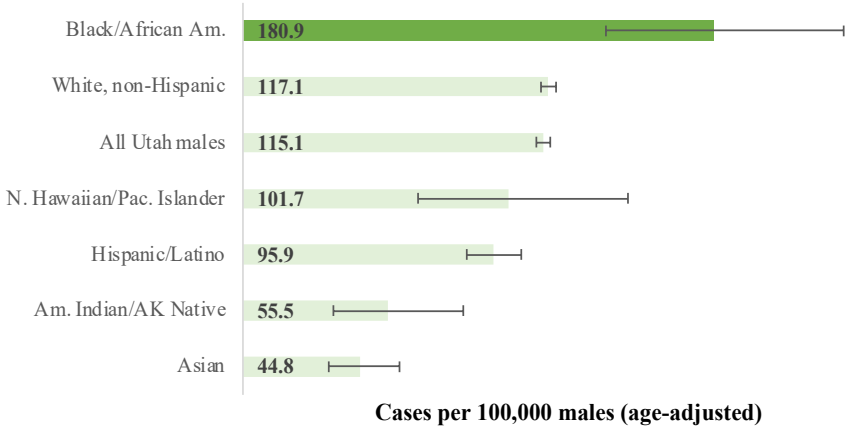
Why is it important?

Prostate cancer is the most commonly occurring form of cancer (excluding skin cancer) among men and is the second leading cause of cancer-related deaths for men in Utah. All men older than age 40 should visit their doctor for routine health visits annually, which may include a discussion on prostate health.[99]

How are we doing?

Between 2014–2018, the prostate cancer incidence rate (age-adjusted) in Utah was 115.1 per 100,000 males. Men who identified as Black/African American had significantly higher rates (180.9 per 100,000) than all Utah men. Men who identified as Native Hawaiian/Pacific Islander (101.7 per 100,000), Hispanic/Latino (95.9 per 100,000), American Indian/Alaska Native (55.5 per 100,000), and Asian (44.8 per 100,000) had significantly lower incidence rates than all Utah men.

Prostate Cancer Incidence, Utah, 2014–2018



How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The American Cancer Society recommends health care professionals discuss the potential benefits and limitations of prostate cancer screening starting when patients are 50. The recommended screening is for prostate specific antigen (PSA), with the option of digital rectal examination. People with a prostate who identify as Black/African American and those with one first degree relative with prostate cancer should be screened starting at age 45. The UDOH initiated the UCAN, who mission is to lower cancer incidence and mortality in Utah through collaborative efforts.[100]

Utah Prostate Cancer Incidence Rate, 2014–2018

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 Utah males	1,504	1,531,694	98.2 (96.0–100.4)	115.1 (112.5–117.8)	n/a
Am. Indian/AK Native	5	14,266	33.7 (21.6–50.1)	55.5 (34.6–84.5)	↓
Asian	10	33,509	29.8 (22.2–39.3)	44.8 (32.6–60.0)	↓
Black/ African Am.	18	19,022	95.7 (77.0–117.5)	180.9 (139.3–230.9)	↑
N. Hawaiian/Pac. Islander	7	14,878	49.7 (35.0–68.6)	101.7 (67.1–147.8)	
White, non-Hispanic	1,356	1,203,402	112.7 (110.1–115.4)	117.1 (114.3–120.0)	
Hispanic/Latino	81	216,129	37.4 (33.8–41.2)	95.9 (85.9–106.7)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
Utah Cancer Registry, contract HHSN261201800016I, National Cancer Institute's SEER Program with support from the University of Utah and Huntsman Cancer Foundation. Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, US Census Bureau, IBIS Version 2019
**Arrows indicate whether the age-adjusted rate was higher or lower than for all Utahns.*

Prostate Cancer Death

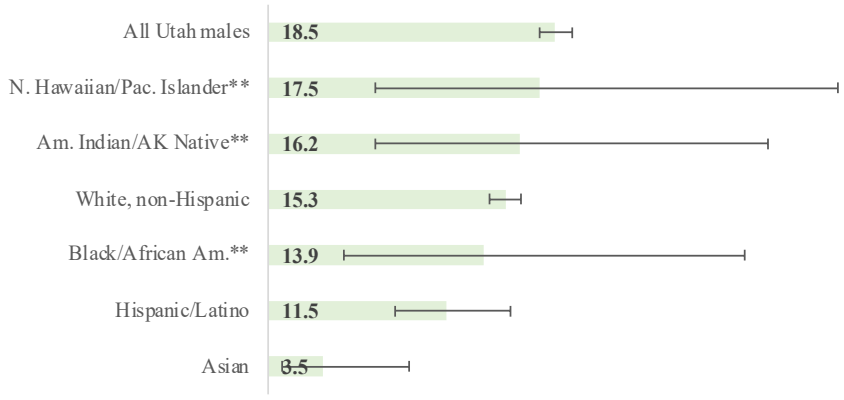
Why is it important?

Prostate cancer is the most commonly occurring form of cancer (excluding skin cancer) among men and is the second leading cause of cancer-related deaths for men in Utah. All people with a prostate older than age 40 should visit their doctor for routine health visits annually, which may include a discussion on prostate health.[101]

How are we doing?

Between 2015–2019, the age-adjusted prostate cancer death rate in Utah was 18.5 per 100,000 males. Men who identified as White, non-Hispanic (15.3 per 100,000), Hispanic/Latino (11.5 per 100,000), and Asian (3.5 per 100,000) had significantly lower rates of prostate cancer death than all Utah men.

Prostate Cancer Death, Utah, 2015–2019



Deaths per 100,000 males (age-adjusted)

How can we improve?

The UDOH OHD Health Equity Framework outlines how structural and social determinants of health impact health equity and quality of life. Utah's public health, health care, and social systems should be adequate and accessible to promote health for all Utahns of every race and ethnicity. The American Cancer Society recommends health care professionals discuss the potential benefits and limitations of prostate cancer screening starting when patients are 50. The recommended screening is for prostate specific antigen (PSA), with the option of digital rectal examination. People with a prostate who identify as Black/African American and those with one first degree relative with prostate cancer should be screened starting at age 45. The UDOH initiated the UCAN, a statewide partnership whose goal is to reduce the burden of cancer. The mission of the UCAN is to lower cancer incidence and mortality in Utah through collaborative efforts directed toward cancer prevention and control.[102]

Utah Prostate Cancer Death Rate, 2015–2019

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 Utah males	230	1,559,275	14.8 (13.9–15.7)	18.5 (17.5–19.6)	n/a
Am. Indian/AK Native**	2	24,108	6.6 (2.9–13.1	16.2 (6.9–32.2)	
Asian**	1	37,003	2.2 (0.6–5.5)	3.5 (0.9–9.1)	↓
Black/ African Am.**	1	24,614	5.7 (2.3–11.7)	13.9 (4.9–30.7)	
N. Hawaiian/Pac. Islander**	1	16,616	8.4 (3.4–17.4)	17.5 (6.9–36.7)	
White, non-Hispanic	171	1,219,567	14.0 (13.1–15.0)	15.3 (14.3–16.3)	↓
Hispanic/Latino	9	222,970	3.9 (2.8–5.2)	11.5 (8.2–15.6)	↓

+Race is of any ethnicity unless otherwise noted and Hispanic/Latino is of any race.
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 2019
ICD-10 code: C61.
**Arrows indicate whether 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.*

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

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