Twenty years of health data

for American Indian/Alaska Native communities in Utah

A technical report

Utah Department of
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Health Equity

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Contents

Acknowledgments

Primary authors
Deepani Surangana Jinadasa, MPH (DHHS Office of Health Equity)
Brittney Okada, MPH, CHES (formerly DHHS Office of Health Equity)

Contributors
Dulce Díez, MPH, MCHES (DHHS Office of Health Equity)
Shannon Robinson, MPH (DHHS Office of Health Equity)
Alex Merrill, BS (DHHS Office of American Indian/Alaska Native Health and Family Services)
Leonardo D. Buniak, MSF (formerly DHHS Office of Health Equity)
Tasmia Mostafiz, MPH, MBBS (DHHS Office of Health Equity)
Kyle Doubrava (DHHS Office of Health Equity)
Charla Haley (DHHS Office of Public Affairs & Education)

Special thanks: The format of these reports is based on previous Moving Forward reports published in 2016 by the Utah Department of Health Office of Health Disparities. For previous editions of these reports, please contact the Office of Health Equity at healthequity@utah.gov. The data in these reports are from data compiled in the Utah Health Status by Race and Ethnicity reports published in 2005, 2010, 2015, and 2021. A special thanks to all who helped produce these reports for their contributions.

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Office of Health Equity
healthequity@utah.gov
healthequity.utah.gov

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Other reports in this series

For information on health data for other racial and ethnic communities, see these additional reports in this series:

Twenty years of health data for Asian/Asian American communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty-Years_Asian.pdf

Twenty years of health data for Black/African American communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_BAA.pdf

Twenty years of health data for Hispanic/Latino communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_Hispanic_Latino.pdf

Twenty years of health data for Native Hawaiian/Pacific Islander communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_NHPI.pdf

Twenty years of health data for White, non-Hispanic communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_White.pdf

Overview

This technical report was developed using data presented in the 2005, 2010, 2015, and 2021 editions of the Utah Health Status by Race and Ethnicity reports, published by the Utah Department of Health Office of Health Disparities, now the Utah Department of Health and Human Services (DHHS) Office of Health Equity (OHE).

This is one of six technical reports which provide data and analyses about health status among racial and ethnic populations in Utah, namely American Indian/Alaska Native, Asian/Asian American, Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, and White, non-Hispanic populations. These technical reports provide 20 years of health trend data and analyses for racial and ethnic populations in Utah. In these reports, health disparities were identified with (1) a thorough understanding of the difficulties in measuring health outcomes in small populations; and (2) an application of statistical methods. Both techniques are important to epidemiology, and this is the balanced approach taken in these reports.

Health disparities are more than differences in health outcomes. Health disparities adversely affect groups of people who have experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; or geographic location. In this report, a health disparity is identified with respect to a health indicator when specific racial and ethnic groups in Utah experience some level of inequity compared to the reference group of Utah's population as a whole.[1]

The vision of DHHS is to ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. These reports identify health disparities experienced by specific racial and ethnic groups in Utah and help DHHS to plan, implement, and evaluate data-supported efforts to close health disparity gaps and improve health outcomes for all Utahns.[2]

[1] Office of Disease Prevention and Health Promotion. (n.d.). *Health Equity in Healthy People 2030.* Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

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

Data sources

Data for these technical reports were obtained from Utah Health Status by Race and Ethnicity 2005, 2010, 2015, and 2021 reports. Data from 1998–2004 were reported in Utah Health Status by Race and Ethnicity 2005. Data from 2005–2009 were reported in Utah Health Status by Race and Ethnicity 2010. Data from 2010–2014 were reported in Utah Health Status by Race and Ethnicity 2015. Data from 2015–2019 were reported in Utah Health Status by Race and Ethnicity 2021. In 2020, due to the Utah Department of Health response to the COVID-19 pandemic, Utah Health Status by Race and Ethnicity 2020 was postponed until 2021.

Throughout this profile, the years 2005, 2010, 2015, and 2021 refer to the publication dates of the Utah Health Status by Race and Ethnicity report and not the year the presented data were collected. Data sources and years are listed below each graph.

To view any of the Moving Forward reports, please make a request to the Office of Health Equity by contacting healthequity@utah.gov.

Methodology

Data on the health status of racial and ethnic populations were obtained from the Utah Health Status by Race and Ethnicity 2005, 2010, 2015, and 2021 reports for a variety of health indicators. For each health indicator, a line graph visually presents the health status of the racial/ethnic population and the health status of the Utah population overall for comparison. An accompanying text box provides the health disparity, disparity ratio, health disparity gap, health trend, additional interpretation, and commentary.

Analysis of health indicators was conducted through examination and interpretation of differences between a racial/ethnic population and the overall Utah population. Much of the focus of the analysis was on the examination and interpretation of changes over time. Numeric differences and ratios between racial/ethnic populations and the Utah population overall were charted (not shown) and assessed along with the line graphs to identify health disparities, categorize health disparity gaps, and describe health trends.

The years of data analysis vary depending on methodology, data availability, and data reliability. Health disparities were assessed based on data points from the 2021 report (or next most recent report, if data from the 2021 report were not available). Disparity ratios were calculated for data points from the 2021 report (or next most recent). Health disparity gap and health trend analysis considered the full reporting period covering data reported in 2005 through 2021 (except in cases where data points for specific years were not available).

Reference population

The reference population was the overall Utah population or the relevant overall Utah sub-population, such as Utah adults. Throughout these reports, the health status of racial/ethnic populations was compared to this reference population.

Health disparity and disparity ratio

For these reports, a health disparity was identified by determining whether there was a statistically significant difference between a racial/ethnic population and the Utah population overall at 2021 reporting. When the health status of a racial/ethnic population was significantly worse than Utah overall, a health disparity was identified for that health indicator.

A statistically significant difference was defined as when "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"[3]. A significantly different health outcome

[3] Office of Health Disparities (2021). *Utah Health Status by Race and Ethnicity 2021*. Salt Lake City, UT: Utah Department of Health.

for a racial/ethnic population compared with the statewide health outcome was marked with a caret (^). Data points with insufficient relative standard error to meet DHHS standards for data reliability were marked with an asterisk (*). Data points suppressed due to a relative standard error greater than 50% or undetermined relative standard error were marked with a double asterisk (**). For more information on statistical methods, refer to the Utah Health Status by Race and Ethnicity reports (links provided on page 5).

Potential health disparities were identified by calculation of disparity ratios. Disparity ratios were used to assess disparities and the magnitude of disparities between racial/ethnic populations and the Utah population overall. Health disparities were identified using a methodology similar to that described by the Multnomah County Health Department in its 2014 Report Card on Racial and Ethnic Disparities.[4] A disparity ratio was defined as the rate or prevalence in a population of interest (e.g., racial/ethnic population) divided by the rate or prevalence in a reference population (e.g., Utah population overall). Depending on the context, the population of interest was placed in the numerator when a decrease in a measure signals improvement (such as diabetes prevalence) and was placed in the denominator when an increase in a measure signals improvement (such as daily vegetable consumption). Thus, a disparity ratio greater than 1.0 meant the measure for the population of interest was worse than that of the reference population. A disparity ratio of 1.0 meant the measure for the population of interest was the same as that of the reference population. A disparity ratio less than 1.0 meant the measure for the population of interest was better than that of the reference population.

Health disparities, informed by disparity ratios, were categorized into the following three health disparity groups:

- **Yes** = the health status of the racial/ethnic population during 2021 reporting was **statistically significantly worse** than the Utah population overall. These health disparities warrant further investigation for improved understanding to inform efforts to address them.

- **Potential** = the health status of the racial/ethnic population during 2021 reporting was **worse** than the Utah population overall **and** the disparity ratio was **greater than or equal to 1.1**. The difference between the racial/ethnic population and the reference population was not statistically significant; however, this does not mean there is no health disparity. Further information is required.

- **No** = the health status of the racial/ethnic population was **better** than the Utah population overall **and/or** the disparity ratio was **less than or equal to 1.0**. If a racial/ethnic group showed little or no difference or fared better in their health status compared with the reference population, there was no health disparity.

[4] Multnomah County Health Department. (2014). *2014 Report Card on Racial and Ethnic Disparities*, Full Report: https://www.multco.us/file/2014-report-card-racial-and-ethnic-disparities-full-report-v121214pdf-0. Executive Summary: https://multco-web7-psh-files-usw2.s3-us-west-2.amazonaws.com/s3fs-public/2014%20Report%20Card%20on%20Racial%20and%20Ethnic%20Disparities%20-%20Executive%20Summary_0.pdf

Table 1 shows an example of how disparity ratios and difference ratios were calculated for the indicator "recent poor mental health." Percentages of the population with recent poor mental health were obtained for the Utah population overall and six racial/ethnic populations from the 2005, 2010, 2015, and 2021 editions of Utah Health Status by Race and Ethnicity. The percentage in the racial/ethnic population was divided by the percentage in the Utah population overall to calculate the disparity and difference ratios.

Table 1: Disparity ratio and difference ratio calculation table

Recent poor mental health		2005 report	2010 report	2015 report	2021 report
Utah overall	Percentage	15.0%	14.7%	15.8%	19.0%
American Indian/Alaska Native	Percentage	22.9%	22.9%	20.0%	20.2%
	Disparity ratio	1.5	1.6	1.3	1.1
Asian/Asian American	Percentage	9.9%	9.3%	11.7%	16.0%
	Disparity ratio	0.7	0.6	0.7	0.8
Black/African American	Percentage	27.1%	13.4%	12.9%	21.4%
	Disparity ratio	1.8	0.9	0.8	1.1
Hispanic/Latino	Percentage	16.9%	15.7%	16.9%	14.3%
	Disparity ratio	1.1	1.1	1.1	0.8
Native Hawaiian/ Pacific Islander	Percentage	15.9%	16.2%	14.1%	23.2%
	Disparity ratio	1.1	1.1	0.9	1.2
White, non-Hispanic	Percentage	14.7%	14.7%	15.8%	18.5%
	Disparity ratio	1.0	1.0	1.0	1.0

Health disparity gap

A health disparity gap was defined as the difference between the value of an indicator in a racial/ethnic population compared to the value of that indicator in the Utah population overall. In these reports, changes in the health disparity gap over time were assessed. These trends were evaluated by examining changes in both the numeric differences and the disparity ratios between a racial/ethnic population and the statewide population over time.

For the purpose of these reports, the health disparity gap for an indicator was identified as: increased, recently increased, decreased, recently decreased, persisted, fluctuated, or emerged. Health disparity gaps were only classified for indicators with health disparities or potential health disparities at 2021 reporting. If there was no health disparity, the health disparity gap was classified as "N/a" (not applicable).

- **Increased** = the numeric difference between the Utah population overall and the racial/ethnic group for 2021 reporting was generally larger than previous years of reporting and/or the disparity ratio increased by at least 0.2 over time.
- **Recently increased** = the numeric difference between the Utah population overall and the racial/ethnic group for 2021 reporting was larger than for 2015 reporting, but prior to 2015 reporting, the disparity ratio decreased or persisted over time.
- **Decreased** = the numeric difference between the Utah population overall and the racial/ethnic group for 2021 reporting was generally smaller than previous years of reporting and/or the disparity ratio decreased by at least 0.2 over time.
- **Recently decreased** = the numeric difference between the Utah population overall and the racial/ethnic group for 2021 reporting was smaller than for 2015 reporting, but prior to 2015 reporting, the disparity ratio increased or persisted over time.
- **Persisted** = the numeric difference between the Utah population overall and the racial/ethnic group for 2021 reporting was generally the same when compared with previous years of reporting and/or the change in disparity ratio was less than 0.3.
- **Fluctuated** = the numeric difference between the Utah population overall and the racial/ethnic group increased and decreased over time and/or the disparity ratio increased and decreased over time.
- **Emerged** = the numeric difference between the Utah population overall and the racial/ethnic group for 2021 reporting increased since 2015 reporting and/or the disparity ratio changed from no health disparity to a potential health disparity, or from a potential health disparity to a health disparity. Previous health disparity gaps that closed and then re-emerged were classified as emerged.

Note: The criteria for persisted sometimes overlapped with the criteria for increased and decreased, particularly between 0.2 and 0.3. Subject matter expertise informed decisions in these cases. Also, improvement in health status did not definitively mean a health disparity gap decreased. For example, if a racial/ethnic group's measures and the overall population's measures equally improved, the health status improved, but the health disparity gap persisted. Finally, in instances where health disparity gaps met criteria for both fluctuated and increased (or another category), categorizing health disparity gaps as fluctuated was avoided to the extent possible. Categories other than fluctuated provided more useful information to encourage further investigation.

Health trend

The health trend was defined as the change in the health status of an indicator of a racial/ethnic group over time. Two general categories of trends were observed—monotonic trends and inflected trends. Monotonic trends only increased or only decreased. Inflected trends started to increase or decrease, experienced an inflection point, then moved in the opposite direction.

For the purpose of these reports, the health trend for each indicator was classified as: improved, recently improved, worsened, recently worsened, changed little, fluctuated, or N/a (not applicable)

- **Improved** = the health status of a racial/ethnic group at 2021 reporting was better than the health status during previous years of reporting and the indicator improved by more than three to five percentage points. Improved trends were either monotonic or inflected.
- **Recently improved** = the health status of a racial/ethnic group experienced a notable improvement between 2015 and 2021 reporting following an inflection point up to which the trend had been worsening.
- **Worsened** = the health status of a racial/ethnic group at 2021 reporting was worse than the health status during previous years of reporting and the indicator worsened by more than three to five percentage points. Worsened trends were either monotonic or inflected.
- **Recently worsened** = the health status of a racial/ethnic group experienced a notable worsening between 2015 and 2021 reporting following an inflection point up to which the trend had been improving.
- **Changed little** = the health status of a racial/ethnic group at 2021 reporting was generally the same as the health status during at least two of the previous years of reporting, and any changes in the health status were within or less than three to five percentage points.
- **Fluctuated** = the health status of a racial/ethnic population both increased and decreased by more than three to five percentage points or there was no conclusive trend in the health status.
- **N/a (not applicable)** = the health status of a racial/ethnic group could not be determined based on the availability of only two data points. Two data points are insufficient to establish a trend and must be interpreted with caution.

Note: The criteria for changed little sometimes overlapped with the criteria for improved and worsened, particularly when changes in health trends occurred within the range of three to five percentage points. Knowledge of the health indicator and subject matter expertise about its context in Utah informed decisions in these cases.

How to use these reports

This series of reports provides trend data compiled across four consecutive reporting periods. The purpose of these reports is to track changes in health indicators over time and present data through visualizations and trend interpretations to identify health gaps.

Through these reports, DHHS OHE seeks to elevate awareness of health disparities in Utah to stimulate meaningful discussion and research, enhance existing programming, and facilitate future interventions and collaborations to better understand and address these health disparities.

Note: All data in these reports were collected prior to the start of the COVID-19 pandemic, so changes to health trends and health disparity gaps cannot be explained by the effects of COVID-19.

Limitations

- These reports utilize various data sources, all of which have different strengths and weaknesses. Public health datasets that contributed to the data used in these reports include birth certificates, death certificates, communicable disease surveillance, the Utah Cancer Registry, and health surveys. Not all data sources were consistent across the 20-year span covered by the series of Utah Health Status by Race and Ethnicity reports. Therefore, interpretations identifying long-term trends or shifts in health status across the 2005, 2010, 2015, and 2021 reporting years should be examined with this awareness in mind. Beginning in 2011, data collected from the Behavioral Risk Factor Surveillance System (BRFSS) include both landline and cell phone respondent data along with a new weighting methodology called iterative proportional fitting, or raking.[5] Data collected before and after this change in methodology should be compared with caution.

- Not all indicators from the Utah Health Status by Race and Ethnicity reports are presented in these reports, due to various limitations. For example, data for colon cancer screenings could not be compared over time due to changes in survey methodology that capture this information. Indicators listed in the 2021 Utah Health Status by Race and Ethnicity report but not listed in the Moving Forward in 2023 reports are: cost as a barrier to healthcare, routine dental checkup, first trimester prenatal care, colon cancer screening, pneumonia immunization, adolescent obesity, high cholesterol, exposure to secondhand smoke, e-cigarette use by youth, adolescent suicide ideation, recommended aerobic physical activity, low birth weight, obesity in pregnancy, smoking during pregnancy, gestational diabetes, ever breastfed, postpartum depression, major structural birth defects, orofacial

[5] Utah Department of Health and Human Services Public Health Indicator Based Information System (IBIS). Utah's Behavioral Risk Factor Surveillance System (BRFSS) Query Module Configuration Selection. https://ibis.health.utah.gov/ibisph-view/query/selection/brfss/BRFSSSelection.html

clefts, critical congenital heart defects, Down syndrome, neural tube defects, human immunodeficiency virus (HIV), hepatitis C, unintentional poisoning deaths, poor physical health status, poor mental health status, major depression, and chronic obstructive pulmonary disease (COPD).

- When data are disaggregated by race, sample numbers can be small. Data are often compiled from a series of years in order to obtain reliable estimates. Even then, some samples may not be large enough to yield statistically significant differences. Statistically significant differences are noted with a caret (^).
- Some health status estimates for racial and ethnic populations have insufficient relative standard error due to small numbers to meet DHHS standards for data reliability and are marked with an asterisk (*). These data must be interpreted with caution or investigated further.
- For the 2005 report, no data suppression rules were applied. This means estimates from the 2005 report with high relative standard error have not been marked with an asterisk (*) to caution about data reliability or double asterisks (**) to suppress data with very high relative standard error.
- Analysis of health trends did not take confidence intervals into account but rather focused on the point estimates in the time series of an indicator. When comparing data to the Utah population overall, confidence intervals for data from small populations are often large and overlap with Utah overall even when point estimates are substantially different. While non-overlapping confidence intervals provide convincing evidence of a difference, by only classifying trends for indicators with non-overlapping confidence intervals, important health disparities and differences may be missed. This approach may overestimate the existence of health disparities, but awareness of health disparities and their disproportionate impact on racial and ethnic populations is central to the pursuit of health equity in Utah.
- The differences in how indicators were interpreted were influenced by knowledge of contextual factors and expertise of the authors and contributors of these reports. Readers may have different knowledge, expertise, and information and may interpret the health trends and health disparity gaps differently.
- Race and ethnicity data in the Utah Health Status by Race and Ethnicity reports were grouped according to standards set in 1997 by the federal Office of Management and Budget. Nevertheless, in some instances, reported race is of any ethnicity and reported ethnicity is of any race. This may lead to overlapping categories within an indicator and may also mean the same race and ethnicity categories may not be strictly comparable across years.

- Significant diversity exists in each of the broad race and ethnicity categories used in this report series and the use of these broad categories will mask health disparities among smaller subgroups and among multiracial and multiethnic communities. Collecting more granular race and ethnicity data can help reveal further health disparities and differences within a racial/ethnic group.

American Indian/Alaska Native populations in Utah

More than 56,000 people who identify as American Indian/Alaska Native reside in Utah.[6] Salt Lake County has the state's highest proportion of American Indian/Alaska Native populations, at 32%, followed by Utah County (14%), and San Juan County (13%).[7] American Indian/Alaska Native populations in Utah are growing—they increased by 26% between 2010 and 2020.[8] The median age of American Indian/Alaska Native populations in Utah is 30.4 years.[9]

Many of those who identify as American Indian/Alaska Native are enrolled in one of the eight federally recognized tribes of Utah: Northwestern Band of Shoshone Nation, Confederated Tribes of the Goshute Reservation, Skull Valley Band of Goshute, Paiute Indian Tribe of Utah, San Juan Southern Paiute Tribe, Ute Indian Tribe of the Uintah and Ouray Reservation, Ute Mountain Ute Tribe, and Navajo Nation. Utah is also home to people who self-identify with or who are enrolled in tribal nations not indigenous to Utah—such as Apache, Cherokee, and Sioux—as well as Alaska Natives such as the Inupiat and Tsimshian.[10]

Health status

Overall, the data presented in this report show that in Utah, American Indian/Alaska Native populations have significantly lower rates of infant mortality, breast cancer incidence, breast cancer deaths, and prostate cancer incidence compared with the Utah population overall. However, data over the past 20 years of reporting indicate health disparity gaps between American Indian/Alaska Native populations and the Utah population overall increased or recently increased in the areas of child poverty, no health insurance, flu shot, current cigarette smoking, heavy drinking of alcohol, chlamydia incidence, and gonorrhea incidence. Health disparity gaps persisted in the areas of life expectancy at birth, poverty, no primary care provider, high blood pressure, overweight or obesity, births to adolescents, preterm birth, tuberculosis incidence, diabetes prevalence, arthritis prevalence, and asthma prevalence. In addition, health disparity gaps decreased or recently decreased in the areas of recent poor mental health, blood cholesterol screening, prostate cancer screening, no physical activity, binge drinking of alcohol, unintended pregnancy births, unintentional injury deaths, and vehicle crash deaths. Health disparity gaps fluctuated in the areas of fair or poor health, daily fruit consumption, and suicide. Recently, a health disparity gap emerged in colorectal cancer incidence.

[6] U.S. Census Bureau 2016–2020 ACS 5-Year Estimates, Table B02010, American Indian and Alaska Native Alone or in Combination with One or More Other Races
[7] U.S. Census Bureau 2016–2020 ACS 5-Year Estimates, Table DP05, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races
[8] U.S. Census Bureau 2006–2010 & 2016–2020 ACS 5-Year Estimates, Table DP05, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races
[9] U.S. Census Bureau 2017–2021 ACS 5-Year Estimates, Table B01002C, Median Age by Sex (American Indian and Alaska Native alone).
[10] U.S. Census Bureau 2016–2020 ACS 5-Year Estimates, Table B02014, American Indian and Alaska Native Alone for Selected Tribal Groupings

Overview of health disparities for American Indian/Alaska Native populations in Utah

Table 2 presents an overview of health disparities and potential health disparities (referred to collectively as "health disparities") among American Indian/Alaska Native populations in Utah. Of 46 indicators analyzed, 31 indicators (67%) showed health disparities for American Indian/Alaska Native populations when compared with Utah overall. Of 31 indicators showing health disparities, the health disparity gap decreased or recently decreased in seven indicators, persisted in 13 indicators, increased or recently increased in seven indicators, emerged in one indicator, and fluctuated in three indicators.

Table 2: Overview of health disparities for American Indian/Alaska Native populations in Utah, 1997–2019 data

No health disparity	Health disparity gap decreased/recently decreased	Health disparity gap persisted	Health disparity gap increased/recently increased/emerged	Health disparity gap fluctuated
Routine medical checkup	Recent poor mental health	Life expectancy at birth	Child poverty	Fair or poor health
Pap testing	Blood cholesterol screening	Poverty	No health insurance	Daily fruit consumption
Mammograms	Prostate cancer screening	No primary care provider	Flu shot	Suicide
Daily vegetable consumption	No physical activity	High blood pressure	Current cigarette smoking	
Daily folic acid consumption	Unintended pregnancy births	Binge drinking of alcohol	Heavy drinking of alcohol	
Infant mortality	Unintentional injury deaths	Overweight or obesity	Chlamydia incidence	
Coronary heart disease deaths	Vehicle crash deaths	Births to adolescents	Gonorrhea incidence	
Stroke deaths		Preterm birth	Colorectal cancer incidence*	
Lung cancer incidence		Tuberculosis incidence		
Lung cancer deaths		Diabetes prevalence		
Colorectal cancer deaths		Diabetes deaths		
Breast cancer incidence		Arthritis prevalence		
Breast cancer deaths		Asthma prevalence		
Prostate cancer incidence				
Prostate cancer deaths				

*The health disparity gap for this indicator was classified as "Emerged."

Health disparities occur along with changes to the health status of a population over time. A health disparity gap can exist while the underlying health status of a racial/ethnic population may have improved, changed little, worsened, or fluctuated over time.

Table 3 catalogs 26 indicators with health disparity gaps that increased/recently increased/emerged, persisted, or decreased/recently decreased cross-referenced by health trends that improved/recently improved, changed little, or worsened/recently worsened for American Indian/Alaska Native populations in Utah. Not included in Table 3 are three indicators in which the health disparity gap fluctuated: fair or poor health, daily fruit consumption, and suicide, and one indicator in which the health trend fluctuated: unintentional injury deaths. Also not included is one indicator in which the health trend was marked as "N/a": no primary care provider.

Table 3: Health disparity gaps and health trends for American Indian/Alaska Native populations in Utah, 1997–2019 data

Health trend	Health disparity gap: Decreased/recently decreased	Health disparity gap: Persisted	Health disparity gap: Increased/recently increased/emerged
Improved/recently improved	▶ Blood cholesterol screening ▶ Unintended pregnancy births ▶ Vehicle crash deaths ▶ No physical activity	▶ Life expectancy at birth ▶ Poverty ▶ Overweight or obesity ▶ Births to adolescents ▶ Arthritis prevalence ▶ Diabetes deaths	
Changed little	▶ Recent poor mental health	▶ Preterm birth ▶ Binge drinking of alcohol ▶ Tuberculosis incidence	▶ Current cigarette smoking
Worsened/recently worsened	▶ Prostate cancer screening	▶ High blood pressure ▶ Asthma prevalence ▶ Diabetes prevalence	▶ Child poverty ▶ No health insurance ▶ Flu shot ▶ Heavy drinking of alcohol ▶ Chlamydia incidence ▶ Gonorrhea incidence ▶ Colorectal cancer incidence

There were no health disparities in 15 of 46 indicators (33%) for American Indian/Alaska Native populations in Utah. However, it is still important to monitor the health trends of these indicators, as some may worsen over time. The health trend of an indicator shows whether the health status of the population improved, changed little, worsened, or fluctuated over time.

Table 4 presents 15 indicators with a determined health trend and no health disparities for American Indian/Alaska Native populations in Utah. The health trend improved or recently improved in 7 indicators, changed little in 2 indicators, worsened or recently worsened in 2 indicators, and fluctuated in 4 indicators. One health trend marked as "N/a" is not shown in this table (no primary care provider).

Table 4: Health trends of indicators with no health disparities for American Indian/Alaska Native populations, Utah, 1997–2019 data

Improved/recently improved	Changed little	Worsened/recently worsened	Fluctuated
▶ Routine medical checkup	▶ Prostate cancer incidence	▶ Lung cancer incidence	▶ Daily vegetable consumption
▶ Pap testing	▶ Prostate cancer deaths	▶ Breast cancer incidence	▶ Daily folic acid consumption
▶ Mammograms			▶ Stroke deaths
▶ Infant mortality			▶ Colorectal cancer deaths
▶ Coronary heart disease deaths			
▶ Lung cancer deaths			
▶ Breast cancer deaths			

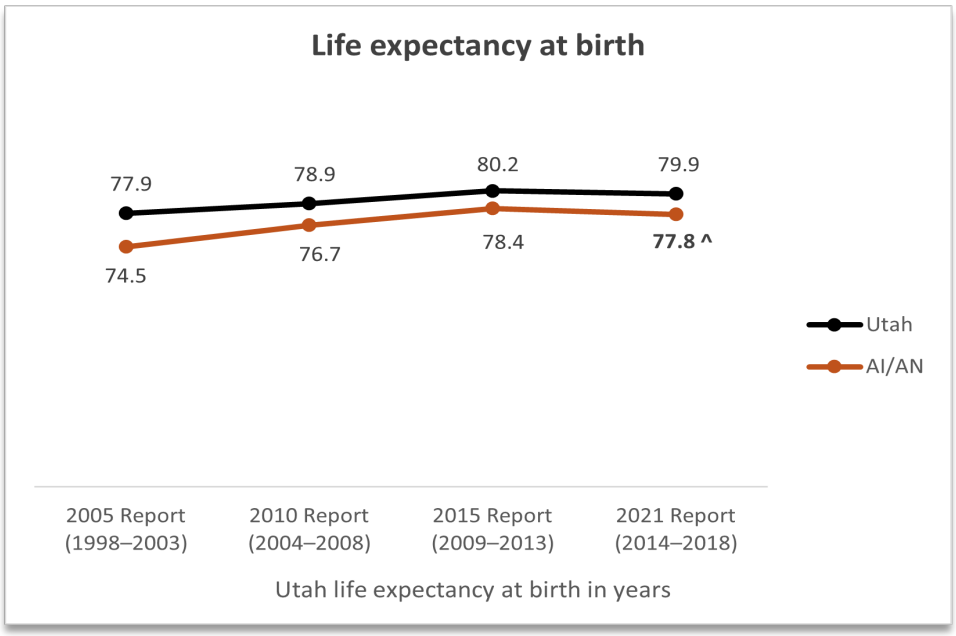
Conclusion

Health disparities can be understood and addressed with the availability of high-quality information. Data that track health disparities and differences over time, such as in these health trend reports, function as an important starting point to stimulate further discussion. They serve the ultimate goal of taking action to reduce health disparities and advance health equity.

Health indicators

Throughout this section, 'AI/AN' is used to refer to 'American Indian/Alaska Native.'

Socio-demographics

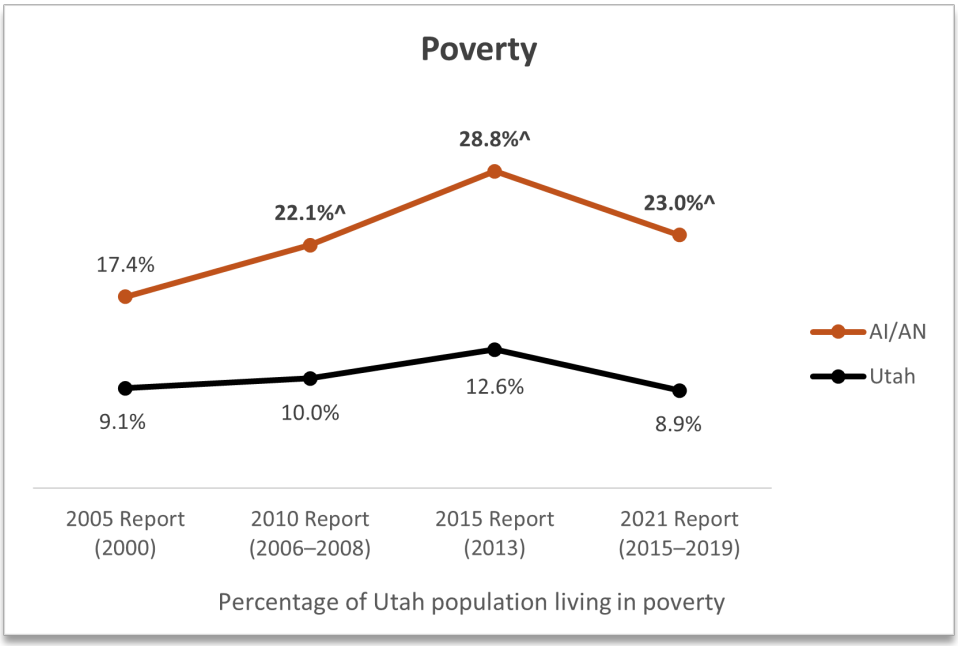


Health disparity: **Yes^**
Disparity ratio: **1.0**
Health disparity gap: **Persisted**
Health trend: **Improved**

Life expectancy at birth among AI/AN populations was lower than Utah overall since 2005 reporting. As of 2021 reporting, life expectancy was 2.1 years lower among AI/AN populations than Utah overall. Life expectancy among AI/AN populations increased since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: UDOH Office of Public Health Assessment, Death Certificate Database, 2004–2008. UDOH Office of Public Health Assessment, Population Estimate, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race & Hispanic Origin for Counties in Utah, IBIS version 2013: 2021 Report: UDOH Office of Vital Records & Statistics, Death Certificate Database, 2014–2018. US Census Bureau, Population Estimates by Age, Sex, Race & Hispanic Origin for Counties in Utah, IBIS version 2019.

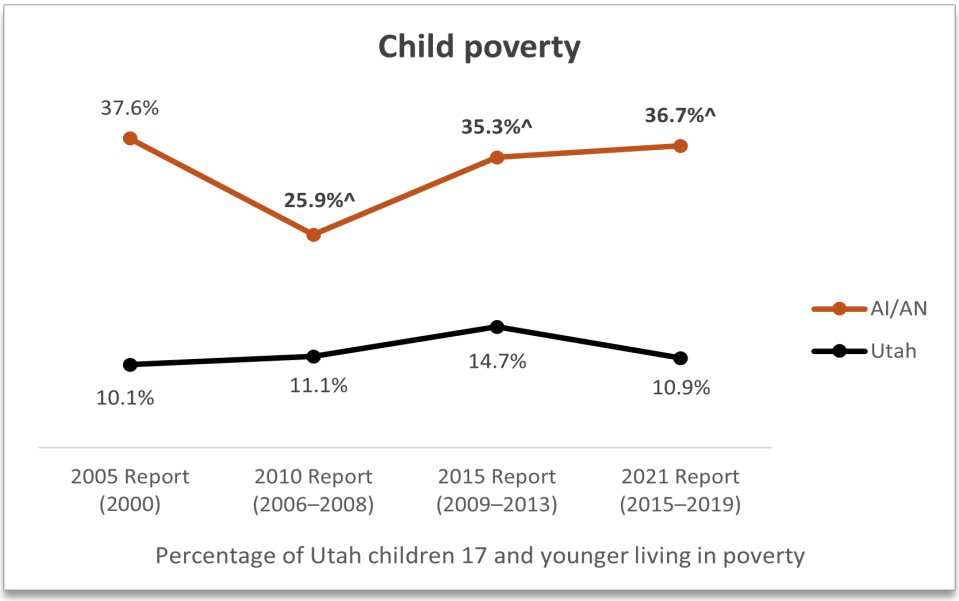


Health disparity: **Yes^**
Disparity ratio: **2.6**
Health disparity gap: **Persisted**
Health trend: **Recently improved**

Poverty among AI/AN populations was higher than Utah overall since 2005 reporting and rose to a high of 28.8% in 2015 reporting. Since 2015 reporting, poverty and the health disparity gap decreased among AI/AN populations.

^Statistically significantly different than Utah overall

Sources—2005 Report: US Census Bureau, US Census, 2000; 2010 Report: US Census Bureau, American Community Survey 3-Year Estimates, 2006–2008; 2015 Report: US Census Bureau, American Community Survey 1-Year Estimate, 2013; 2021 Report: US Census Bureau, American Community Survey 5-Year Estimates Tables B17001, B17001C, B17001D, B17001B, B17001E, B17001H, and B17001.



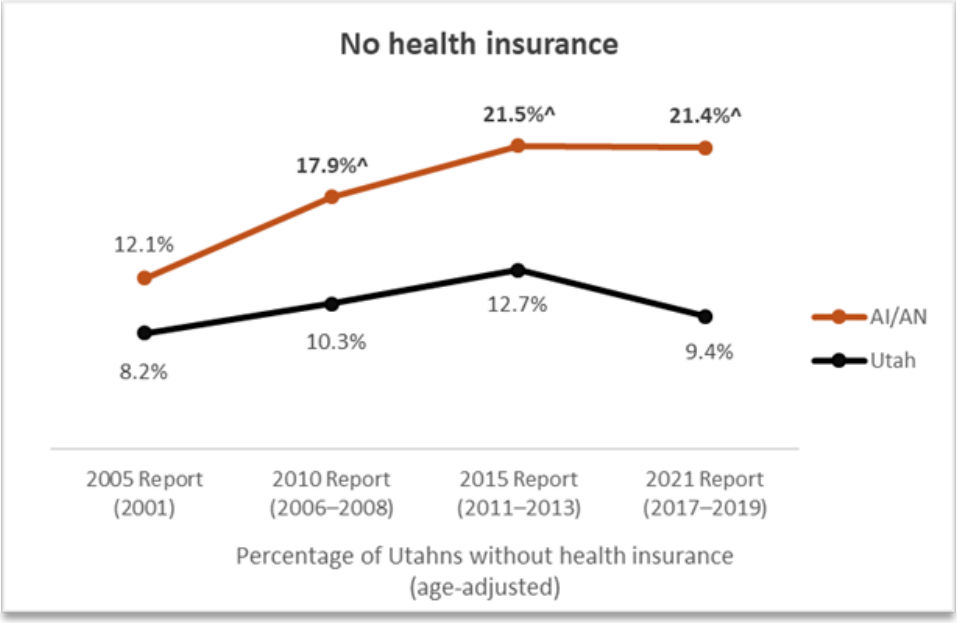
Health disparity: **Yes^**
Disparity ratio: **3.4**
Health disparity gap: **Increased**
Health trend: **Worsened**

Child poverty among AI/AN populations was higher than Utah overall since 2005 reporting. Child poverty and the health disparity gap increased among AI/AN populations since 2010 reporting. As of 2021 reporting, one in three AI/AN children in Utah lived in poverty.

^Statistically significantly different than Utah overall

Sources—2005 Report: US Census Bureau, US Census 2000; 2010 Report: US Census Bureau, American Community Survey 3-Year Estimates, 2006–2008; 2015 Report: US Census Bureau, American Community Survey 5-Year Estimates, 2009–2013; 2021 Report: US Census Bureau, American Community Survey 5-Year Estimates Tables B17001, B17001C, B17001D, B17001B, B17001E, B17001H, and B17001.

Access to healthcare and health status

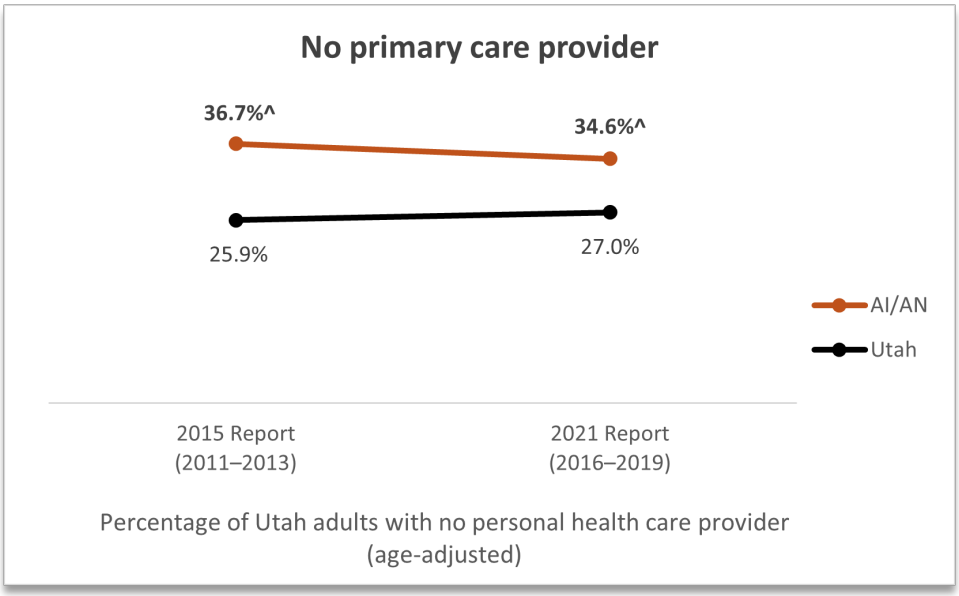


Health disparity: **Yes^**
Disparity ratio: **2.3**
Health disparity gap: **Increased**
Health trend: **Worsened**

No health insurance among AI/AN populations was higher than Utah overall since 2005 reporting. The percentage of uninsured AI/AN populations increased since 2005 reporting. The health disparity gap also increased since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH, Utah Health Status Survey, 2001; 2010 Report: UDOH, Utah Healthcare Access Survey, 2006–2008. UDOH Office of Public Health Assessment, Population Estimates, 2007; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, Population estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, Population estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

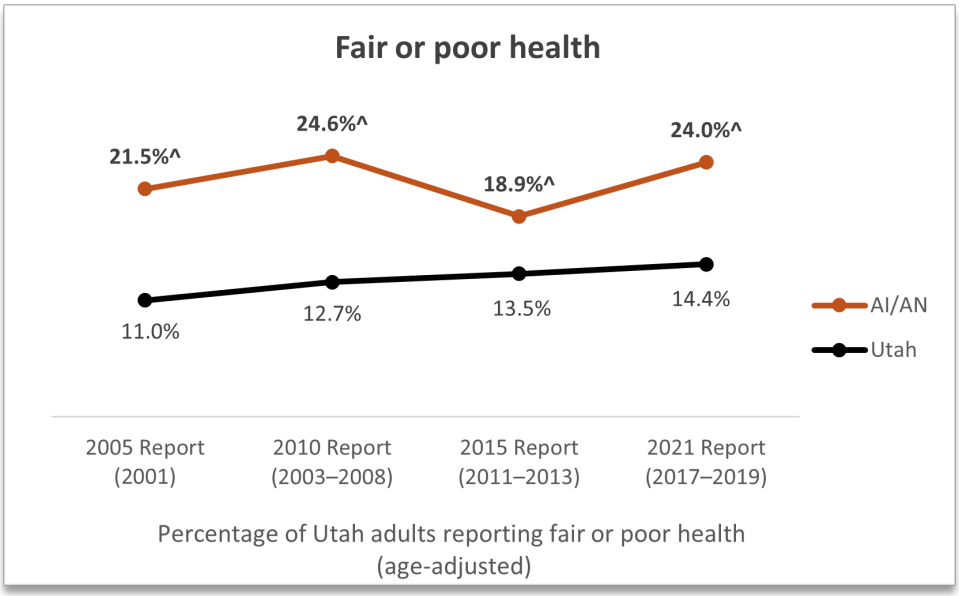


Health disparity: **Yes^**
Disparity ratio: **1.3**
Health disparity gap: **Persisted**
Health trend: **N/a**

The percentage of AI/AN adults without a primary care provider (PCP) was higher than Utah adults overall since 2015 reporting. Lack of a PCP changed little among AIAN adults since 2015 reporting, and a health disparity gap persisted.

Note: This indicator changed from total population in 2005-2010 to adults from 2015 onwards
^Statistically significantly different than Utah overall

Sources—2015 Report: UDOH, Utah Healthcare Access Survey, 2011–2013. UDOH Office of Public Health Assessment, Population Estimates, 2007. 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016–2019. Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.

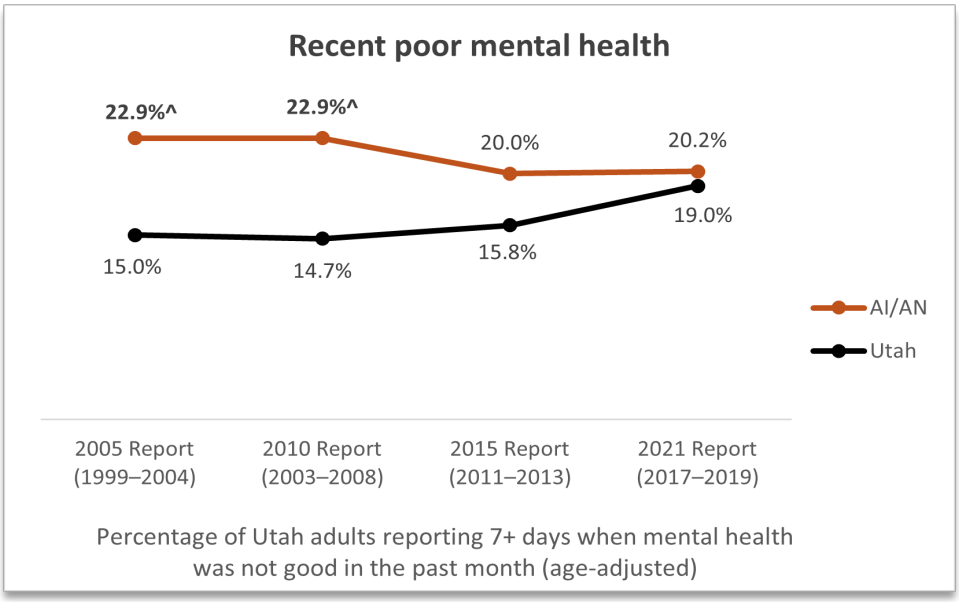


Health disparity: **Yes^**
Disparity ratio: **1.7**
Health disparity gap: **Fluctuated**
Health trend: **Fluctuated**

The percentage of AI/AN adults who self-reported their general health status as “fair” or “poor” (instead of “excellent,” “very good,” or “good”) was higher than Utah overall since 2005 reporting. Fair or poor health increased among Utah overall and fluctuated among AI/AN adults since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH, Utah Health Status Survey, 2001; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011-2013. 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.

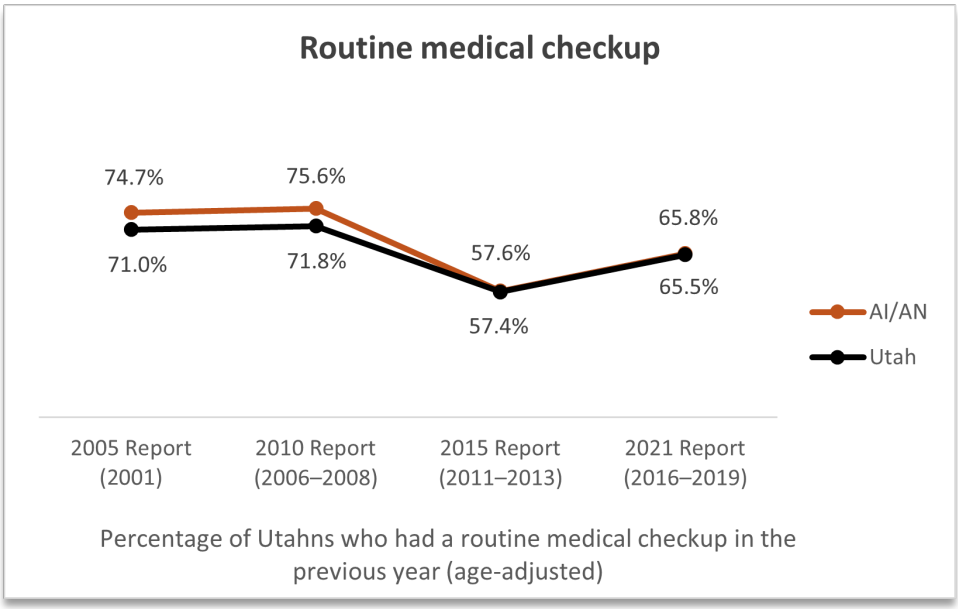


Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Decreased**
Health trend: **Changed little**

Recent poor mental health among AI/AN adults was higher than Utah adults overall between 2005 and 2015 reporting and similar as of 2021 reporting. Recent poor mental health increased among Utah adults overall and changed little among AI/AN adults, which decreased the health disparity gap.

^Statistically significantly different than Utah overall
Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013. 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. Population estimates averaged from 2017–2019 American Community Survey 1-Year Estimates.

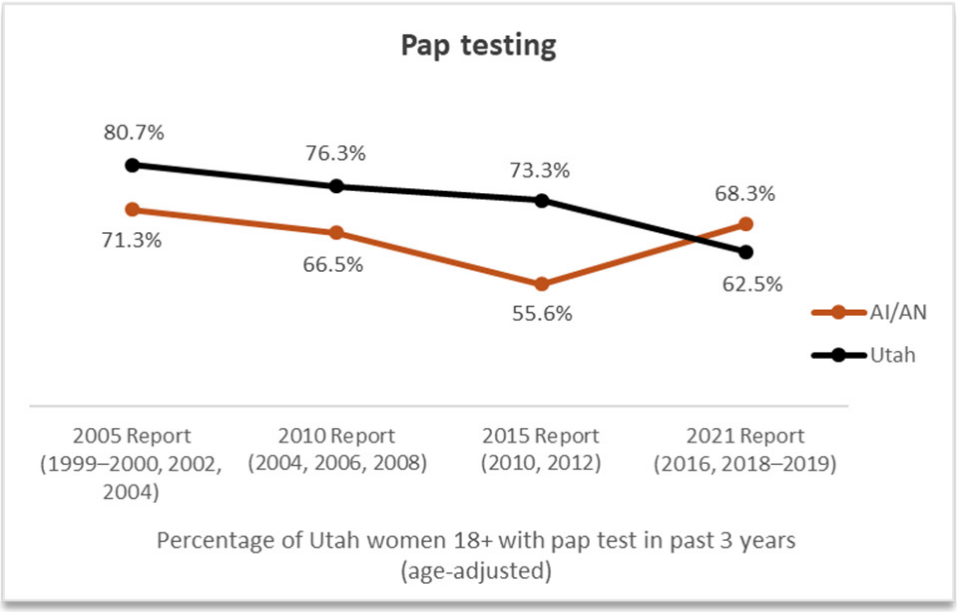
Preventive services



Health disparity: **No^**
Disparity ratio: **1.0**
Health disparity gap: **N/a**
Health trend: **Recently improved**

Routine medical checkups among AI/AN populations were slightly higher than Utah overall between 2005 and 2010 reporting. Between 2010 and 2021 reporting, routine medical checkups declined then improved again in both populations. As of 2021 reporting, routine medical checkups among AI/AN populations were similar to Utah overall.

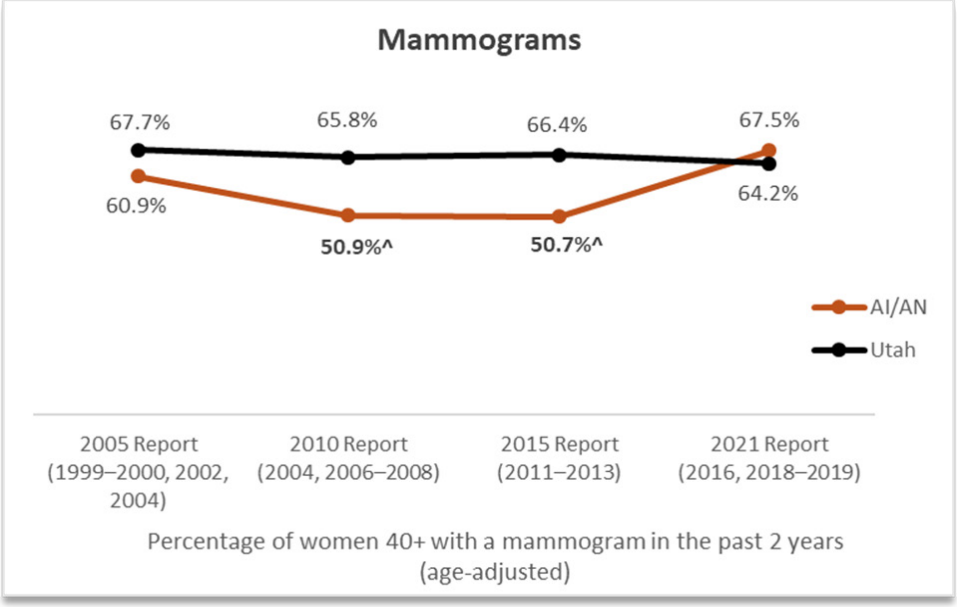
^Statistically significantly different than Utah overall
Sources—2005 Report: UDOH, Utah Health Status Survey, 2001; 2010 Report: UDOH, Utah Healthcare Access Survey, 2006–2008. UDOH Office of Public Health Assessment, Population Estimates, 2007; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013. 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016–2019. Population estimates averaged from 2016–2019 American Community Survey 1-Year Estimates.



Health disparity: **No**
Disparity ratio: **0.9**
Health disparity gap: **N/a**
Health trend: **Recently improved**

Pap testing among AI/AN women 18+ was lower than Utah women 18+ overall between 2005 and 2015 reporting. Pap testing declined in both populations between 2005 and 2015 reporting. Since 2015 reporting, testing continued to decline among Utah women overall but increased among AI/AN women, which closed the health disparity gap.

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2000, 2002, 2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2004, 2006, 2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessments, Utah BRFSS, 2010, 2012. US Census Bureau, American Community Survey 1-Year Estimates, 2010, 2012; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016, 2018–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2016, 2018, 2019.

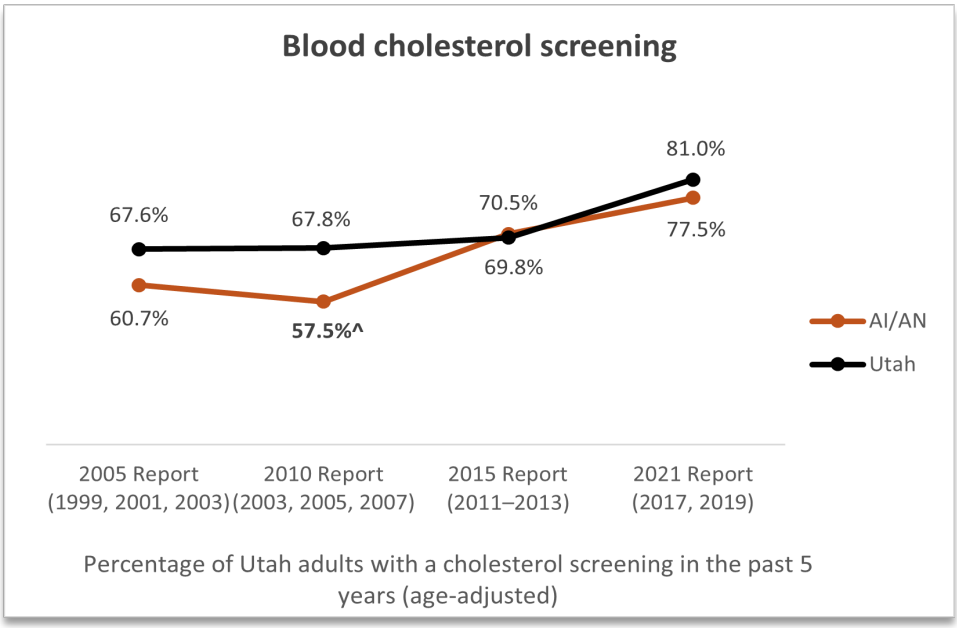


Health disparity: **No**
Disparity ratio: **1.0**
Health disparity gap: **N/a**
Health trend: **Improved**

Mammograms among AI/AN women 40+ were lower than Utah women 40+ overall between 2005 and 2015 reporting. The percentage of AI/AN women obtaining mammograms increased since 2015 reporting, which closed the health disparity gap.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2000, 2002, 2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2004, 2006–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016, 2018–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

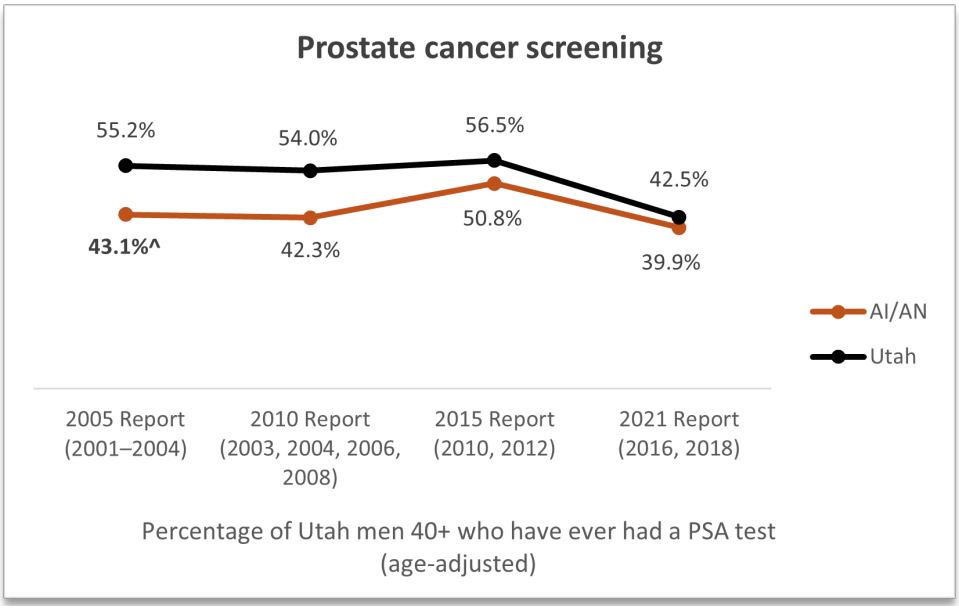


Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Decreased**
Health trend: **Improved**

Blood cholesterol screening among AI/AN adults was generally lower than Utah adults overall since 2005 reporting. Since 2010 reporting, blood cholesterol screening among both populations increased.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999, 2001, 2003; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003, 2005, 2007. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. Population Estimates: US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017, 2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017, 2019.

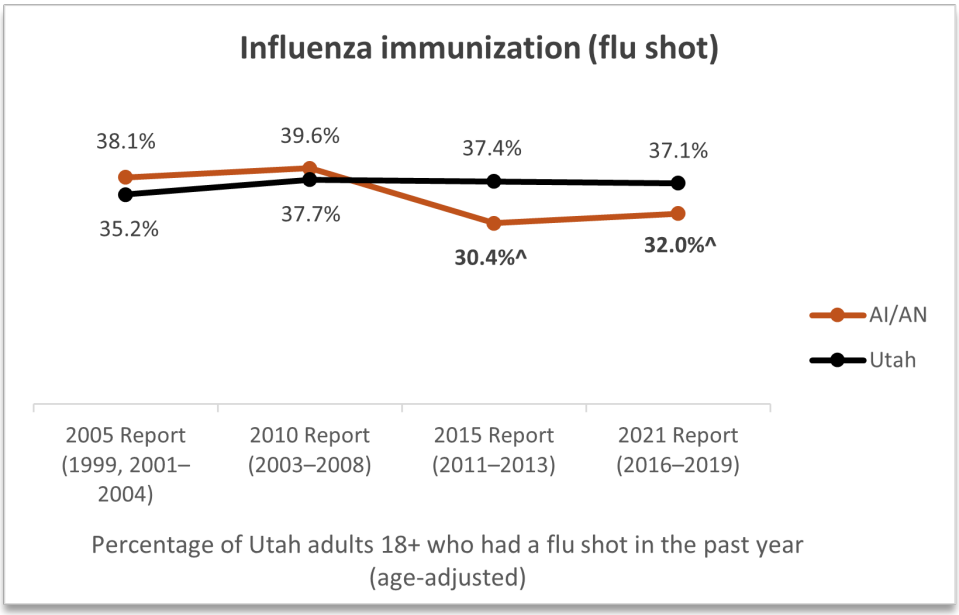


Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Decreased**
Health trend: **Recently worsened**

Prostate cancer screening among AI/AN men 40+ was lower than Utah men 40+ overall since 2005 reporting. Prostate cancer screening declined in both populations since 2015 reporting—an expected outcome since routine PSA-based prostate cancer screening was no longer recommended as of 2012.‡ The health disparity gap between AI/AN men and Utah men overall decreased.

^Statistically significantly different than Utah overall
‡Reference: Public Health Indicator Based Information System (IBIS), Complete Health Indicator Report of Prostate Cancer Screening (2021) Cancer Control Program, Bureau of Health Promotion, Utah Department of Health. ibis.health.utah.gov/ibisph-view/indicator/complete_profile/ProsCAScr.html

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2000, 2002, 2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2004, 2006–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016, 2018–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.



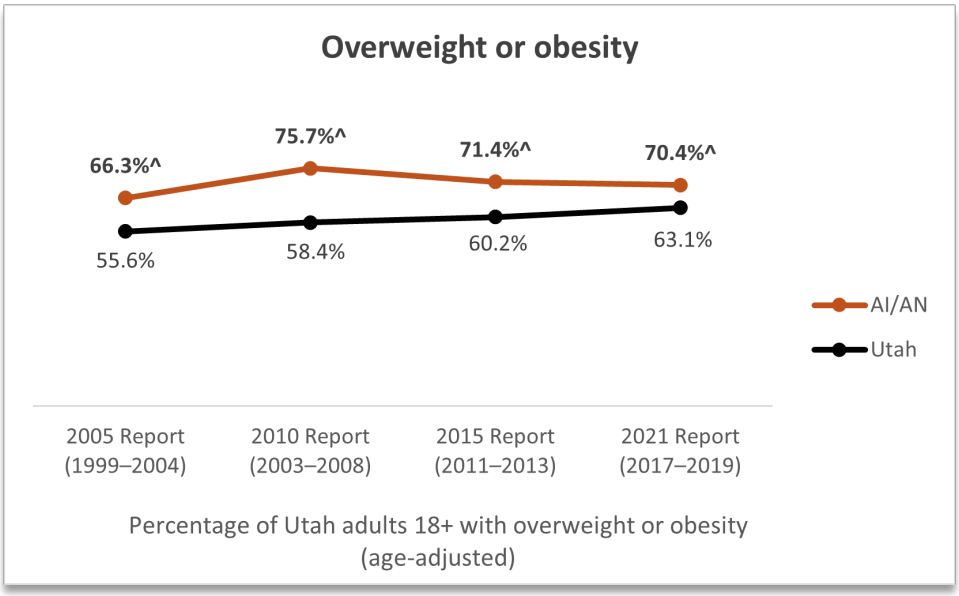
Health disparity: **Yes^**
Disparity ratio: **1.2**
Health disparity gap: **Increased**
Health trend: **Worsened**

Influenza immunization among AI/AN adults was similar to Utah adults overall between 2005 and 2010 reporting. Between 2010 and 2021 reporting, influenza immunization among AIAN adults declined and the health disparity gap increased. Influenza immunization among Utah adults overall changed little since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999, 2001–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003-2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2016–2019.

Physical activity and nutrition

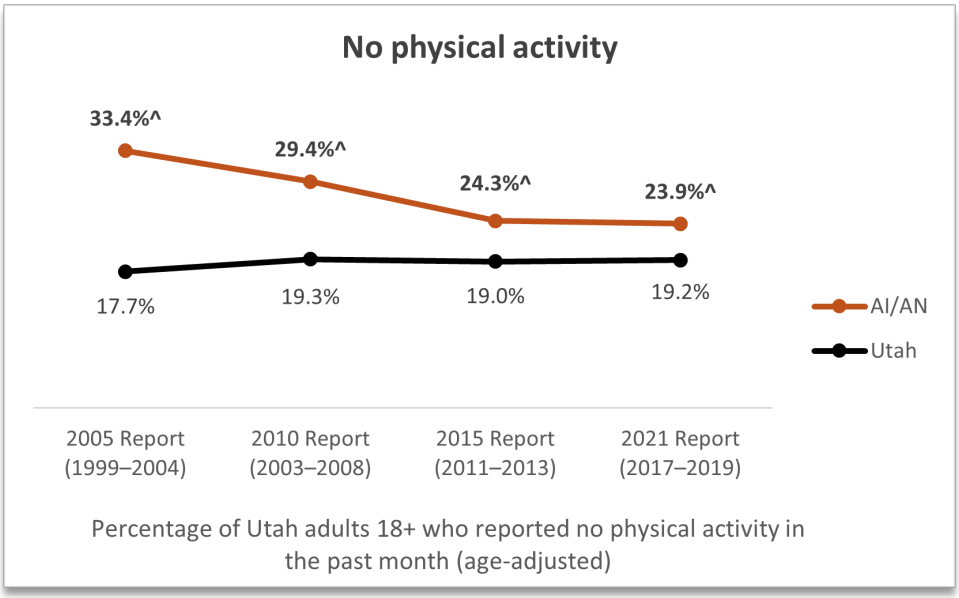


Health disparity: **Yes^**
Disparity ratio: **1.1**
Health disparity gap: **Persisted**
Health trend: **Improved**

Overweight or obesity among AI/AN adults was higher than Utah adults overall since 2005 reporting. Overweight or obesity increased among Utah adults since 2005 reporting and decreased among AI/AN adults since 2010 reporting. The health disparity gap has persisted.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003-2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey, 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

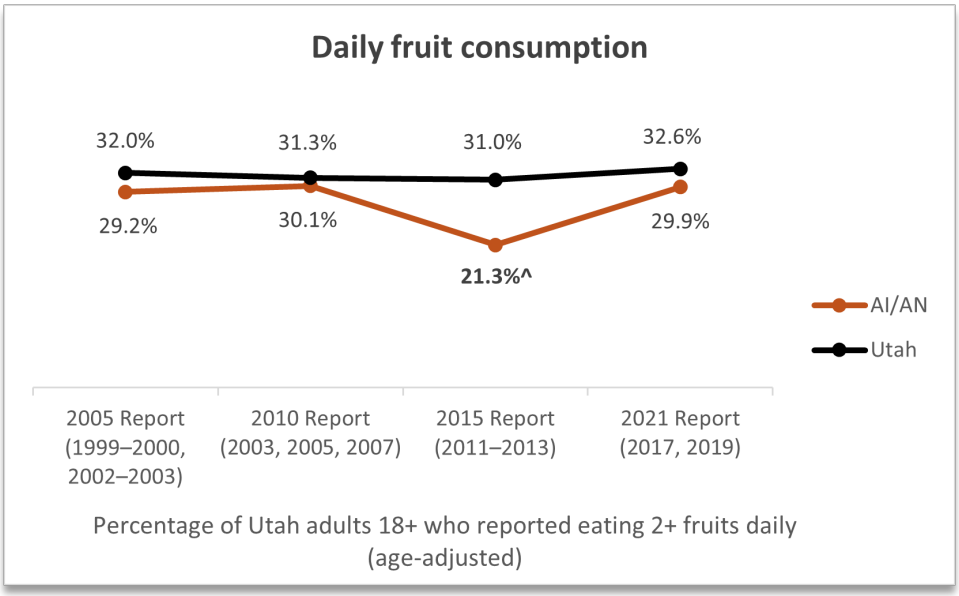


Health disparity: **Yes^**
Disparity ratio: **1.2**
Health disparity gap: **Decreased**
Health trend: **Improved**

Lack of physical activity among AI/AN adults was higher than Utah adults overall since 2005 reporting. Percentage of people reporting no physical activity improved among AI/AN adults and changed little among Utah adults overall, which decreased the health disparity gap. As of 2021 reporting, approximately one-fourth of AI/AN adults reported no physical activity in the previous month.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

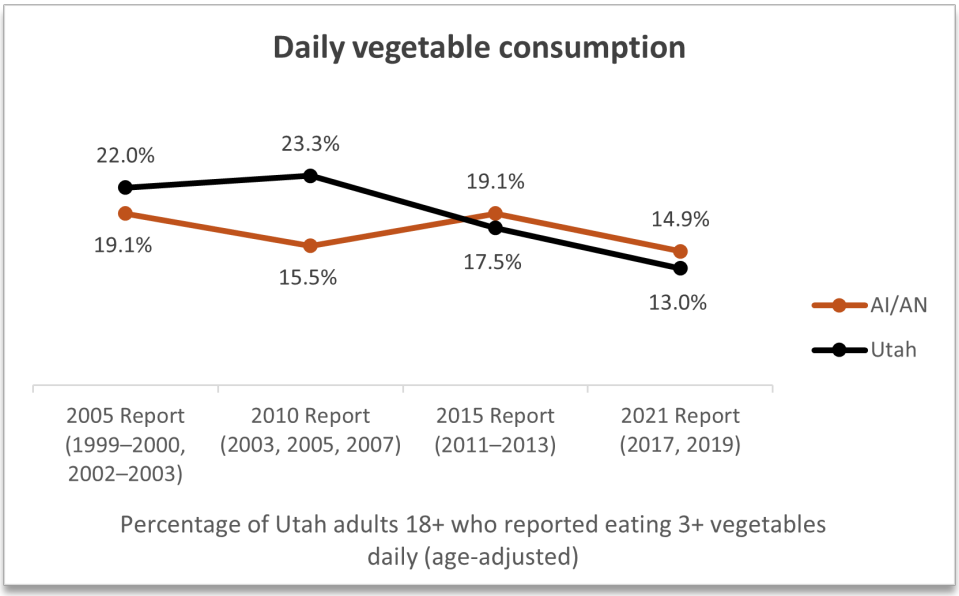


Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Fluctuated**
Health trend: **Fluctuated**

Daily fruit consumption among AI/AN adults was similar to or lower than Utah adults overall since 2005 reporting. Daily fruit consumption changed little among Utah adults overall and fluctuated among AI/AN adults since 2005 reporting. As of 2021 reporting, one-third of AI/AN adults consumed two or more fruits daily.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2000, 2002–2003; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003, 2005, 2007. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017, 2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017, 2019.

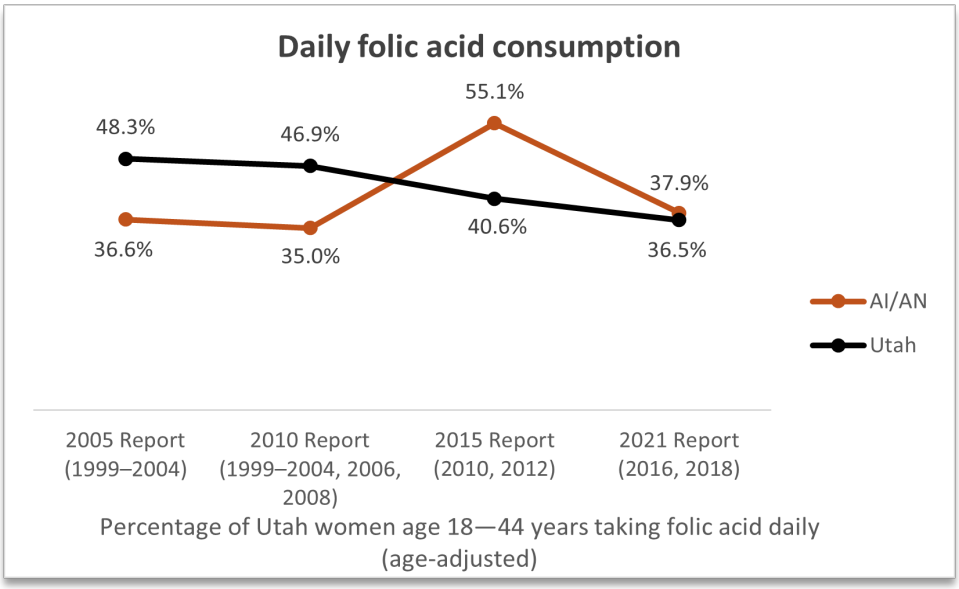


Health disparity: **No**
Disparity ratio: **0.9**
Health disparity gap: **N/a**
Health trend: **Fluctuated**

Daily vegetable consumption among AI/AN adults was lower than or similar to Utah overall since 2005 reporting. Daily vegetable consumption declined among Utah adults overall and fluctuated among AI/AN adults since 2005 reporting.

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2000, 2002–2003; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003, 2005, 2007. UDOH Office of Public Health Assessment, Population Estimates, 2005 –2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017, 2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017, 2019

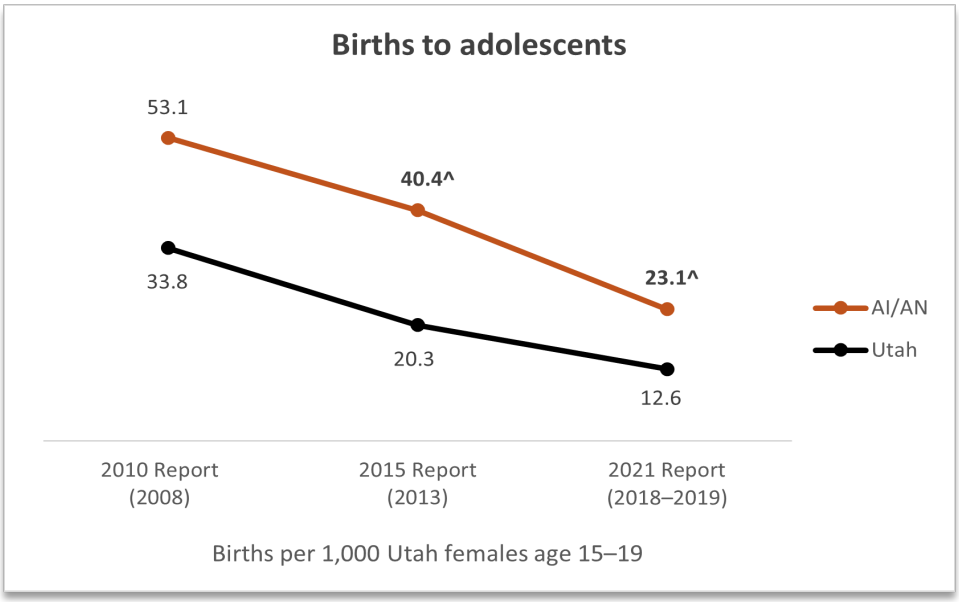
Health of mothers and infants



Health disparity: **No**
Disparity ratio: **1.0**
Health disparity gap: **N/a**
Health trend: **Fluctuated**

Daily folic acid consumption among AI/AN women 18–44 was lower than Utah women 18–44 overall between 2005 and 2010 reporting, then increased. Daily folic acid consumption declined among Utah women and fluctuated among AI/AN women.

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2004, 2006, 2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2010, 2012. US Census Bureau, American Community Survey 1-Year Estimates, 2010, 2012; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2016, 2018. US Census Bureau, American Community Survey 1-Year Estimates, 2016, 2018.

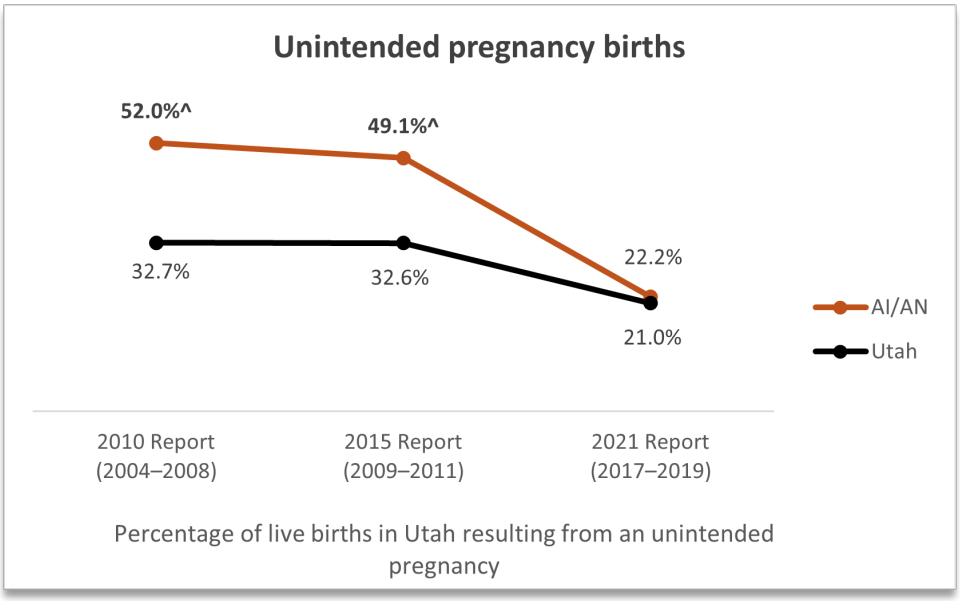


Health disparity: **Yes^**
Disparity ratio: **1.8**
Health disparity gap: **Persisted**
Health trend: **Improved**

Births to adolescents among AI/AN populations were higher than Utah overall since 2010 reporting. The birth rate among adolescents in both populations declined, and the health disparity gap persisted. The adolescent birth rate among AI/AN populations was approximately double Utah overall as of 2021 reporting.

Note: In 2010, the adolescent birth rate was of live births only. It is unclear whether the rate for the other years were also live births only.
^Statistically significantly different than Utah overall

Sources—2010 Report: UDOH Office of Vital Records and Statistics, Birth Certificate Database, 2008. UDOH Office of Public Health Assessment, Population Estimates, 2008; 2015 Report: UDOH Office of Vital Records and Statistics, Birth Certificates Database, 2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Birth Certificates Database, 2018–2019.

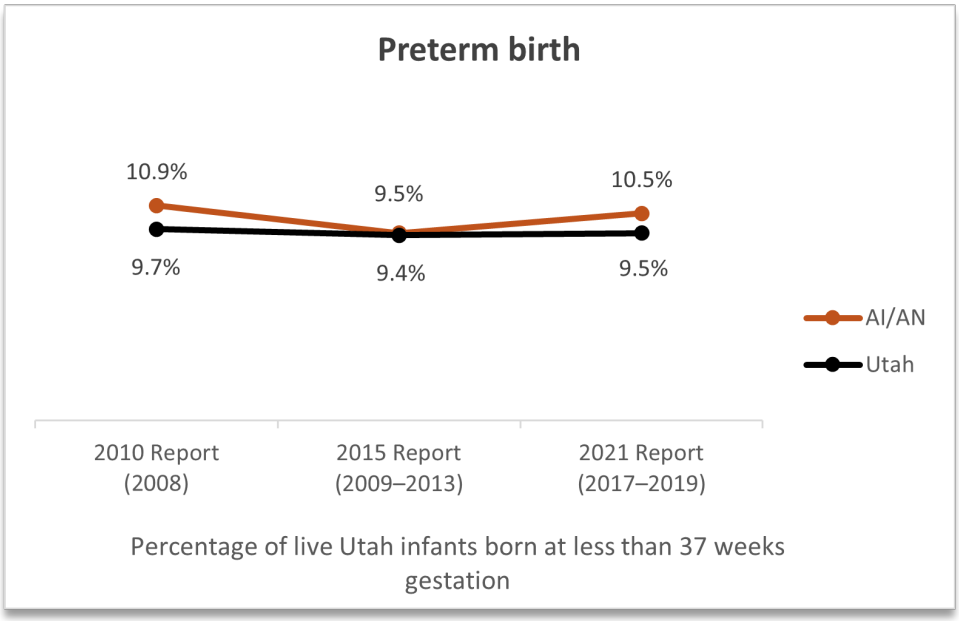


Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Decreased**
Health trend: **Improved**

Births resulting from unintended pregnancy among AI/AN populations was higher than Utah overall since 2010 reporting. Births from unintended pregnancy declined in both populations since 2015 reporting and declined faster among AI/AN populations, which decreased the health disparity gap.

^Statistically significantly different than Utah overall

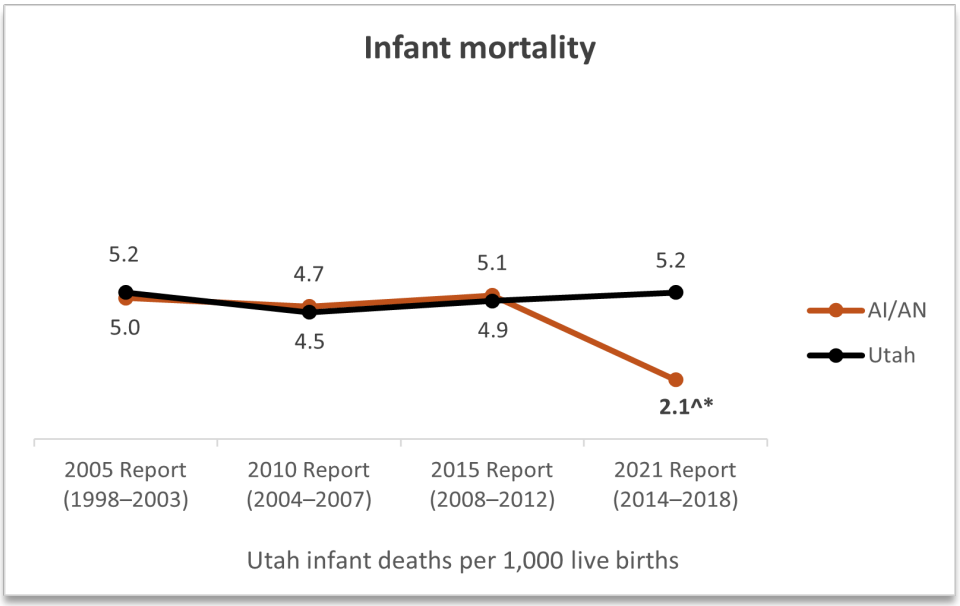
Sources—2010 Report: Utah Pregnancy Risk Assessment Monitoring System. UDOH Office of Vital Records and Statistics, Birth Certificate Database, 2004–2008; 2015 Report: Utah Pregnancy Risk Assessment Monitoring System, 2009–2011; 2021 Report: Utah Pregnancy Risk Assessment Monitoring System, 2017–2019.



Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Persisted**
Health trend: **Changed little**

Preterm birth among AI/AN infants was similar to Utah infants overall since 2010 reporting. Preterm birth changed little among both populations since 2010 reporting.

Sources—2010 Report: UDOH Office of Vital Records and Statistics, Birth Certificate Database, 2008; 2015 Report: UDOH Office of Vital Records and Statistics, Birth Certificate Database, 2009–2013; 2021 Report: UDOH Office of Vital Records and Statistics, Birth Certificates Database, 2017–2019.



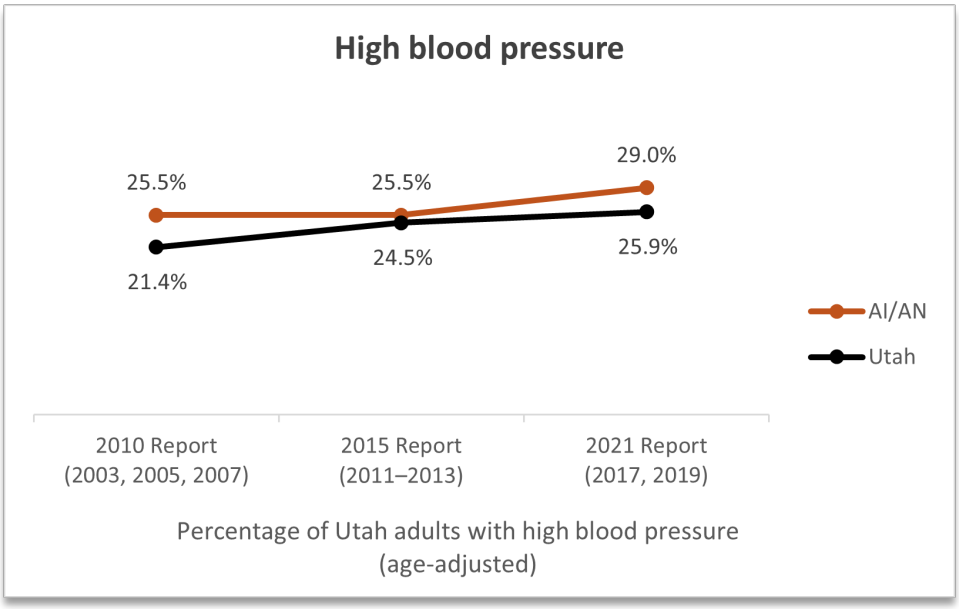
Health disparity: **No^***
Disparity ratio: **0.4**
Health disparity gap: **N/a**
Health trend: **Improved***

Infant mortality among AI/AN populations was similar to Utah overall between 2005 and 2015 reporting. Infant mortality changed little in both populations since 2005 reporting. In 2021 reporting, infant mortality among AI/AN populations declined,* but this may have been a fluctuation.

^Statistically significantly different than Utah overall
*Insufficient relative standard error to meet DHHS standard for data reliability, interpret with caution

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: UDOH Office of Vital Records and Statistics, Birth Certificate Database, 2004–2007; 2015 Report: UDOH Office of Vital Records and Statistics, Linked Birth and Death Certificate Database, Birth Cohort, 2008–2012; 2021 Report: UDOH Office of Vital Records and Statistics, Linked Birth and Death Certificate Database, Birth Cohort, 2014–2018.

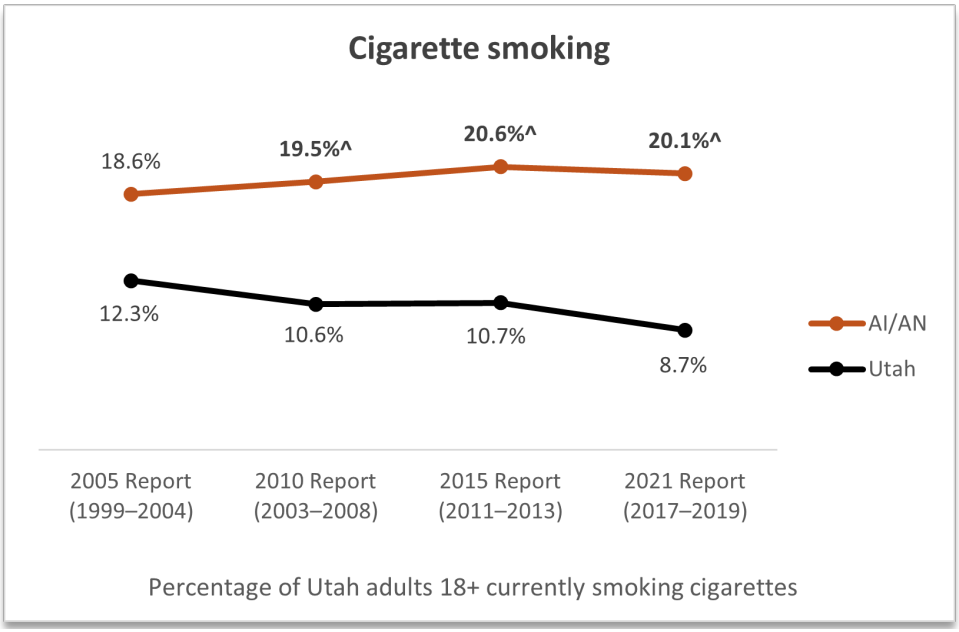
Risk factors



Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Persisted**
Health trend: **Worsened**

High blood pressure among AI/AN adults was slightly higher than Utah adults overall since 2010 reporting. The percentage of adults with high blood pressure increased in both populations since 2010 reporting.

Sources—2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003, 2005, 2007. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–201; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017, 2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017, 2019.

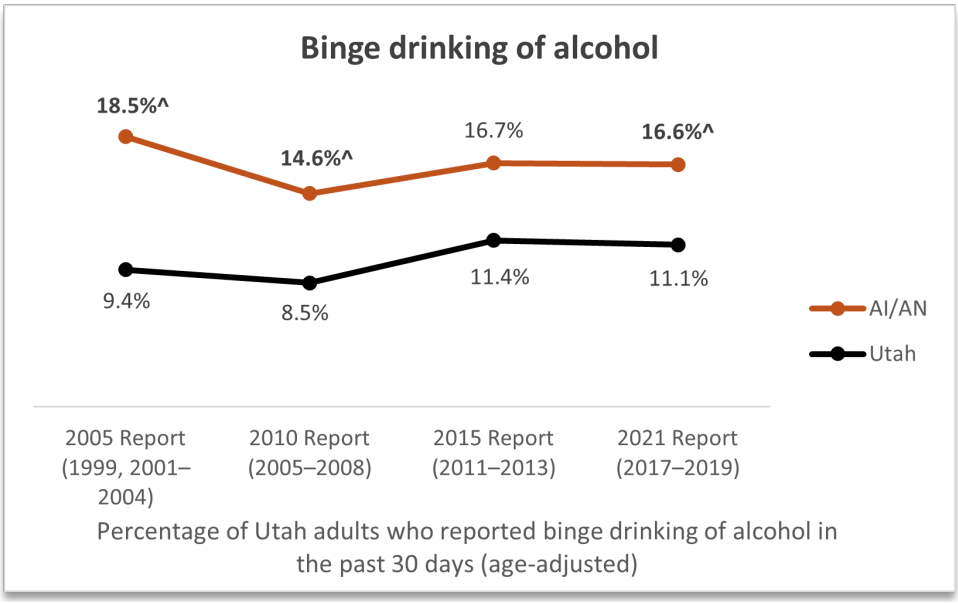


Health disparity: **Yes^**
Disparity ratio: **2.3**
Health disparity gap: **Increased**
Health trend: **Changed little**

Cigarette smoking among AI/AN adults was higher than Utah adults overall since 2005 reporting. Cigarette smoking declined among Utah adults overall and changed little among AI/AN adults since 2005 reporting, which increased the health disparity gap.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

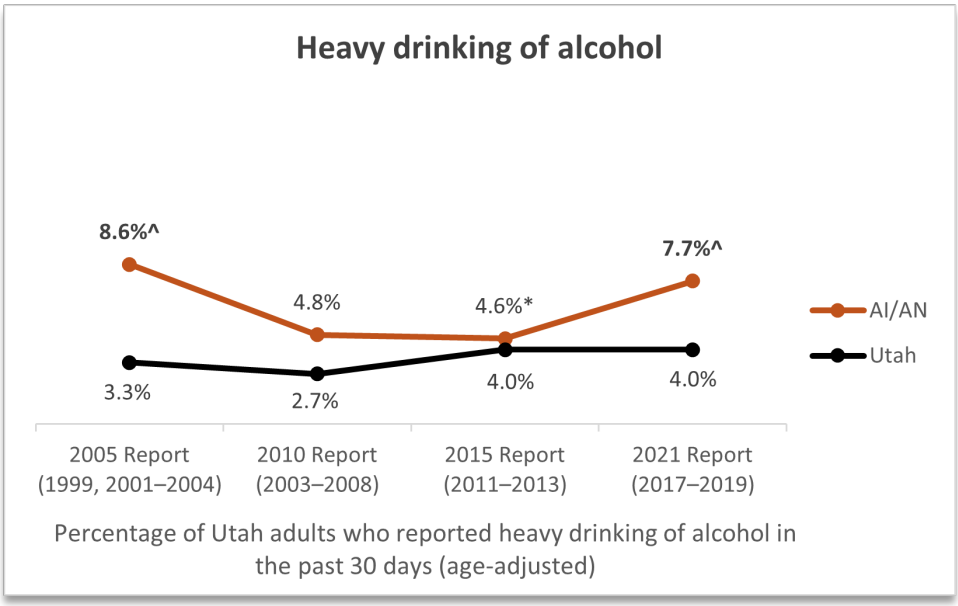


Health disparity: **Yes^**
Disparity ratio: **1.5**
Health disparity gap: **Persisted**
Health trend: **Changed little**

Binge drinking of alcohol among AI/AN adults was higher than Utah adults overall since 2005 reporting. Binge drinking (consuming 4–5 or more drinks in two hours) changed little among AI/AN adults and increased slightly among Utah adults overall since 2005 reporting, and the health disparity gap persisted.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999, 2001–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2005–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.



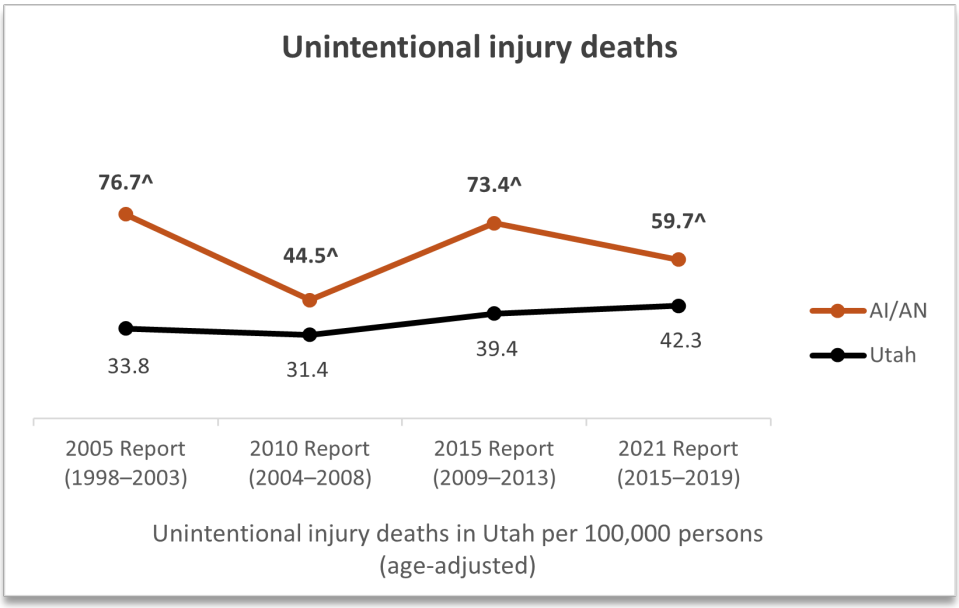
Health disparity: **Yes^**
Disparity ratio: **1.9**
Health disparity gap: **Recently increased**
Health trend: **Recently worsened**

Heavy drinking of alcohol among AI/AN adults was higher than Utah adults overall since 2005 reporting. Heavy drinking (consuming 8+ alcoholic beverages per week for women and 15+ per week for men) decreased among AI/AN adults between 2005 and 2015 reporting, then increased since 2015 reporting. Heavy drinking changed little among Utah adults overall.

^Statistically significantly different than Utah overall
*Insufficient relative standard error to meet DHHS standard for data reliability, interpret with caution

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 1999, 2001–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

Injuries

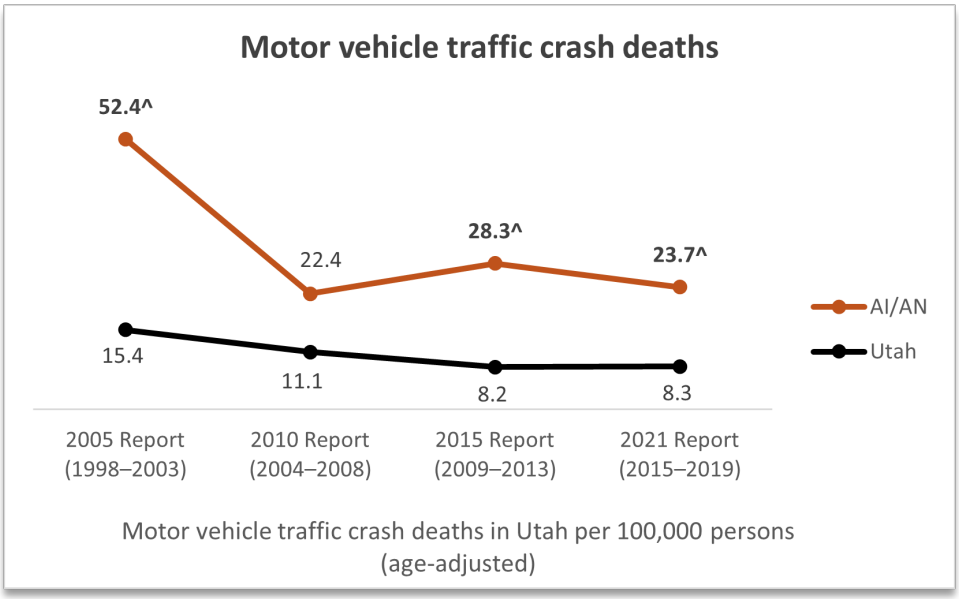


Health disparity: **Yes^**
Disparity ratio: **1.4**
Health disparity gap: **Decreased**
Health trend: **Fluctuated**

Unintentional injury death rates among AI/AN populations were higher than Utah overall since 2005 reporting. Unintentional injury death rates among Utah overall increased since 2005 reporting while deaths among AI/AN populations fluctuated.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2004–2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

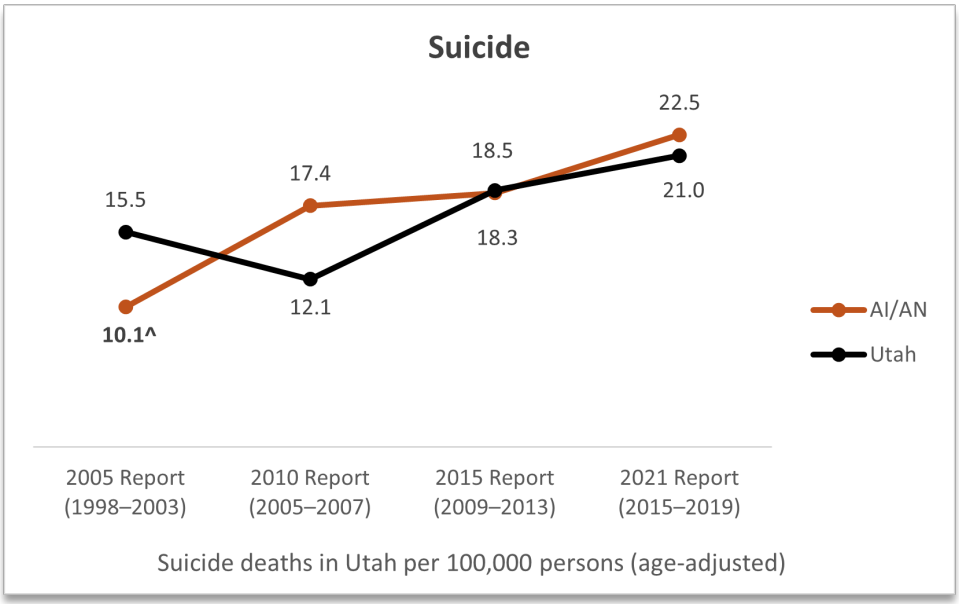


Health disparity: **Yes^**
Disparity ratio: **2.9**
Health disparity gap: **Decreased**
Health trend: **Improved**

Motor vehicle traffic crash (MVTC) death rates were higher among AI/AN populations than Utah overall between since 2005 reporting. Overall, MVTC deaths improved in both populations since 2005 reporting, and the health disparity gap decreased.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2004–2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau. Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.



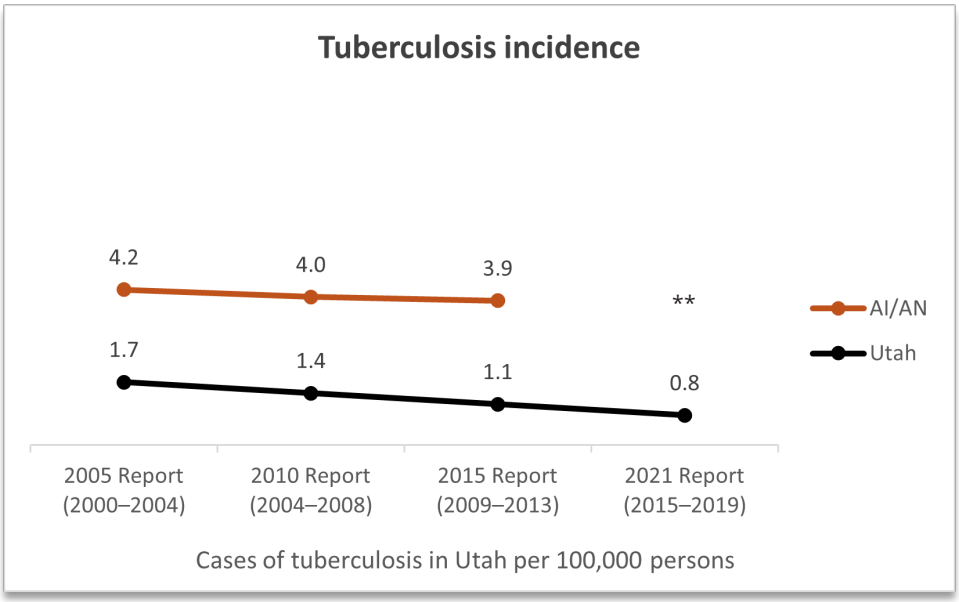
Health disparity: **Potential**
Disparity ratio: **1.1**
Health disparity gap: **Fluctuated**
Health trend: **Worsened**

Suicide rates among AI/AN populations fluctuated in comparison with Utah overall. Suicide rates increased among AI/AN populations since 2005 reporting and increased among Utah overall since 2010 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: The Utah Violent Death Reporting System (UTVDRS), 2005–2007. UDOH Center for Health Data, IBIS 2005–2007; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

Infectious diseases

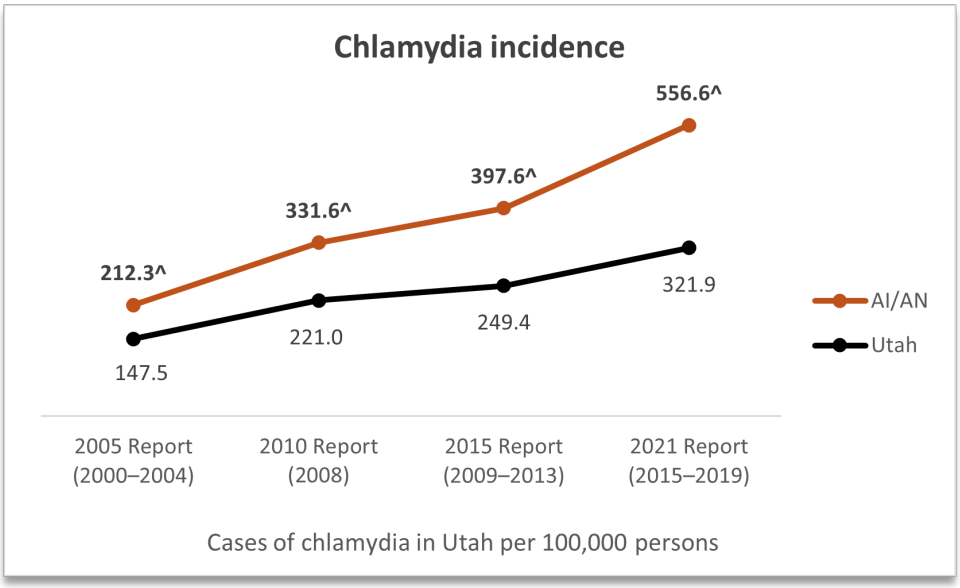


Health disparity: **Potential**
Disparity ratio: **3.6**
Health disparity gap: **Persisted**
Health trend: **Changed little**

Tuberculosis incidence among AI/AN populations was higher than Utah overall since 2005 reporting. Tuberculosis incidence rates changed little among AI/AN populations since 2005 reporting, and the health disparity gap persisted.

**The AI/AN estimate for the 2021 reporting year was suppressed because the standard error was greater than 50% or undetermined. The determination of the health disparity and calculation of the disparity ratio were therefore based on the data estimates reported in 2015.

Sources—2005 Report: UDOH Bureau of Communicable Disease Control, 2000–2004; 2010 Report: UDOH Bureau of Epidemiology, 2004–2008. Governor's Office of Planning and Budget, 2008; 2015 Report: UDOH Bureau of Epidemiology, 2009–2013; 2021 Report: UDOH Bureau of Epidemiology, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

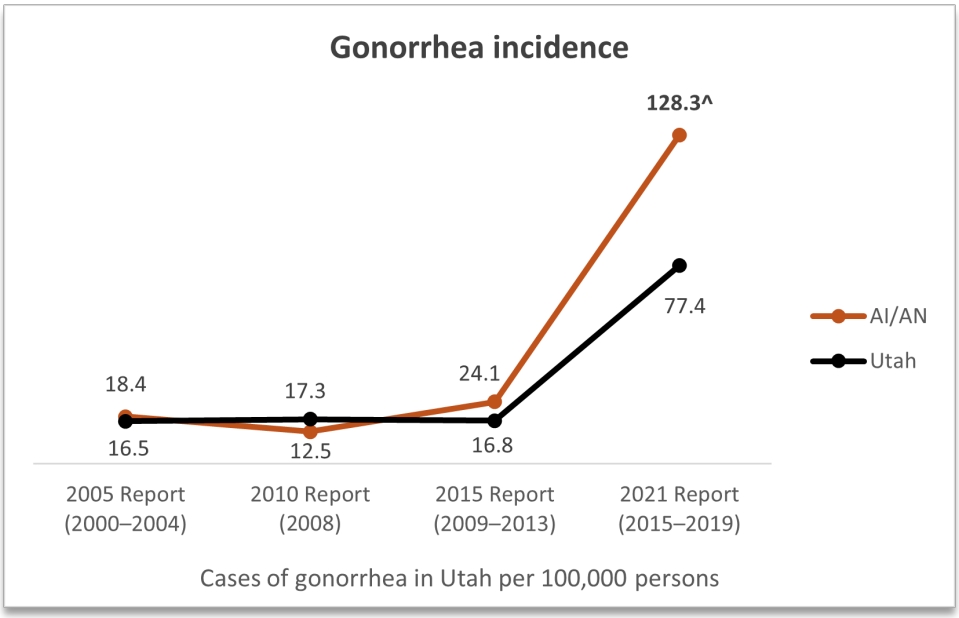


Health disparity: **Yes^**
Disparity ratio: **1.7**
Health disparity gap: **Increased**
Health trend: **Worsened**

Chlamydia incidence among AI/AN populations was higher than Utah overall since 2005 reporting. Chlamydia incidence rates increased among both populations since 2005, and increased faster among AI/AN populations, which increased the health disparity gap.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Bureau of Communicable Disease Control, 2000–2004; 2010 Report: UDOH Bureau of Epidemiology, 2008. Governor's Office of Planning and Budget, 2008; 2015 Report: UDOH Bureau of Epidemiology, UT-NEDSS Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Bureau of Epidemiology, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.



Health disparity: **Yes^**
Disparity ratio: **1.7**
Health disparity gap: **Increased**
Health trend: **Worsened**

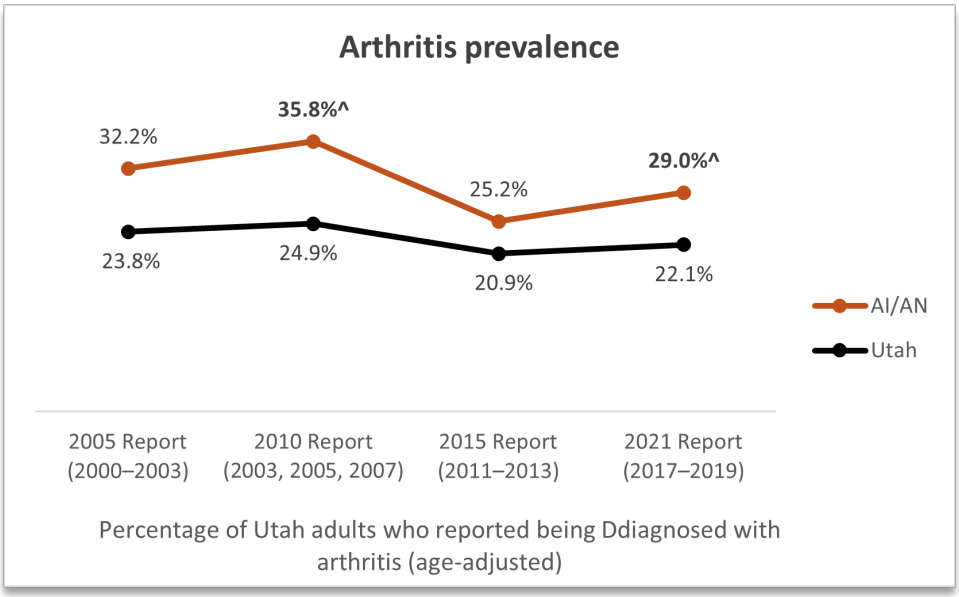
Gonorrhea incidence among AI/AN populations was higher than Utah overall since 2015 reporting. Between 2015 and 2021 reporting, gonorrhea incidence among AI/AN populations increased by over 400%. By 2021 reporting, gonorrhea incidence rates were at an all-time high in Utah due to a shift in gonorrhea epidemiology‡.

^Statistically significantly different than Utah overall

‡Reference: 1. Watson J, Carlile J, Dunn A, et al, Increased Gonorrhea Cases—Utah, 2009–2014. MMWR Morb Mortal Wkly Rep 2016;65:889–893. DOI: http://dx.doi.org/10.15585/mmwr.mm6534a1external icon; 2. Public Health Indicator Based Information System (IBIS), Report of Gonorrhea Cases. (2022) Bureau of Epidemiology, Utah Department of Health. https://ibis.health.utah.gov/ibisph-view/indicator/view/GonCas.html

Sources—2005 Report: UDOH Bureau of Communicable Disease Control, 2000–2004; 2010 Report: UDOH Bureau of Epidemiology, 2008. Governor's Office of Planning and Budget, 2008; 2015 Report: UDOH Bureau of Epidemiology, UT-NEDSS Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Bureau of Epidemiology, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

Chronic diseases

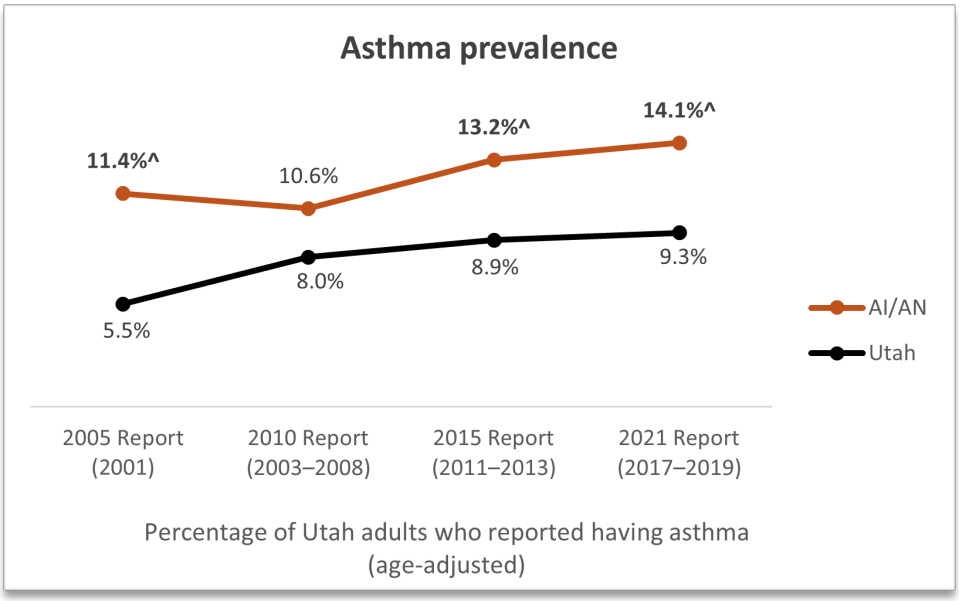


Health disparity: **Yes^**
Disparity ratio: **1.3**
Health disparity gap: **Persisted**
Health trend: **Improved**

Arthritis prevalence among AI/AN adults was higher than Utah adults overall since 2005 reporting. Arthritis prevalence changed little among Utah adults overall since 2005 reporting. Arthritis prevalence decreased overall among AI/AN adults since 2005 reporting, and a health disparity gap persisted.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2000–2003; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003, 2005, 2007. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011-2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

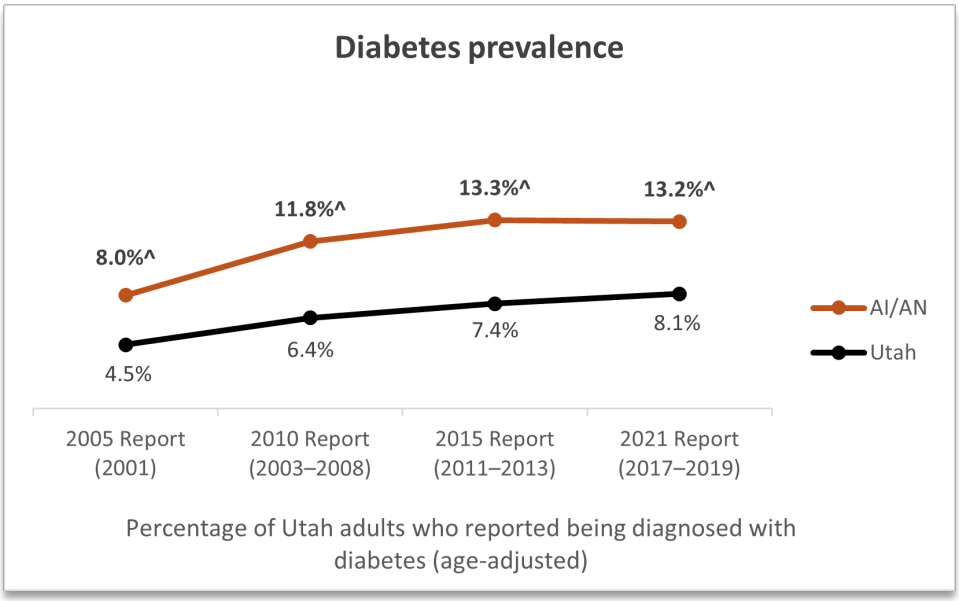


Health disparity: **Yes^**
Disparity ratio: **1.5**
Health disparity gap: **Persisted**
Health trend: **Worsened**

Asthma prevalence among AI/AN adults was higher than Utah adults overall since 2005 reporting. Asthma prevalence among both populations worsened since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH, Health Status Survey, 2001; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008; UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

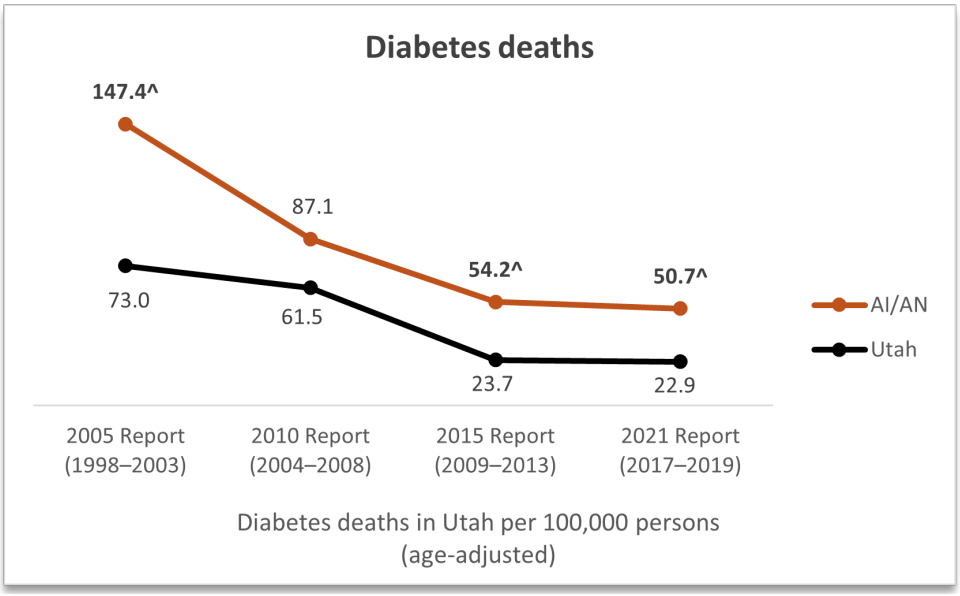


Health disparity: **Yes^**
Disparity ratio: **1.6**
Health disparity gap: **Persisted**
Health trend: **Worsened**

Diabetes prevalence among AI/AN adults was higher than Utah adults overall since 2005 reporting. Diabetes prevalence increased among both populations since 2005 reporting, and the health disparity gap persisted.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH, Health Status Survey, 2001; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003–2008; UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community Survey 3-Year Estimates, 2011–2013; 2021 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2017–2019. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

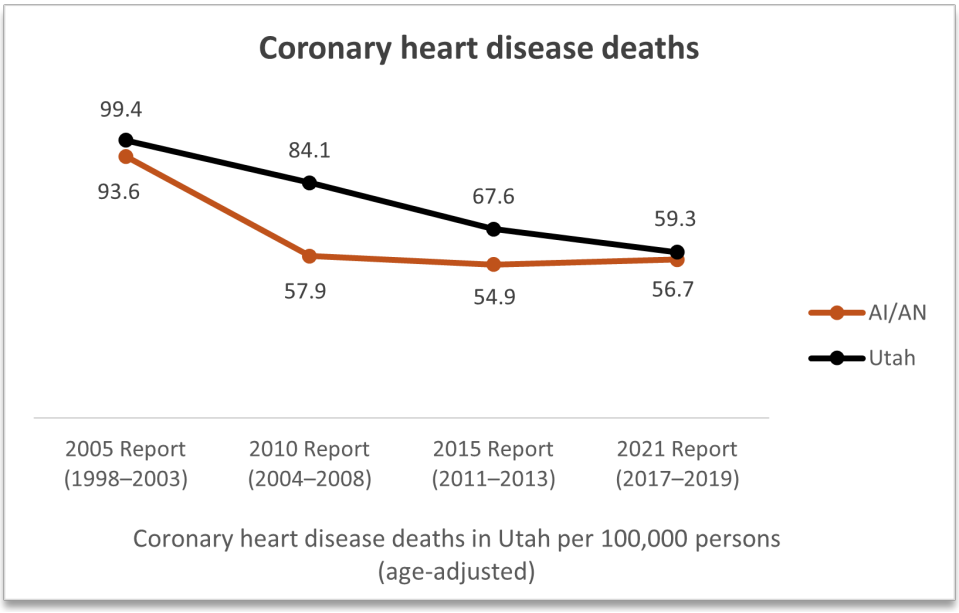


Health disparity: **Yes^**
Disparity ratio: **2.2**
Health disparity gap: **Persisted**
Health trend: **Improved**

Diabetes death rates among AI/AN populations were higher than Utah overall since 2005 reporting. Deaths from diabetes declined in both populations. Among AI/AN populations, diabetes death rates declined by more than 65% since 2005 reporting.

^Statistically significantly different than Utah overall

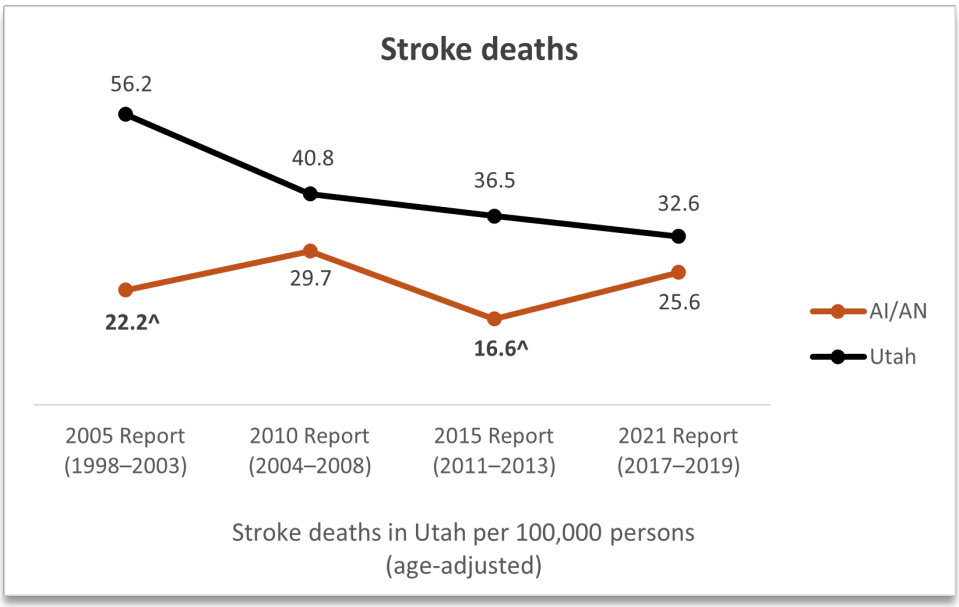
Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2004–2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2017–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.



Health disparity: **No**
Disparity ratio: **1.0**
Health disparity gap: **N/a**
Health trend: **Improved**

Coronary heart disease death rates among AI/AN populations were lower than Utah overall since 2005 reporting. Coronary heart disease deaths among AI/AN populations declined between 2005 and 2010 reporting and changed little since 2010 reporting. Coronary heart disease deaths also declined among Utah overall since 2005 reporting.

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998¬–2003; 2010 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2004–2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2011–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2017–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.



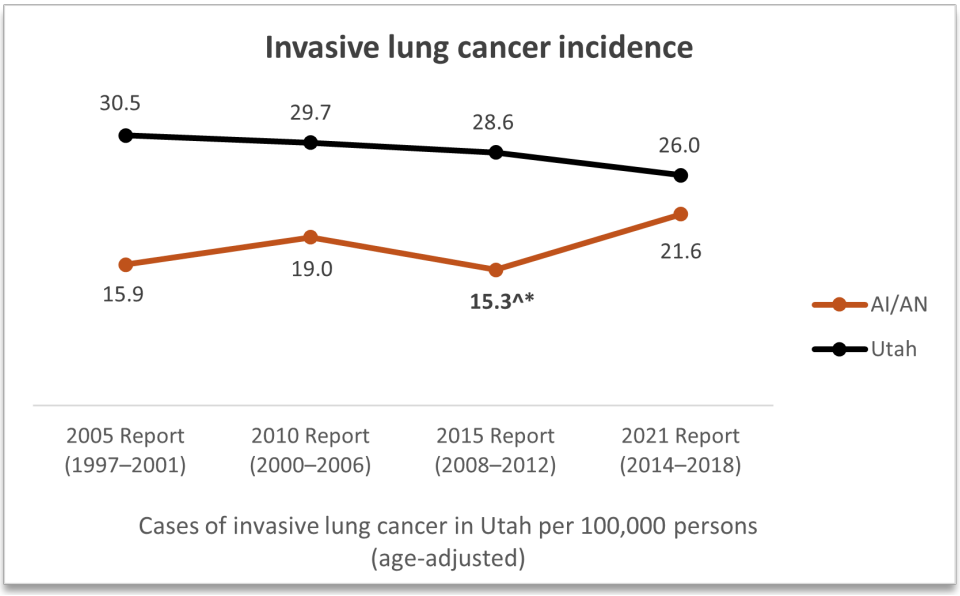
Health disparity: **No**
Disparity ratio: **0.8**
Health disparity gap: **N/a**
Health trend: **Fluctuated**

Stroke death rates among AI/AN populations were lower than Utah overall since 2005 reporting. Deaths from stroke declined among Utah overall and fluctuated among AI/AN populations since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database (2004–2008). UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2011–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2017–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, Version 2019.

Cancer

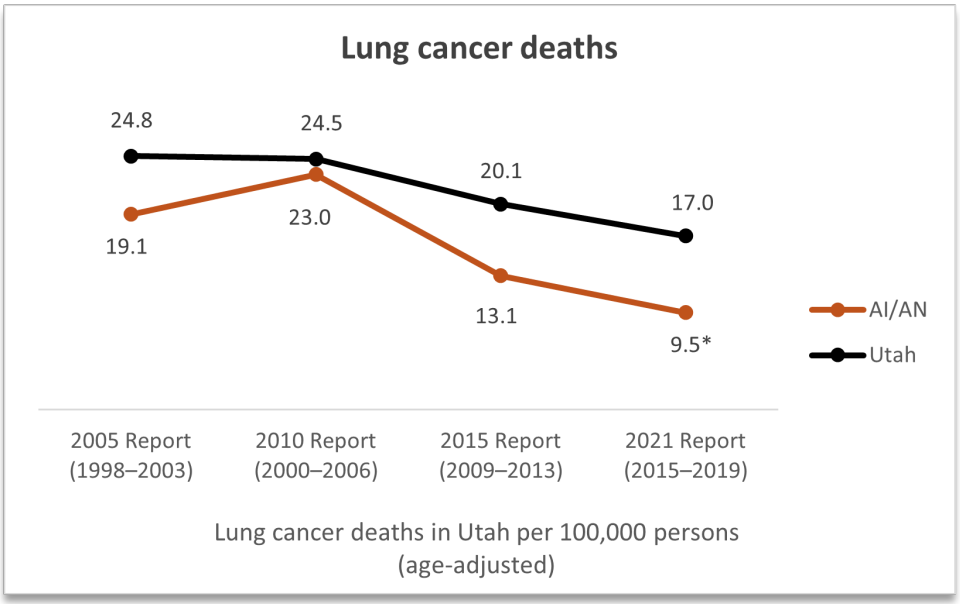


Health disparity: **No**
Disparity ratio: **0.8**
Health disparity gap: **N/a**
Health trend: **Worsened**

Lung cancer incidence rates among AI/AN populations were lower than Utah overall since 2005 reporting. Lung cancer incidence declined among Utah overall and increased among AI/AN populations since 2005 reporting.

^Statistically significantly different than Utah overall
*Insufficient relative standard error to meet DHHS standard for data reliability, interpret with caution.

Sources—2005 Report: Utah Cancer Registry, Surveillance, Epidemiology, and End Results (SEER) Program, 1997–2001; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000–2006; 2015 Report: Utah Cancer Registry, SEER, 2008–2012. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: Utah Cancer Registry, SEER, 2014–2018. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

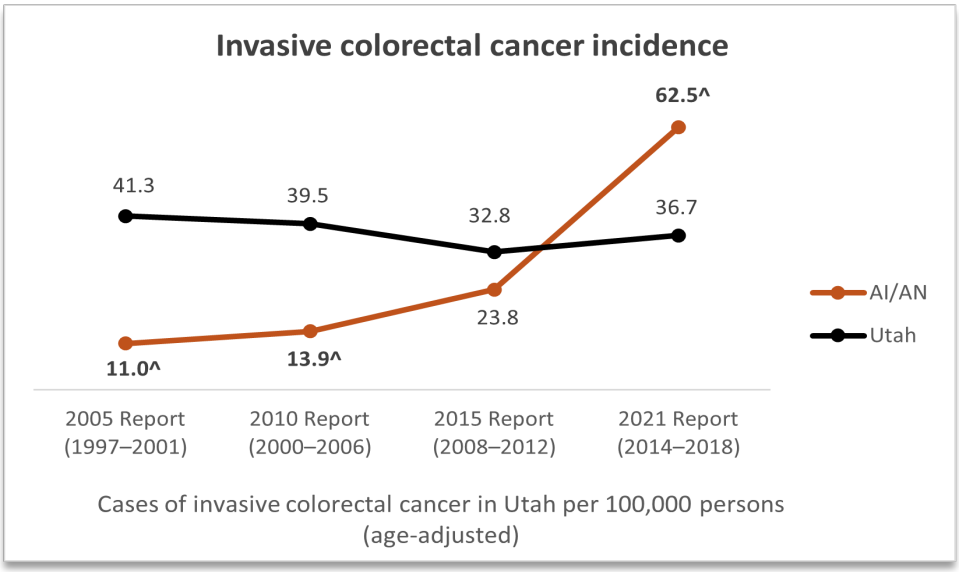


Health disparity: **No***
Disparity ratio: **0.6**
Health disparity gap: **N/a**
Health trend: **Improved***

Lung cancer death rates among AI/AN populations were lower than Utah overall since 2005 reporting. Deaths from lung cancer declined among both populations since 2005 reporting. Lung cancer deaths among AI/AN populations declined by half since 2005 reporting.

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

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000–2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

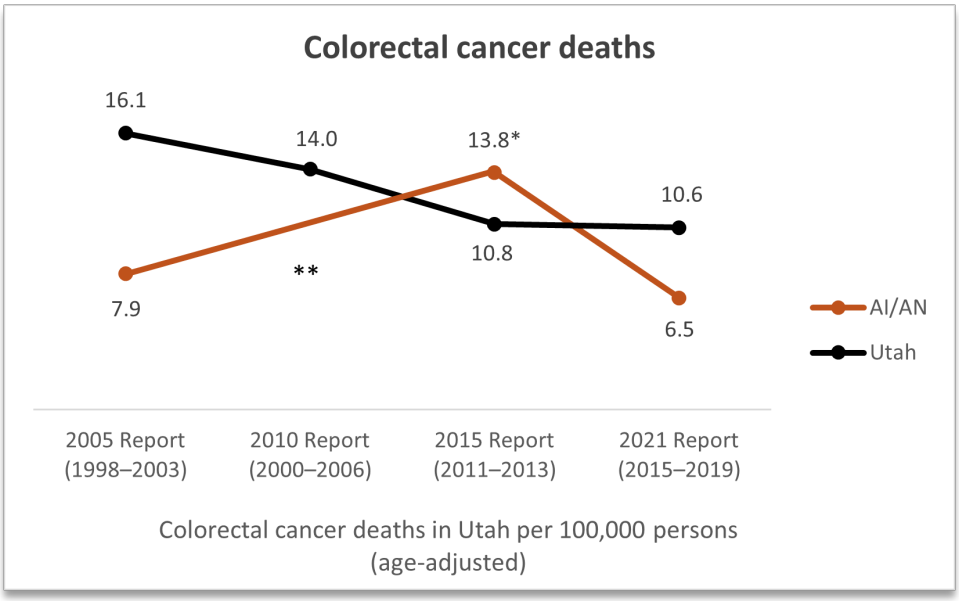


Health disparity: **Yes^**
Disparity ratio: **1.7**
Health disparity gap: **Emerged**
Health trend: **Worsened**

Colorectal cancer incidence rates among AI/AN populations were lower than Utah overall between 2005 and 2015 reporting, with a notable increase since 2010 reporting. As of 2021 reporting, colorectal cancer incidence was higher among AI/AN populations compared with Utah overall, and a health disparity emerged.

^Statistically significantly different than Utah overall

Sources—2005 Report: Utah Cancer Registry, SEER, 1997–2001; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000–2006; 2015 Report: Utah Cancer Registry, SEER, 2008–2012. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: Utah Cancer Registry, SEER, 2014–2018. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

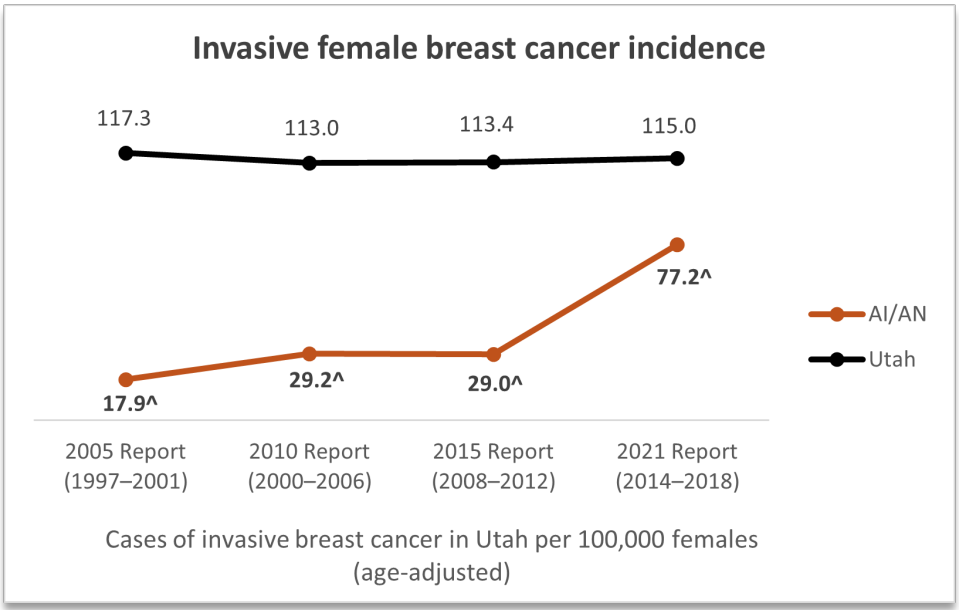


Health disparity: **No**
Disparity ratio: **0.6**
Health disparity gap: **N/a**
Health trend: **Fluctuated**

Colorectal cancer death rates among AI/AN populations increased between 2005 and 2015 reporting, then declined between 2015 and 2021 reporting. Deaths from colorectal cancer declined among Utah overall since 2005 reporting.

*Insufficient relative standard error to meet DHHS standard for data reliability, interpret with caution.
**The AI/AN population estimate for the 2010 reporting year was suppressed because the standard error was greater than 50% or undetermined. The determination of the health disparity and calculation of the disparity ratio were therefore based on the data estimates reported in 2015.

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000–2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2011–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

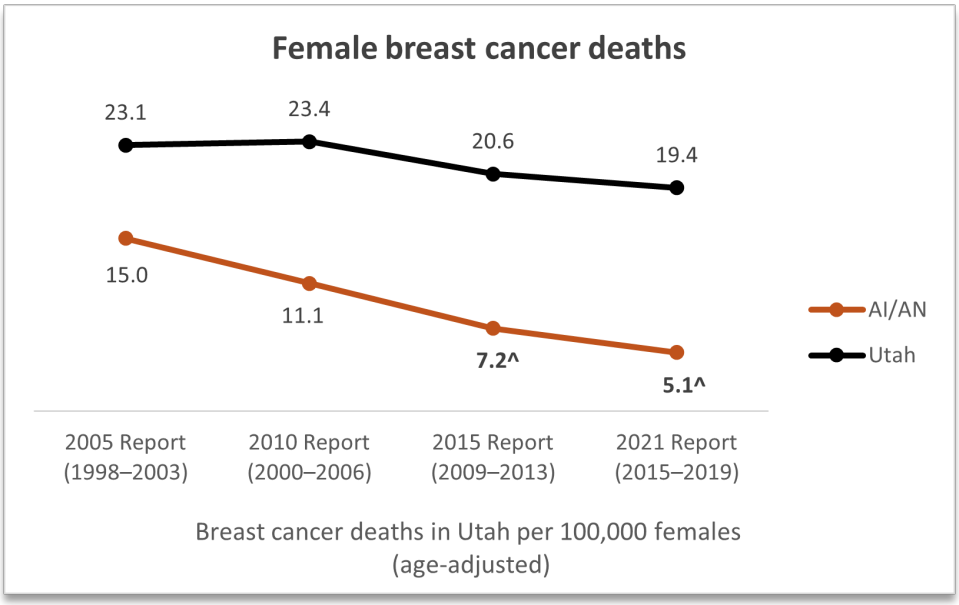


Health disparity: **No^**
Disparity ratio: **0.7**
Health disparity gap: **N/a**
Health trend: **Worsened**

Breast cancer incidence rates among AI/AN females were lower than Utah females overall since 2005 reporting. Breast cancer incidence increased among AI/AN females since 2005 reporting, with a large increase between 2015 and 2021 reporting. Breast cancer incidence changed little among Utah females overall since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: Utah Cancer Registry, SEER, 1997–2001; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000-2006; 2015 Report: Utah Cancer Registry, SEER, 2008–2012. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: Utah Cancer Registry, SEER, 2014–2018. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

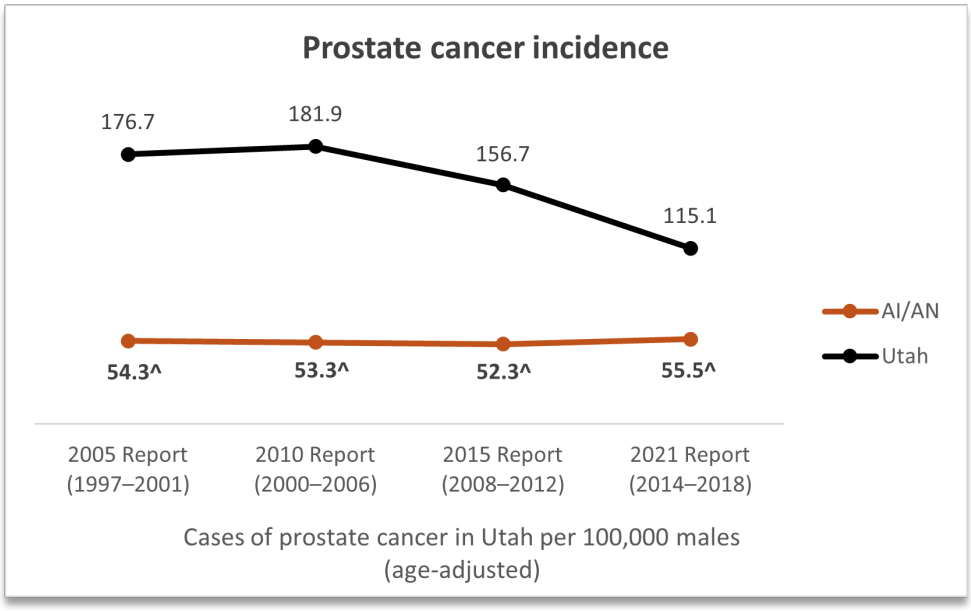


Health disparity: **No^**
Disparity ratio: **0.3**
Health disparity gap: **N/a**
Health trend: **Improved**

Breast cancer death rates among AI/AN females were lower than Utah females overall since 2005 reporting. Deaths from breast cancer declined among both populations since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000–2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

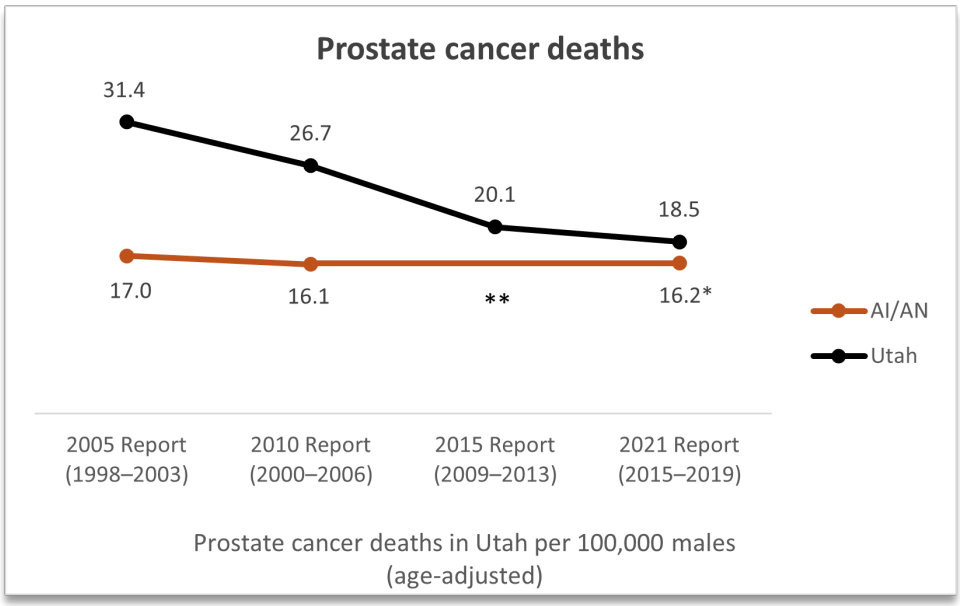


Health disparity: **No^**
Disparity ratio: **0.5**
Health disparity gap: **N/a**
Health trend: **Changed little**

Prostate cancer incidence rates among AI/AN males were lower than Utah males overall since 2005 reporting. Prostate cancer incidence generally declined among Utah males overall and changed little among AI/AN males since 2005 reporting.

^Statistically significantly different than Utah overall

Sources—2005 Report: Utah Cancer Registry, SEER, 1997–2001; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000-2006; 2015 Report: Utah Cancer Registry, SEER, 2008–2012. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: Utah Cancer Registry, SEER, 2014–2018. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.



Health disparity: **No***
Disparity ratio: **0.9**
Health disparity gap: **N/a**
Health trend: **Changed little***

Prostate cancer death rates among AI/AN males were lower than Utah males overall since 2005 reporting. Deaths from prostate cancer declined among Utah males overall and changed little* among AI/AN males since 2005 reporting.

*Insufficient relative standard error to meet DHHS standard for data reliability, interpret with caution.
**The AI/AN population estimate for the 2015 reporting year was suppressed because the standard error was greater than 50% or undetermined. The determination of the health disparity and calculation of the disparity ratio were therefore based on the data estimates reported in 2015.

Sources—2005 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 1998–2003; 2010 Report: Utah Cancer Registry, SEER, 2000–2006. US Census Bureau Population Estimates Program, 2000–2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2013; 2021 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

Additional resources

Other reports in this series

Twenty years of health data for American Indian/Alaska Native communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_AIAN.pdf

Twenty years of health data for Asian/Asian American communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_Asian.pdf

Twenty years of health data for Black/African American communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_BAA.pdf

Twenty years of health data trends for Hispanic/Latino communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_Hispanic_Latino.pdf

Twenty years of health data for White, non-Hispanic communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_White-NH.pdf