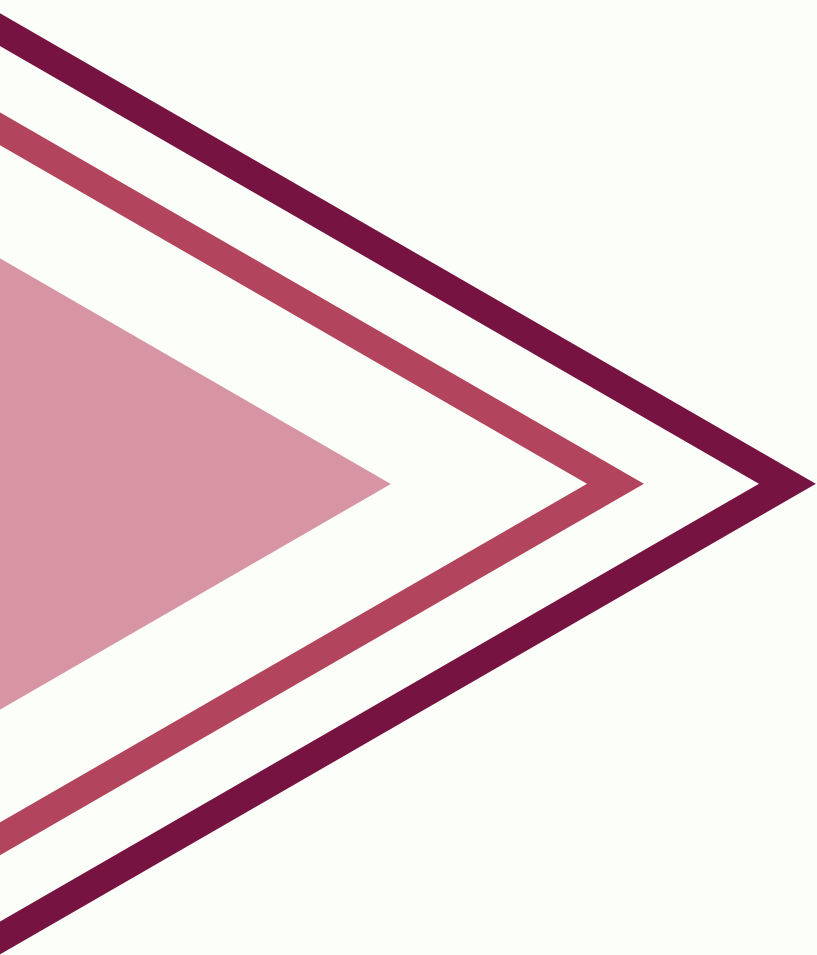

Twenty years of health data

for Native Hawaiian/Pacific Islander
communities in Utah



A technical report



Utah Department of

Health & Human Services

Health Equity

June 2023

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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)
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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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 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 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

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 1997–2004 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 delayed until 2021.

Throughout the Moving Forward reports, 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 gaps were assessed based on 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). For some indicators during some years of data collection, Asian/Asian American and Native Hawaiian/Pacific Islander populations were combined at the point of data collection. In those instances, data are not presented as they are not compatible with data for the Native Hawaiian/Pacific Islander population alone.

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 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.

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

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 clefts, critical congenital heart defects, Down syndrome, neural

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>

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.

Native Hawaiian/Pacific Islander populations in Utah

More than 53,000 people who identify as Native Hawaiian/Pacific Islander reside in Utah. People of Tongan, Samoan, and Native Hawaiian ancestry comprise 82% of Native Hawaiian/Pacific Islander populations in the state.⁶ Additional Pacific Islander populations in Utah include those with Chamorro, Fijian, and Marshallese ancestries. Salt Lake County has the state's highest proportion of Native Hawaiian/Pacific Islander populations, at nearly 53%.⁷ About one in four people of Tongan descent living in the United States live in Utah, and the majority live in Salt Lake County.⁶ Native Hawaiian/Pacific Islander populations in Utah experienced rapid growth in the past decade—they increased by 52% between 2010 and 2020.⁸ The median age of Native Hawaiian/Pacific Islander populations in Utah is 28.3 years.⁹

Health status

Overall, the data presented in this report show that in Utah, Native Hawaiian/Pacific Islander populations experience a large number of health disparities when compared with the Utah population overall. While they have significantly lower rates of suicide, data over 20 years of reporting indicate health disparity gaps in Native Hawaiian/Pacific Islander populations in Utah increased or recently increased in the following: no health insurance, no primary care provider, diabetes prevalence, colorectal cancer incidence, fair or poor health, preterm birth, infant mortality, life expectancy at birth, and heavy drinking of alcohol. Health disparity gaps persisted in the areas of colorectal cancer deaths, stroke deaths, Pap testing, daily vegetable consumption, diabetes deaths, recent poor mental health, and prostate cancer screening. Health disparity gaps decreased or recently decreased in: poverty, child poverty, unintended pregnancy births, breast cancer deaths, births to adolescents, overweight or obesity, lung cancer incidence, and tuberculosis incidence. Health disparity gaps fluctuated for daily folic acid consumption and high blood pressure. Recently, health disparity gaps emerged in the indicators of breast cancer incidence, gonorrhea incidence, current cigarette smoking, no physical activity, binge drinking of alcohol, flu shot, and asthma prevalence.

⁶ U.S. Census Bureau 2016–2020 ACS 5-Year Estimates, Table B02019, Native Hawaiian and Other Pacific Islander Alone or In Any Combination by Selected Groups

⁷ U.S. Census Bureau 2016–2020 ACS 5-Year Estimates, Table B04006, People Reporting Ancestry

⁸ U.S. Census Bureau 2016–2020 ACS 5-Year Estimates, Table DP05, ACS Demographic and Housing Estimates, Race alone or in combination

⁹ U.S. Census Bureau 2017–2021 ACS 5-Year Estimates, Table B01002E, Median Age by Sex (Native Hawaiian and other Pacific Islander alone).

Overview of health disparities for Native Hawaiian/Pacific Islander populations in Utah

Table 2 presents an overview of health disparities and potential health disparities (referred to collectively as “health disparities”) among Native Hawaiian/Pacific Islander populations in Utah. Of 46 indicators analyzed, 34 indicators (74%) showed health disparities for Native Hawaiian/Pacific Islander populations when compared with Utah overall. Of 34 indicators showing health disparities, the health disparity gap decreased or recently decreased in eight indicators, persisted in seven indicators, increased or recently increased in nine indicators, emerged in seven indicators, and fluctuated in three indicators.

Table 2: Overview of health disparities for Native Hawaiian/Pacific Islander 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	▶ Poverty	▶ Recent poor mental health	▶ Life expectancy at birth	▶ No health insurance
▶ Mammograms	▶ Child poverty	▶ Pap testing	▶ No primary care provider	▶ Daily folic acid consumption
▶ Blood cholesterol screening	▶ Overweight or obesity	▶ Prostate cancer screening	▶ Fair or poor health	▶ High blood pressure
▶ Daily fruit consumption	▶ Births to adolescents	▶ Daily vegetable consumption	▶ Flu shot*	
▶ Unintentional injury deaths	▶ Unintended pregnancy births	▶ Diabetes deaths	▶ No physical activity*	
▶ Motor vehicle crash deaths	▶ Tuberculosis incidence	▶ Stroke deaths	▶ Preterm birth	
▶ Suicide	▶ Lung cancer incidence	▶ Colorectal cancer deaths	▶ Infant mortality	
▶ Arthritis prevalence	▶ Breast cancer deaths		▶ Current cigarette smoking*	
▶ Coronary heart disease deaths			▶ Binge drinking of alcohol*	
▶ Lung cancer deaths			▶ Heavy drinking of alcohol	
▶ Prostate cancer incidence			▶ Chlamydia incidence	
▶ Prostate cancer deaths			▶ Gonorrhea incidence*	
			▶ Asthma prevalence*	
			▶ Diabetes prevalence	
			▶ Colorectal cancer incidence	
			▶ Breast cancer incidence*	

*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 minority population may have improved, changed little, worsened, or fluctuated over time.

Table 3 catalogs 27 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 Native Hawaiian/Pacific Islander populations in Utah. Not included in Table 3 are three indicators in which the health disparity gap fluctuated: no health insurance, daily folic acid consumption, and high blood pressure. Also not included are four indicators in which the health trend was marked as "N/a": no primary care provider, unintended pregnancy births, colorectal cancer deaths and breast cancer deaths.

Table 3: Health disparity gaps and health trends for Native Hawaiian/Pacific Islander populations in Utah, 1997–2019 data

		Health disparity gap		
		Decreased/recently decreased	Persisted	Increased/recently increased/emerged
Health trend	Improved/recently improved	<ul style="list-style-type: none"> ▶ Poverty ▶ Child poverty ▶ Births to adolescents ▶ Tuberculosis incidence ▶ Lung cancer incidence 	<ul style="list-style-type: none"> ▶ Stroke deaths ▶ Diabetes deaths 	
	Changed little	<ul style="list-style-type: none"> ▶ Overweight or obesity 		
	Worsened/recently worsened		<ul style="list-style-type: none"> ▶ Pap testing ▶ Recent poor mental health ▶ Prostate cancer screening ▶ Daily vegetable consumption 	<ul style="list-style-type: none"> ▶ Life expectancy at birth ▶ Preterm birth ▶ Fair or poor health ▶ No physical activity* ▶ Flu shot* ▶ Infant mortality ▶ Current cigarette smoking* ▶ Binge drinking of alcohol* ▶ Heavy drinking of alcohol ▶ Chlamydia incidence ▶ Gonorrhea incidence* ▶ Asthma prevalence* ▶ Diabetes prevalence ▶ Colorectal cancer incidence ▶ Breast cancer incidence*

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

There were no health disparities in 12 of 46 indicators (26%) for Native Hawaiian/Pacific Islander 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 10 indicators with a determined health trend and no health disparities for Native Hawaiian/Pacific Islander populations in Utah. The health trend improved or recently improved in 6 indicators, worsened or recently worsened in 2 indicators, and fluctuated in 2 indicators. Two health trends marked as "N/a" are not shown in this table (lung cancer deaths and prostate cancer deaths).

Table 4: Health trends of indicators with no health disparities for Native Hawaiian/Pacific Islander populations, Utah, 1997–2019 data

Improved/recently improved	Worsened/recently worsened	Fluctuated
▶ Blood cholesterol screening	▶ Routine medical checkup	▶ Daily fruit consumption
▶ Mammograms	▶ Suicide	▶ Prostate cancer incidence
▶ Unintentional injury deaths		
▶ Vehicle crash deaths		
▶ Arthritis prevalence		
▶ Coronary heart disease deaths		

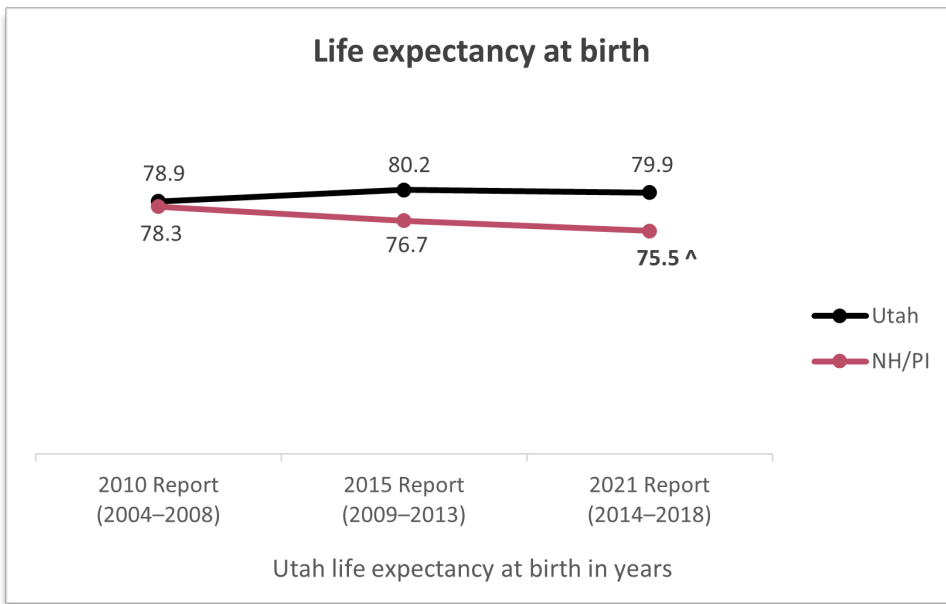
Conclusion

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, 'NHPI' is used to refer to 'Native Hawaiian/Pacific Islander.'

Socio-demographics

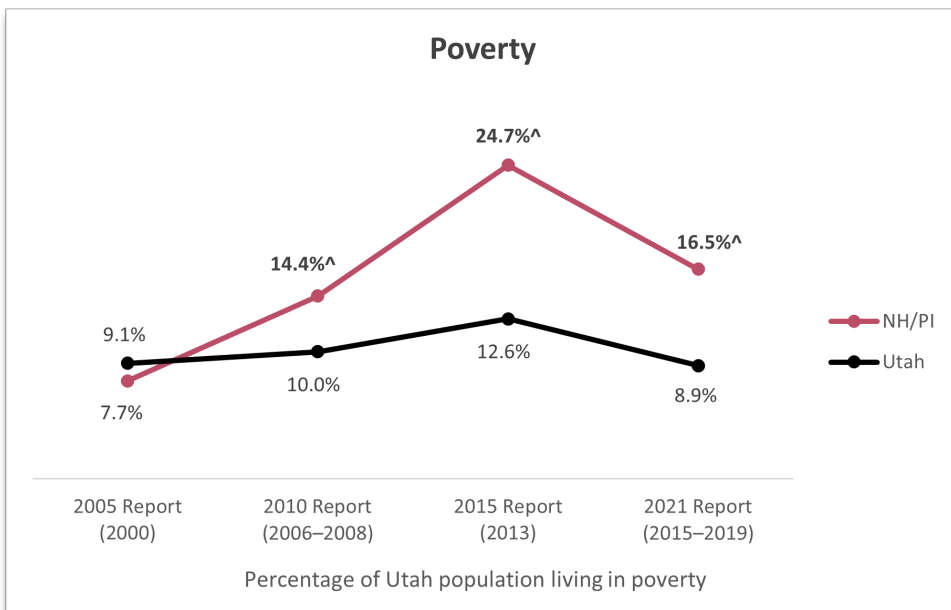


Health disparity: **Yes[^]**
 Disparity ratio: **1.1**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

Life expectancy at birth among NHPI populations was lower than Utah overall since 2010 reporting. Life expectancy among NHPI populations declined since 2010 reporting. As of 2021 reporting, life expectancy among NHPI populations was 4.4 years lower than Utah overall.

[^]Statistically significantly different than Utah overall

Sources—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.

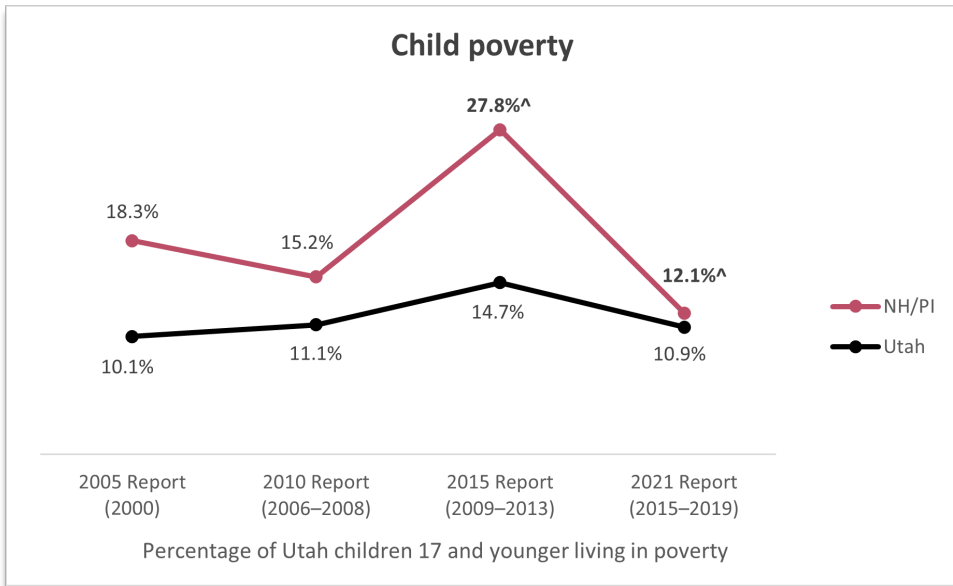


Health disparity: **Yes[^]**
 Disparity ratio: **1.9**
 Health disparity gap: **Recently decreased**
 Health trend: **Recently improved**

Poverty among NHPI populations was lower than Utah overall in 2005 reporting, then rose to a high of 24.7% in 2015 reporting. Since 2015 reporting, poverty and the health disparity gap decreased among NHPI 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.



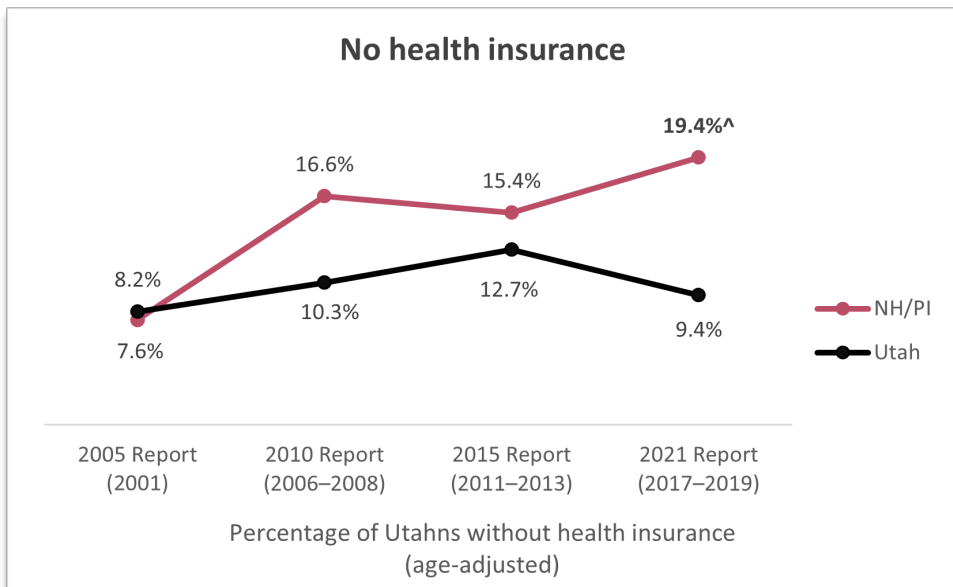
Health disparity: **Yes[^]**
 Disparity ratio: **1.1**
 Health disparity gap: **Recently decreased**
 Health trend: **Improved**

Child poverty among NHPI populations was higher than Utah overall since 2005 reporting. It rose to a high of 27.8% among NHPI populations in 2015 reporting. Between 2015 and 2021 reporting, child poverty among NHPI populations declined substantially, which decreased the health disparity gap.

[^]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



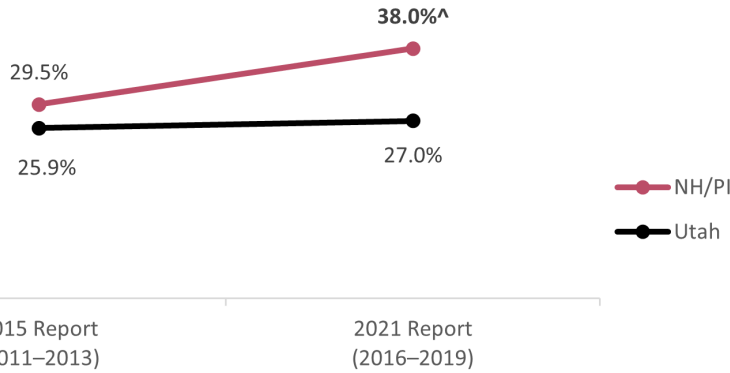
Health disparity: **Yes[^]**
 Disparity ratio: **2.1**
 Health disparity gap: **Fluctuated**
 Health trend: **Worsened**

No health insurance among NHPI populations was generally higher than Utah overall since 2005 reporting. The percentage of uninsured NHPI populations generally increased since 2005 reporting, and the health disparity gap fluctuated.

[^]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.

No primary care provider



Percentage of Utah adults with no personal health care provider (age-adjusted)

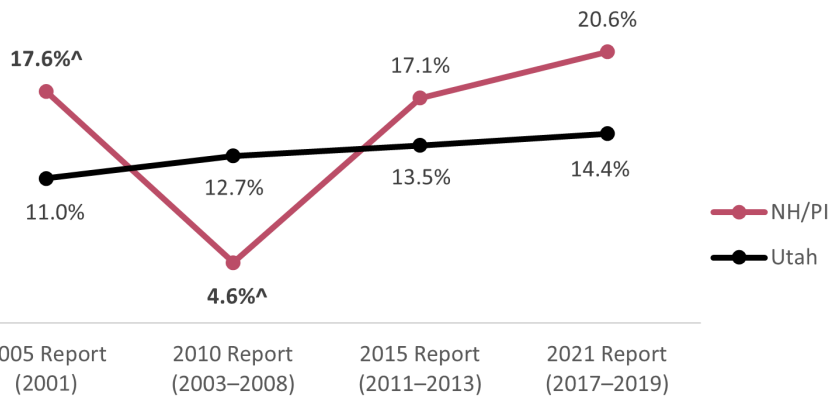
Health disparity: **Yes[^]**
 Disparity ratio: **1.4**
 Health disparity gap: **Increased**
 Health trend: **N/a**

The percentage of NHPI adults without a primary care provider (PCP) was higher than Utah adults overall since 2015 reporting. Lack of a PCP increased substantially among NHPI adults, which increased the health disparity gap. As of 2021 reporting, more than one-third of NHPI adults had no PCP, compared to about one-fourth of Utah adults overall.

[^]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.

Fair or poor health



Percentage of Utah adults reporting fair or poor health (age-adjusted)

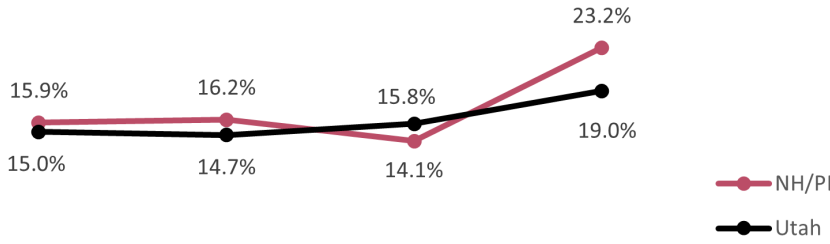
Health disparity: **Potential**
 Disparity ratio: **1.4**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

The percentage of NHPI adults who self-reported their general health status as “fair” or “poor” (instead of “excellent,” “very good,” or “good”) was generally higher than Utah overall since 2005 reporting. Since 2010 reporting, the percentage of adults reporting fair or poor health worsened among NHPI populations, and the health disparity gap increased.

[^]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.

Recent poor mental health



Percentage of Utah adults reporting 7+ days when mental health was not good in the past month (age-adjusted)

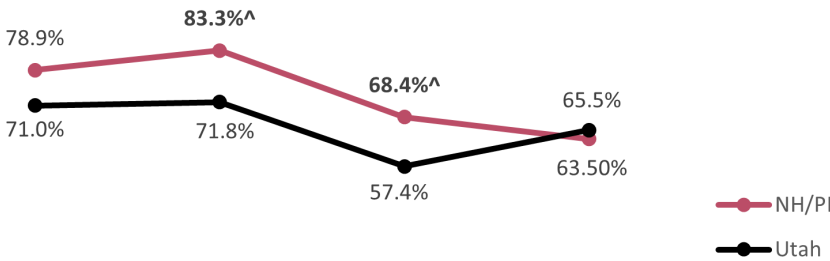
Health disparity: **Potential**
 Disparity ratio: **1.2**
 Health disparity gap: **Persisted**
 Health trend: **Worsened**

Recent poor mental health among NHPI adults was similar to Utah adults overall between 2005 and 2015 reporting. Between 2015 and 2021 reporting, recent poor mental health worsened among NHPI populations. It also worsened among Utah overall since 2005 reporting.

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

Routine medical checkup



Percentage of Utahns who had a routine medical checkup in the previous year (age-adjusted)

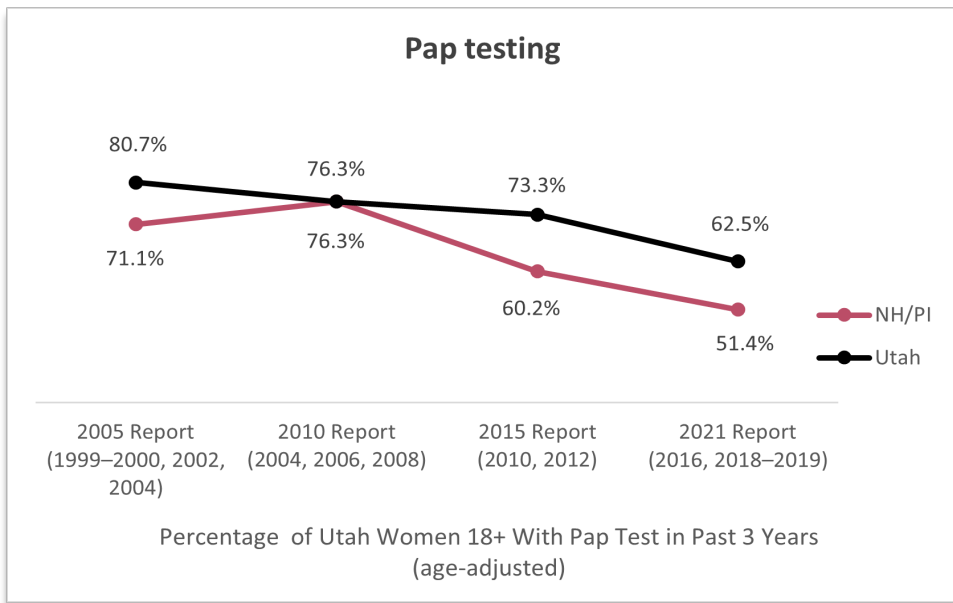
Health disparity: **No**
 Disparity ratio: **1.0**
 Health disparity gap: **N/a**
 Health trend: **Worsened**

Routine medical checkups among NHPI populations were higher than Utah overall between 2005 and 2015 reporting. Between 2010 and 2021 reporting, routine medical checkups among NHPI populations declined and were at similar levels to Utah overall as of 2021 reporting.

^Statistically significantly different than Utah overall

‡Due to an increase in routine medical checkups in the Utah population overall and a decline in routine medical checkups within NHPI populations, a small health disparity gap has begun to emerge.

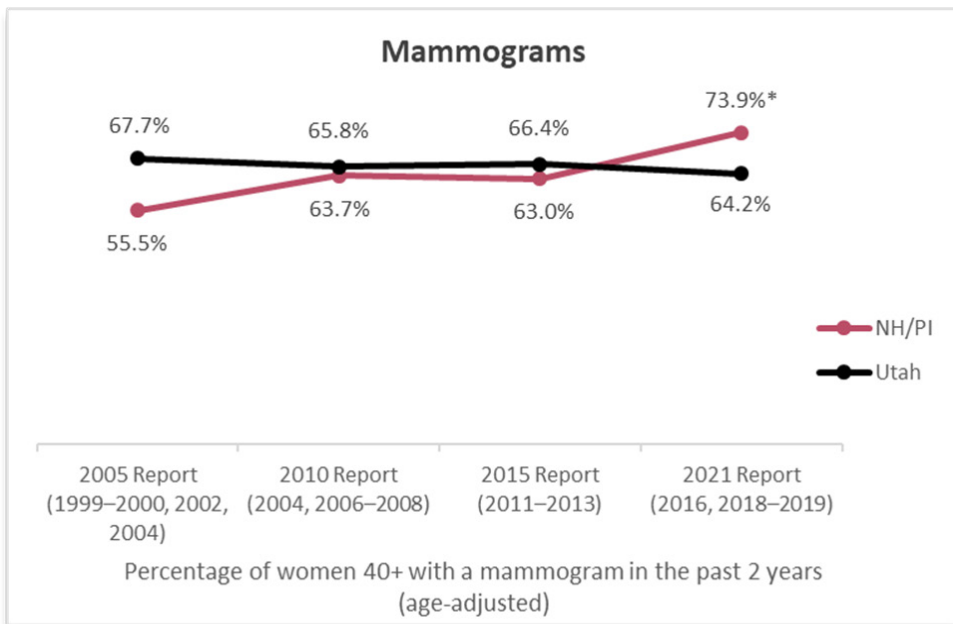
Sources—2005 Report: UDOH, Utah Health Status Survey, 2001; 2010 Report: UDOH, Utah Healthcare Access Survey, 2006–2008. UDOH Office of Public Health Assessment, Population Estimates, 2007; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2011–2013. US Census Bureau, American Community 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: **Potential**
 Disparity ratio: **1.2**
 Health disparity gap: **Persisted**
 Health trend: **Worsened**

Pap testing among NHPI women 18+ was generally lower than Utah women 18+ overall since 2005 reporting. Pap testing declined among both populations since 2005 reporting. A potential health disparity in Pap testing has persisted for NHPI women since 2005 reporting.

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.



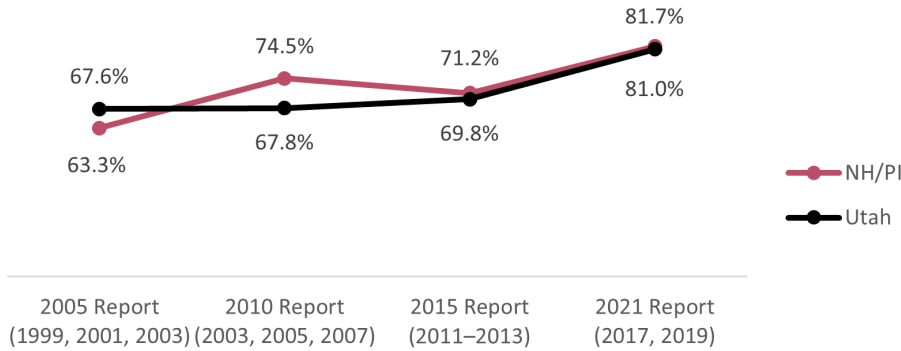
Health disparity: **No***
 Disparity ratio: **0.9**
 Health disparity gap: **N/a**
 Health trend: **Improved***

Mammograms among NHPI women 40+ were lower than or similar to Utah women 40+ overall between 2005 and 2015 reporting. The percentage of NHPI women obtaining mammograms increased since 2005 reporting and as of 2021 reporting was higher* than Utah women overall.

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

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.

Blood cholesterol screening



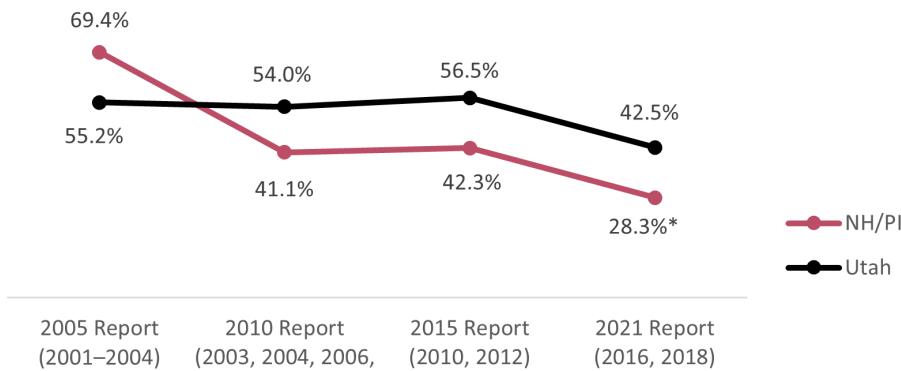
Percentage of Utah adults with a cholesterol screening in the past five years (age-adjusted)

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

Blood cholesterol screening among NHPI adults was generally similar to Utah overall since 2005 reporting. Blood cholesterol screening increased among both populations since 2005 reporting.

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.

Prostate cancer screening



Percentage of Utah men 40+ who have ever had a PSA test (age-adjusted)

Health disparity: **Potential***
 Disparity ratio: **1.5**
 Health disparity gap: **Persisted**
 Health trend: **Worsened***

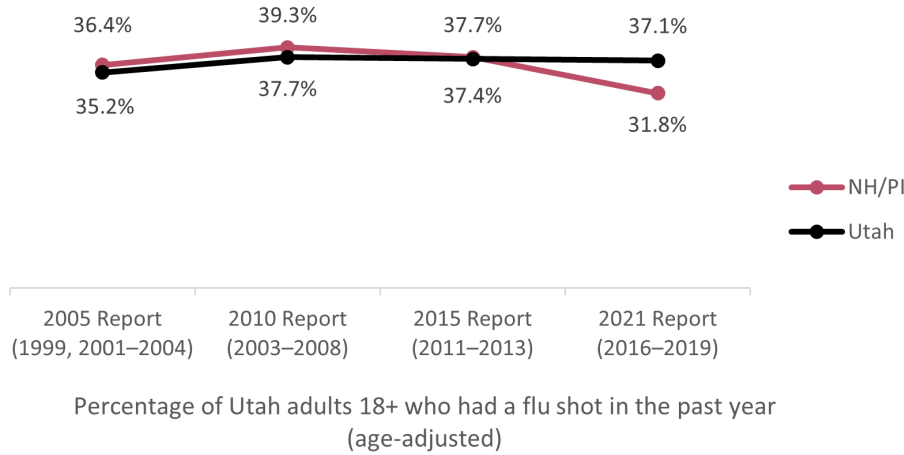
Prostate cancer screening among NHPI men 40+ was lower than Utah men 40+ overall since 2010 reporting. Prostate cancer screening declined among NHPI men between 2005 and 2010 reporting. It declined again in both populations since 2015 reporting—an expected outcome since routine PSA-based prostate cancer screening was no longer recommended as of 2012.‡

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

‡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, 2010, 2012. 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.

Influenza immunization (flu shot)



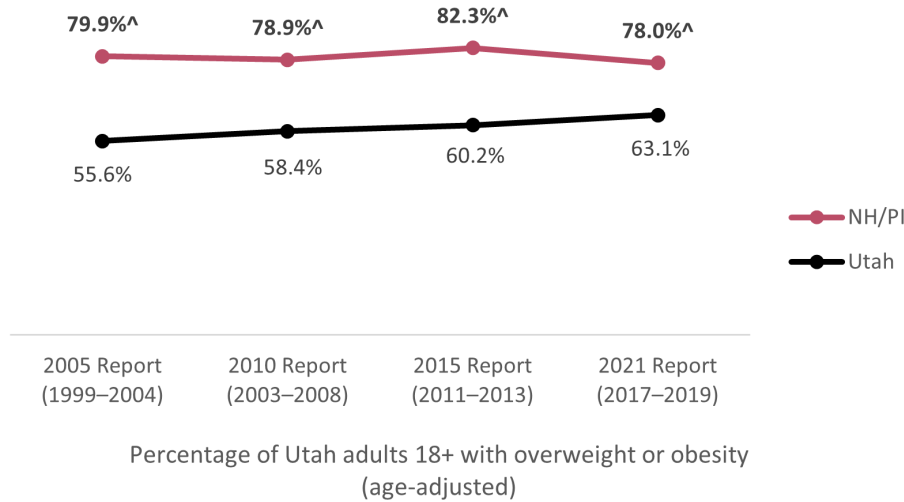
Health disparity: **Potential**
 Disparity ratio: **1.2**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

Influenza immunization among NHPI adults was similar to Utah adults overall between 2005 and 2015 reporting. Between 2015 and 2021 reporting, influenza immunization declined among NHPI adults while it changed little among Utah overall, and a potential health disparity emerged.

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

Overweight or obesity



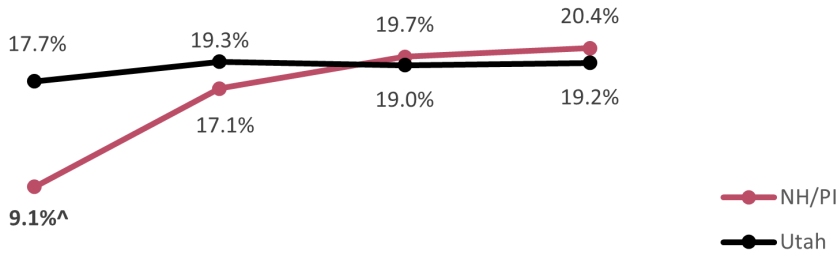
Health disparity: **Yes[^]**
 Disparity ratio: **1.2**
 Health disparity gap: **Decreased**
 Health trend: **Changed little**

Overweight or obesity among NHPI adults was higher than Utah adults overall since 2005 reporting. Overweight or obesity increased among Utah adults and changed little among NHPI adults since 2005 reporting, 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. US Census Bureau, American Community Survey 1-Year Estimates, 2017–2019.

No physical activity



2005 Report (1999–2004) 2010 Report (2003–2008) 2015 Report (2011–2013) 2021 Report (2017–2019)

Percentage of Utah adults 18+ who reported no physical activity in the past month (age-adjusted)

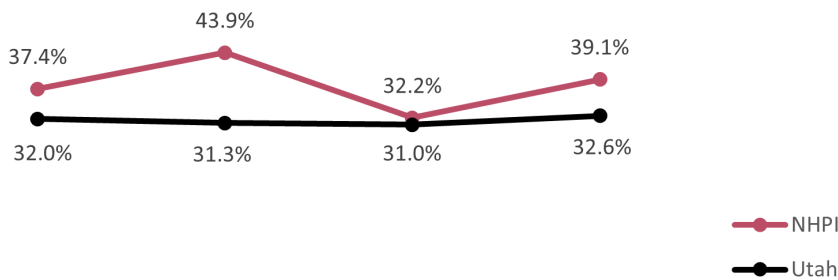
Health disparity: **Potential**
 Disparity ratio: **1.1**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

Lack of physical activity among NHPI adults was about half of Utah adults overall at 2005 reporting. Since 2005 reporting, percentage of people reporting no physical activity increased among NHPI populations and a potential health disparity emerged. As of 2021 reporting, one-fifth of NHPI 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.

Daily fruit consumption



2005 Report (1999–2000, 2002–(2003, 2005, 2007) 2003) 2010 Report (2003, 2005, 2007) 2015 Report (2011–2013) 2021 Report (2017, 2019)

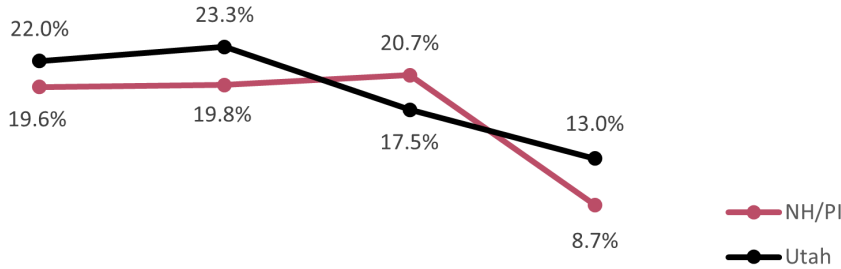
Percentage of Utah adults 18+ who reported eating 2+ fruits daily (age-adjusted)

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

Daily fruit consumption among NHPI adults was higher than Utah adults overall since 2005 reporting. Daily fruit consumption changed little among Utah adults overall and fluctuated among NPHI adults since 2005 reporting. As of 2021 reporting, a little more than one-third of NHPI adults consumed two or more fruits daily.

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.

Daily vegetable consumption



2005 Report (1999–2000, 2002–2003) 2010 Report (2003, 2005, 2007) 2015 Report (2011–2013) 2021 Report (2017, 2019)

Percentage of Utah adults 18+ who reported eating 3+ vegetables daily (age-adjusted)

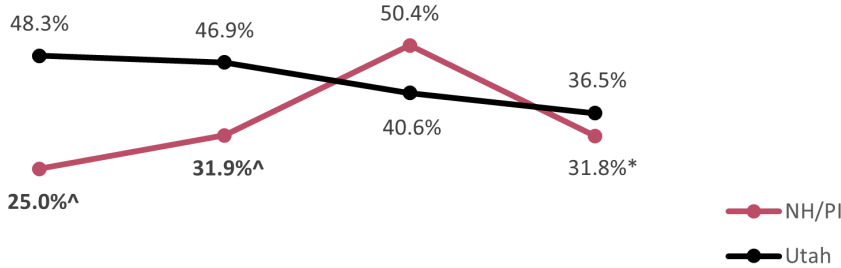
Health disparity: **Potential**
 Disparity ratio: **1.5**
 Health disparity gap: **Persisted**
 Health trend: **Worsened**

Daily vegetable consumption among NHPI adults was generally lower than Utah adults overall since 2005 reporting. Daily vegetable consumption declined overall in both populations since 2005 reporting.

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

Health of mothers and infants

Daily folic acid consumption



2005 Report (1999–2004) 2010 Report (1999–2004, 2006, 2008) 2015 Report (2010, 2012) 2021 Report (2016, 2018)

Percentage of Utah women age 18–44 years taking folic acid daily (age-adjusted)

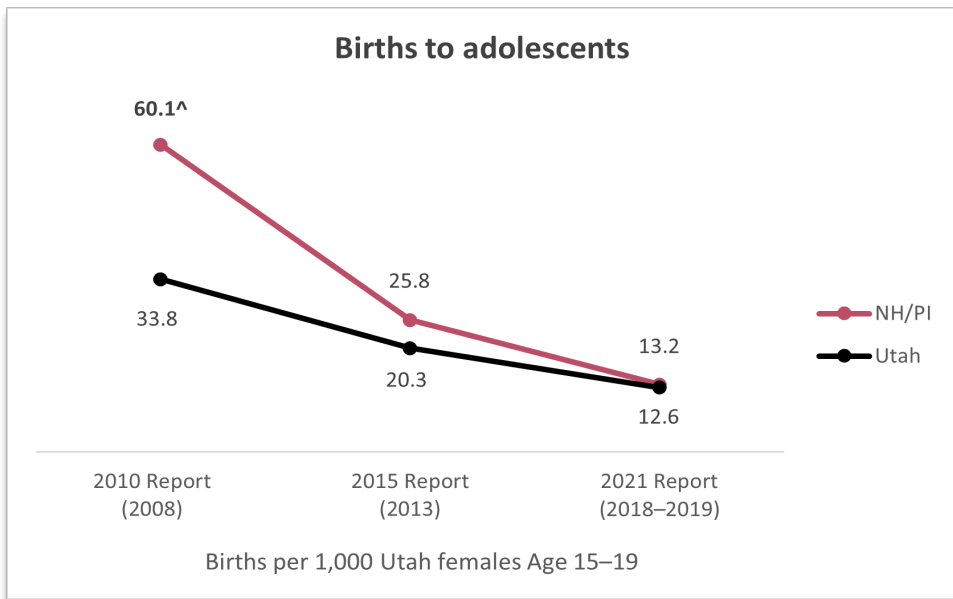
Health disparity: **Potential***
 Disparity ratio: **1.2**
 Health disparity gap: **Fluctuated**
 Health trend: **Recently worsened***

Daily folic acid consumption among NHPI women 18–44 was generally lower than Utah women 18–44 overall. Daily folic acid consumption increased among NHPI women between 2005 and 2015 reporting, then declined* between 2015 and 2021 reporting. Daily folic acid consumption declined among Utah women and fluctuated among NHPI women since 2005 reporting.

^Statistically significantly different than Utah overall

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

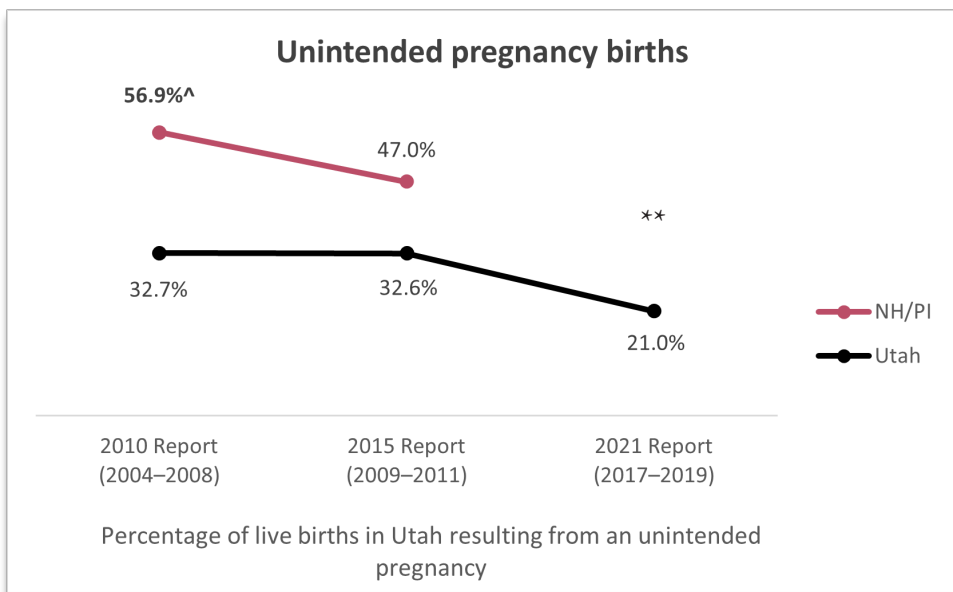
Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFS, 1999–2004; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFS, 1999–2004, 2006, 2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Public Health Assessment, Utah BRFS,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



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

Births to adolescents among NHPI populations were higher than Utah overall between 2010 and 2015 reporting. The birth rate among adolescents in both populations declined, and it declined faster among NHPI populations, which decreased the health disparity gap. The adolescent birth rate among NHPI populations was similar to 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.

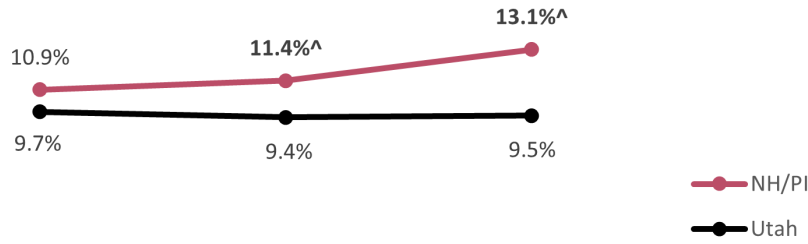


Health disparity: **Potential**
 Disparity ratio: **1.4**
 Health disparity gap: **Decreased**
 Health trend: **N/a**

Births resulting from unintended pregnancy among NHPI populations was higher than Utah overall between 2010 and 2015 reporting. Comparing 2010 and 2015 reporting periods, births from unintended pregnancy declined in NHPI populations.

[^]Statistically significantly different than Utah overall
^{**}The 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 data reported in 2015.
 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.

Preterm birth



2010 Report (2008) 2015 Report (2009–2013) 2021 Report (2017–2019)

Percentage of live Utah infants born at less than 37 weeks gestation

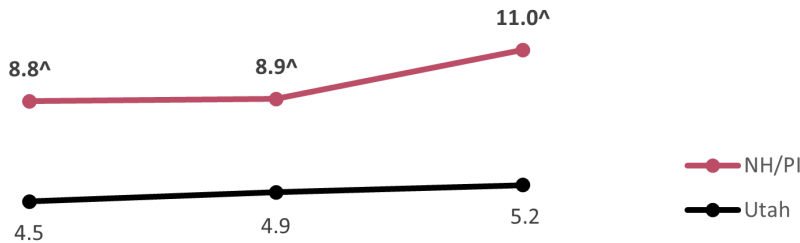
Health disparity: **Yes[^]**
 Disparity ratio: **1.4**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

Preterm birth among NHPI infants was higher than Utah infants overall since 2010 reporting. Preterm birth changed little among Utah infants and increased among NHPI infants since 2010 reporting, which increased the health disparity gap.

[^]Statistically significantly different than Utah overall

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.

Infant mortality



2010 Report (2004–2007) 2015 Report (2008–2012) 2021 Report (2014–2018)

Utah infant deaths per 1,000 live births

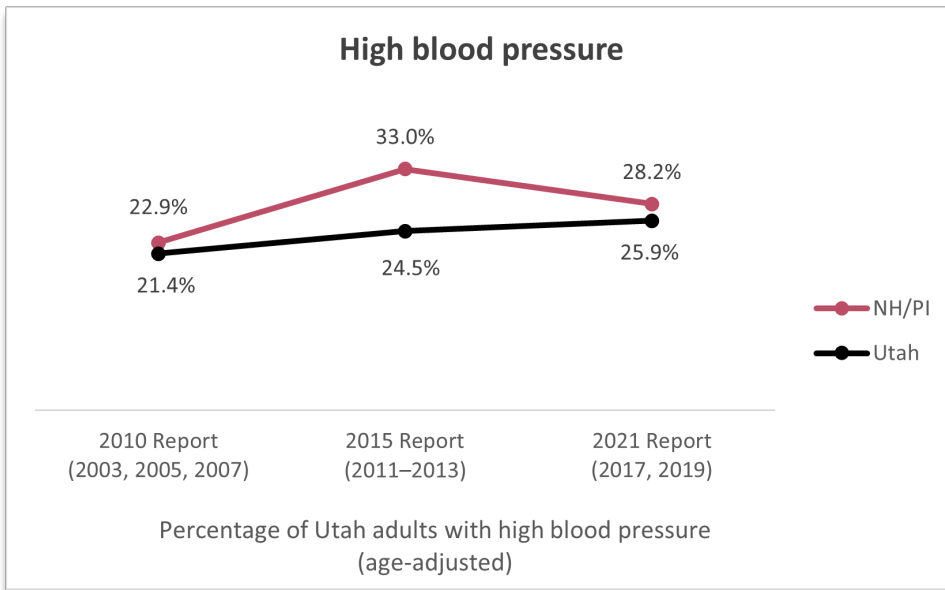
Health disparity: **Yes[^]**
 Disparity ratio: **2.1**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

Infant mortality among NHPI populations was higher than Utah overall since 2010 reporting. Infant mortality increased among NHPI populations, which increased the health disparity gap.

[^]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, 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.

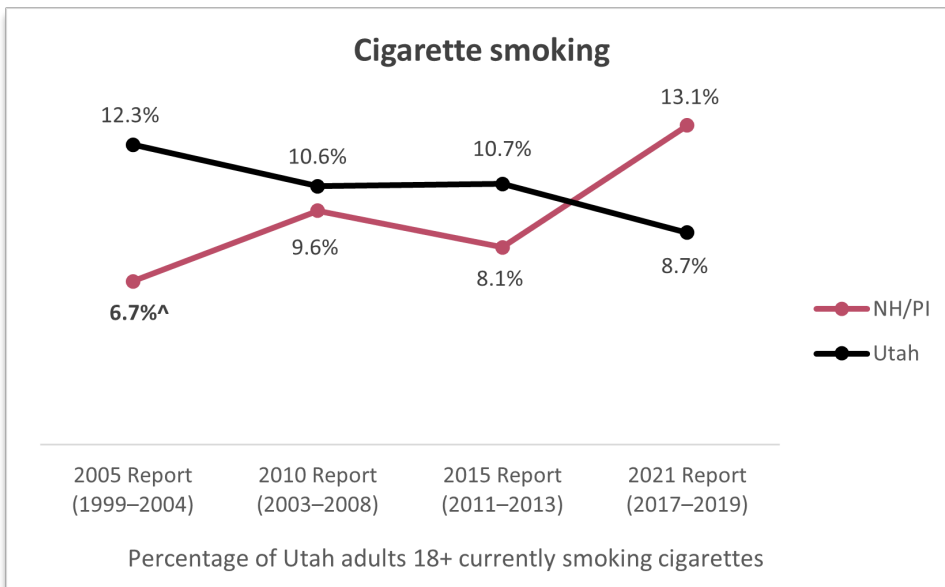
Risk factors



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

High blood pressure among NHPI adults was higher than Utah adults overall since 2010 reporting. The percentage of adults with high blood pressure increased among both populations since 2010 reporting.

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



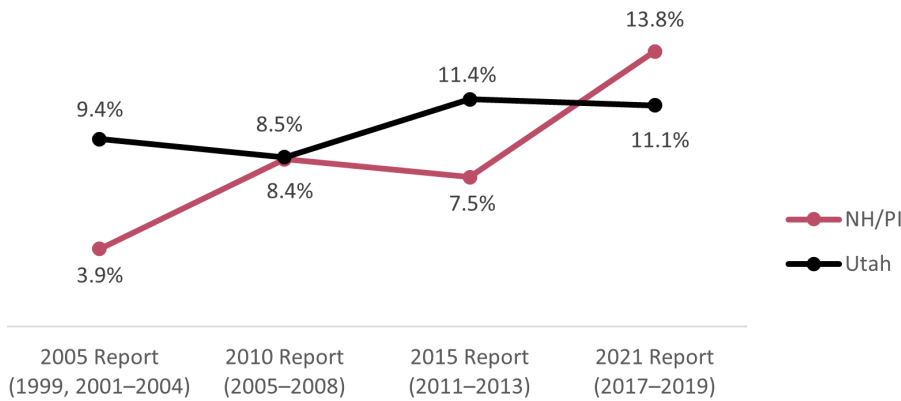
Health disparity: **Potential**
 Disparity ratio: **1.5**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

Cigarette smoking among NHPI adults was lower than Utah adults overall between 2005 and 2015 reporting. Cigarette smoking increased among NHPI adults and decreased among Utah adults overall, and a potential health disparity emerged as of 2021 reporting.

[^]Statistically significantly different than Utah overall

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

Binge drinking of alcohol



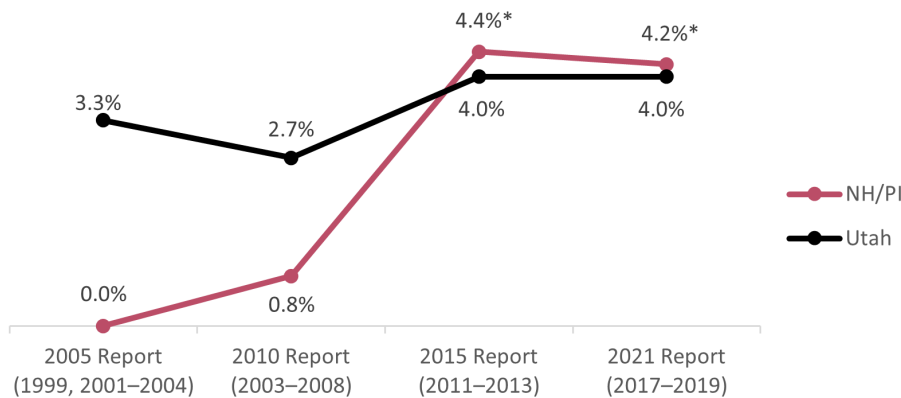
Percentage of Utah adults who reported binge drinking of alcohol in the past 30 days (age-adjusted)

Health disparity: **Potential**
 Disparity ratio: **1.2**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

Binge drinking of alcohol among NHPI adults was lower than Utah adults overall between 2005 and 2015 reporting. Binge drinking (consuming 4–5 or more drinks in two hours) increased among NHPI populations since 2005, and a potential health disparity emerged as of 2021 reporting.

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.

Heavy drinking of alcohol



Percentage of Utah adults who reported heavy drinking of alcohol in the past 30 days (age-adjusted)

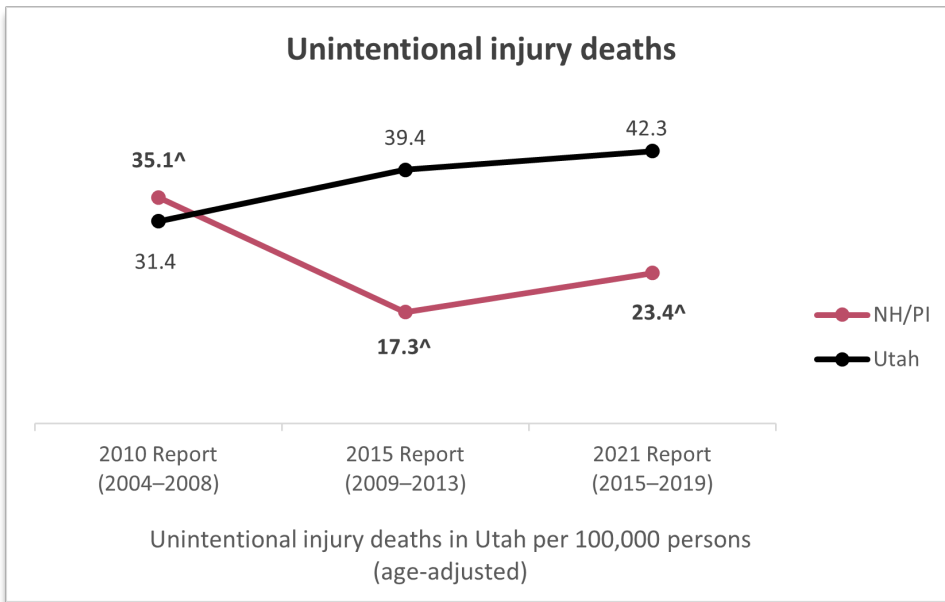
Health disparity: **Potential***
 Disparity ratio: **1.1**
 Health disparity gap: **Increased**
 Health trend: **Worsened***

Heavy drinking of alcohol among NHPI populations increased between 2005 and 2021 reporting. Heavy drinking (consuming 8+ alcoholic beverages per week for women and 15+ per week for men) increased among NHPI adults and changed little among Utah adults overall since 2005 reporting, which led to a potential health disparity.

*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.

Injuries

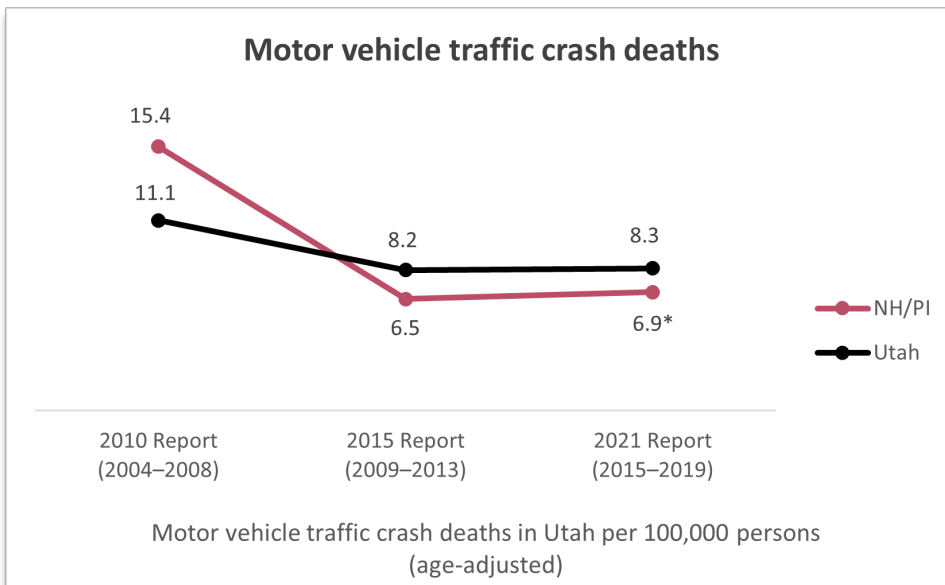


Health disparity: **No**
 Disparity ratio: **0.6**
 Health disparity gap: **N/a**
 Health trend: **Improved**

Unintentional injury death rates among NHPI populations decreased substantially between 2010 and 2015 reporting while they increased among Utah overall since 2010 reporting. Unintentional injury death rates among NHPI populations were lower than Utah overall between 2015 and 2021 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, 2015–2019. US Census Bureau, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, IBIS Version 2019.

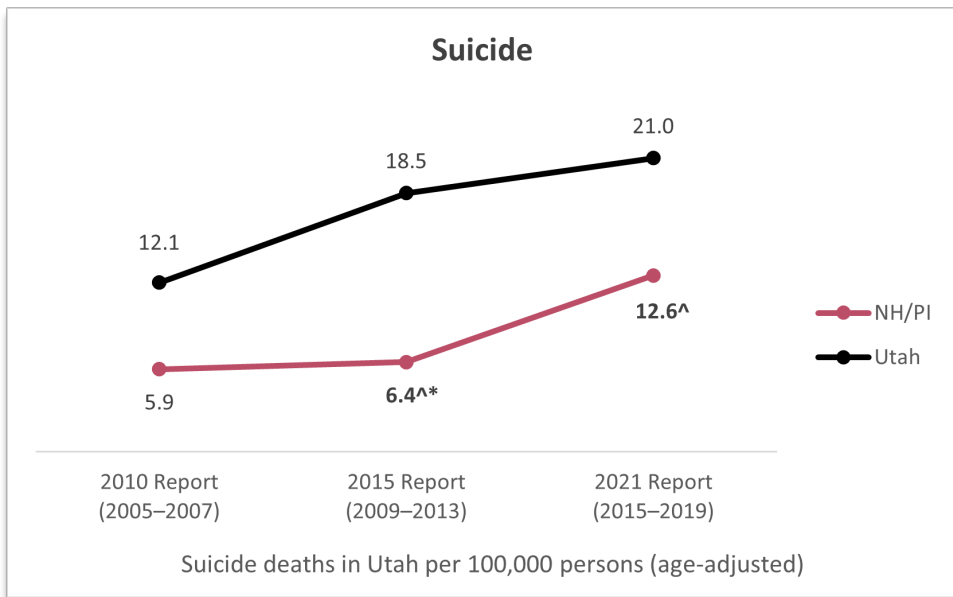


Health disparity: **No***
 Disparity ratio: **0.8**
 Health disparity gap: **N/a**
 Health trend: **Improved***

Motor vehicle traffic crash (MVTC) death rates among NHPI populations were higher than Utah overall at 2010 reporting and lower between 2015 and 2021 reporting. MVTC deaths declined in both populations between 2010 and 2021 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: 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.



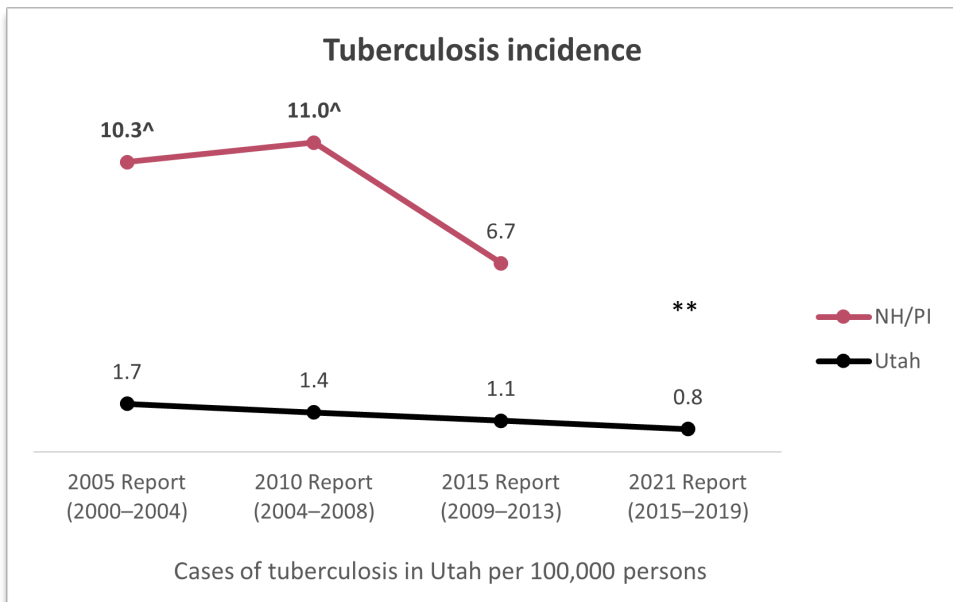
Health disparity: **No[^]**
 Disparity ratio: **0.6**
 Health disparity gap: **N/a**
 Health trend: **Worsened**

Suicide rates among NHPI populations were lower than Utah overall since 2010 reporting. Suicide rates increased among both populations since 2010 reporting.

[^]Statistically significantly different than Utah overall
^{*}Insufficient relative standard error to meet UDOH standard for data reliability, interpret with caution

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

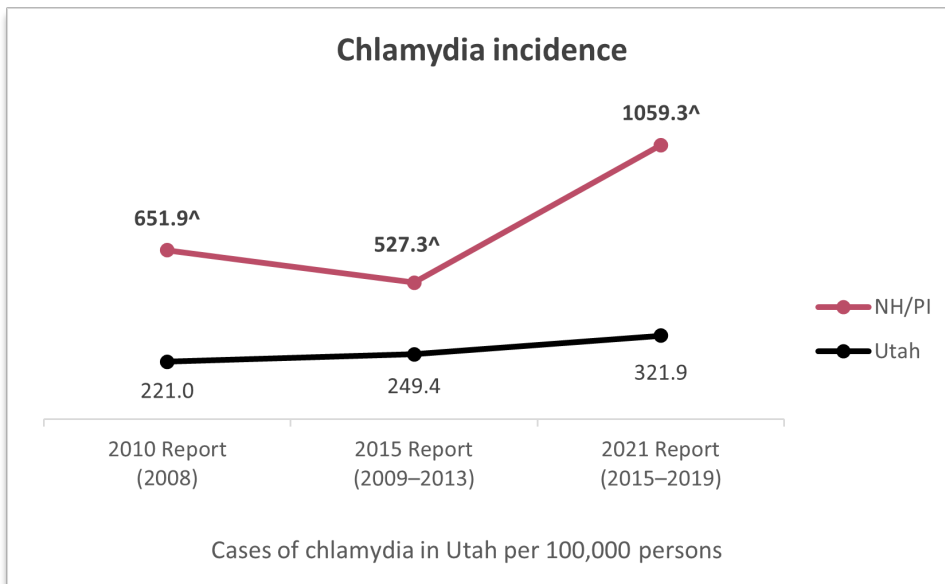


Health disparity: **Potential**
 Disparity ratio: **6.1**
 Health disparity gap: **Recently decreased**
 Health trend: **Improved**

Tuberculosis incidence among NHPI populations was higher than Utah overall since 2005 reporting. Tuberculosis incidence rates declined among NHPI populations, which decreased the health disparity gap.

[^]Statistically significantly different than Utah overall
^{**}The NHPI 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.

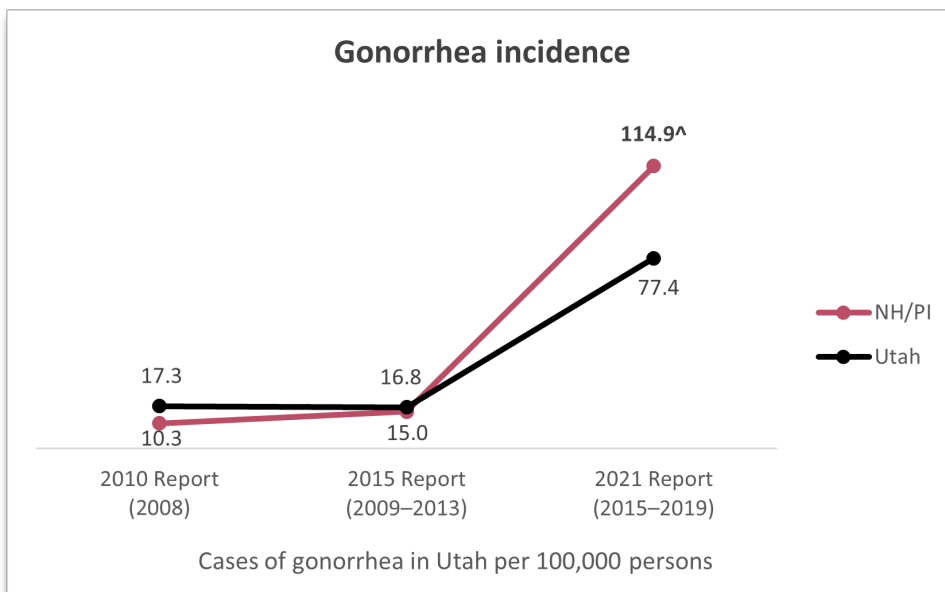


Health disparity: **Yes[^]**
 Disparity ratio: **3.3**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

Chlamydia incidence among NHPI populations was higher than Utah overall since 2010 reporting. Chlamydia incidence rates among NHPI populations decreased then increased between 2010 and 2021 reporting. Chlamydia incidence increased among Utah overall since 2010 reporting.

[^]Statistically significantly different than Utah overall

Sources—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: **1.5**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

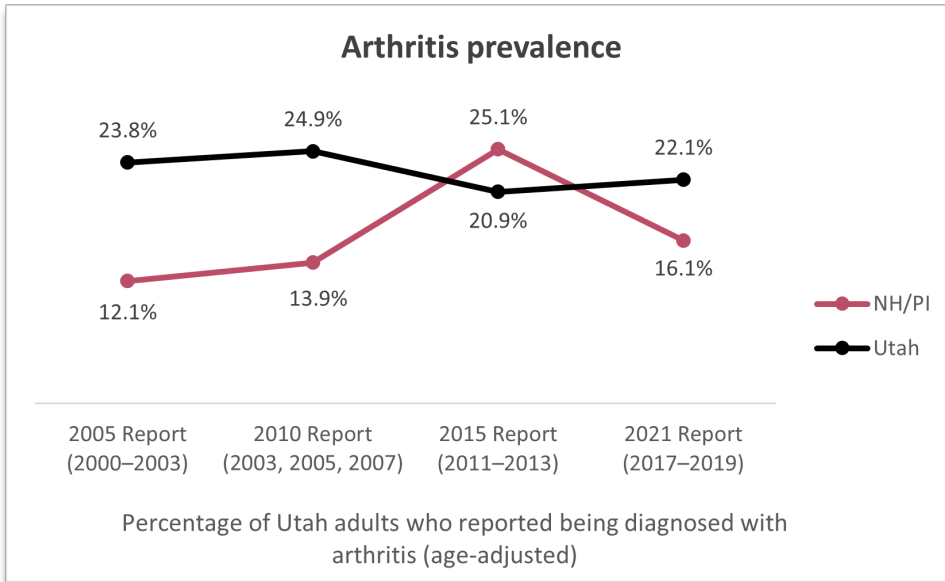
Gonorrhea incidence among NHPI populations was higher than Utah overall at 2021 reporting. Between 2015 and 2021 reporting, gonorrhea incidence among NHPI populations increased by more than 600% and a health disparity emerged. By 2021 reporting, gonorrhea incidence rates were at an all-time high in Utah 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—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.

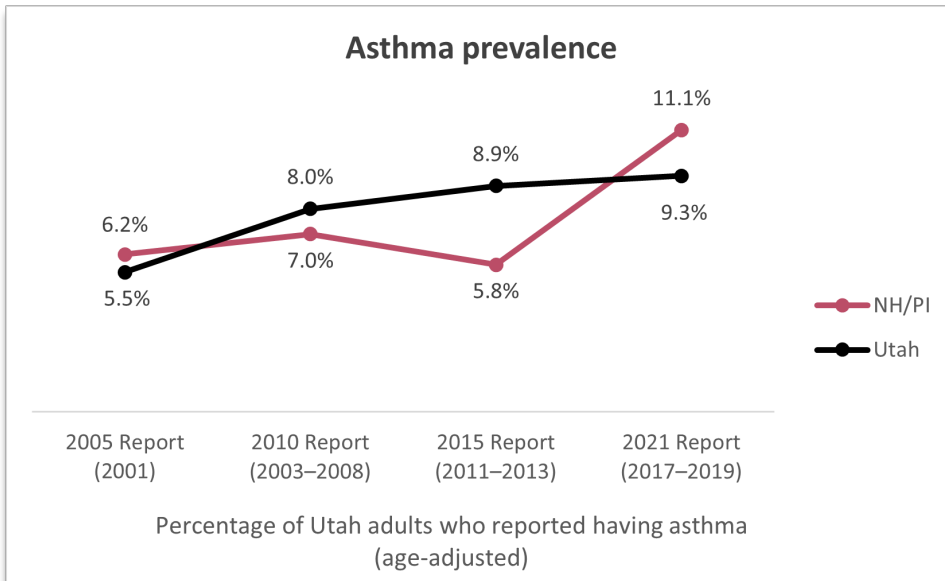
Chronic diseases



Health disparity: **No**
 Disparity ratio: **0.7**
 Health disparity gap: **N/a**
 Health trend: **Recently improved**

Arthritis prevalence among NHPI adults increased between 2005 and 2015 reporting, then decreased since 2015 reporting. As of 2021 reporting, arthritis prevalence among NHPI adults was lower than Utah adults overall.

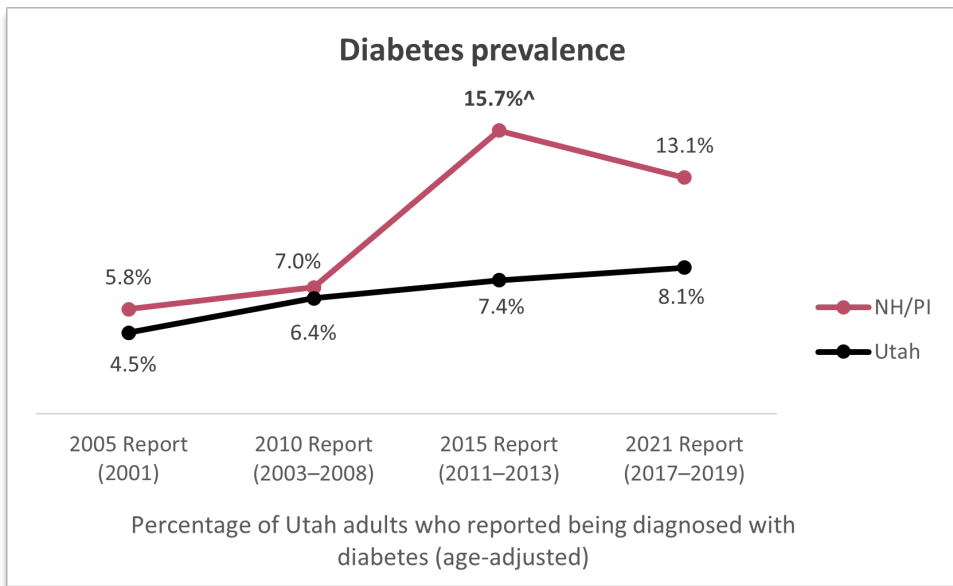
Sources—2005 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2000–2003; 2010 Report: UDOH Office of Public Health Assessment, Utah BRFSS, 2003, 2005, 2007. UDOH Office of Public Health Assessment, Population Estimates, 2005–2006; 2015 Report: UDOH Office of Public Health Assessment, Utah 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: **Potential**
 Disparity ratio: **1.2**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

Asthma prevalence among NHPI adults changed little between 2005 and 2015 reporting, then increased between 2015 and 2021 reporting. A potential health disparity emerged, and as of 2021 reporting, asthma prevalence among NHPI adults was higher than Utah adults 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.

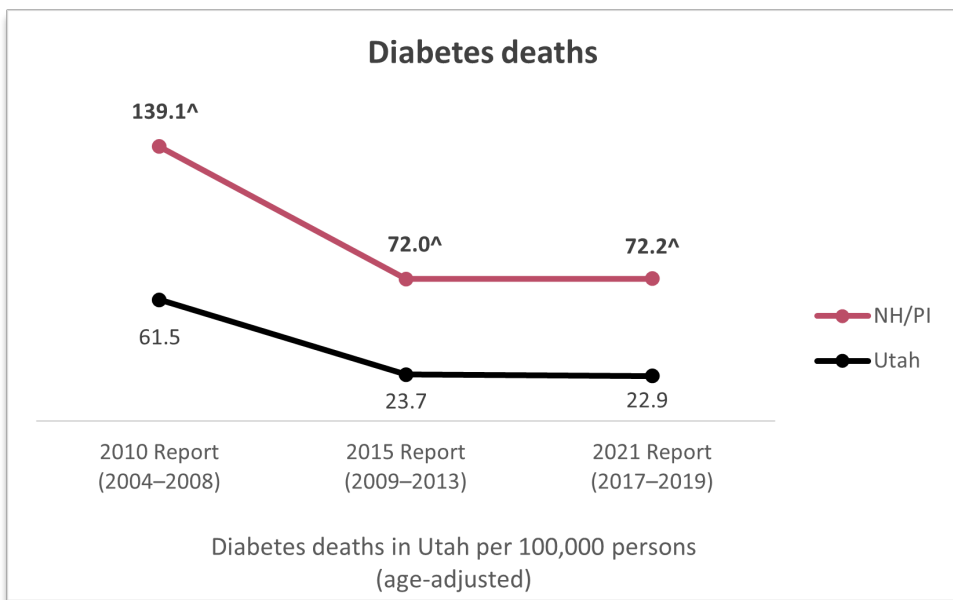


Health disparity: **Potential**
 Disparity ratio: **1.6**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

Diabetes prevalence among NHPI adults was similar to Utah adults overall between 2005 and 2010 reporting. Diabetes prevalence among NHPI adults increased between 2010 and 2015 reporting and remained much higher than Utah adults overall since 2015 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.

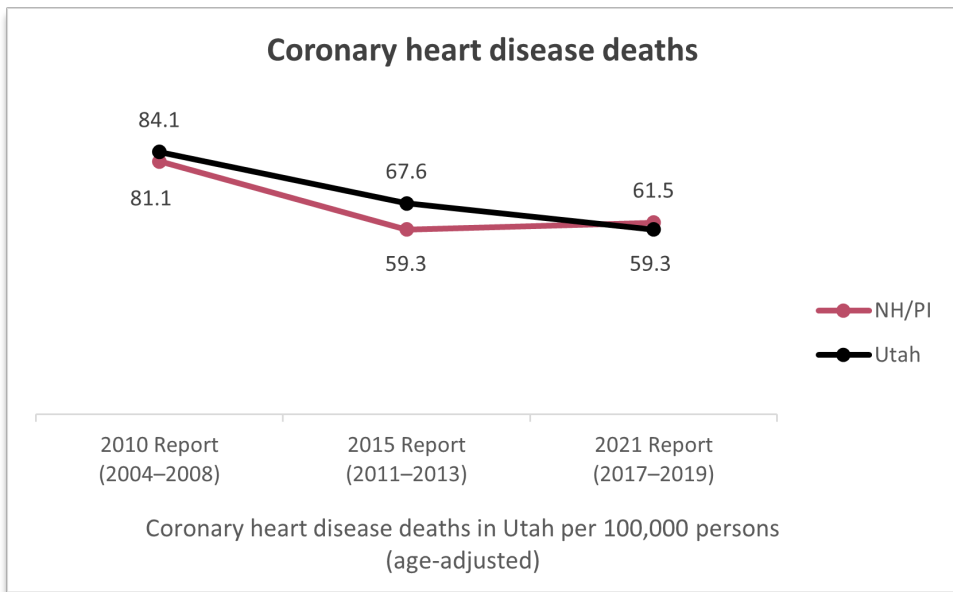


Health disparity: **Yes[^]**
 Disparity ratio: **3.2**
 Health disparity gap: **Persisted**
 Health trend: **Improved**

Diabetes death rates among NHPI populations were higher than Utah overall since 2010 reporting. Deaths from diabetes declined in both populations. Among NHPI populations, diabetes death rates declined by half between 2010 and 2021 reporting.

[^]Statistically significantly different than Utah overall

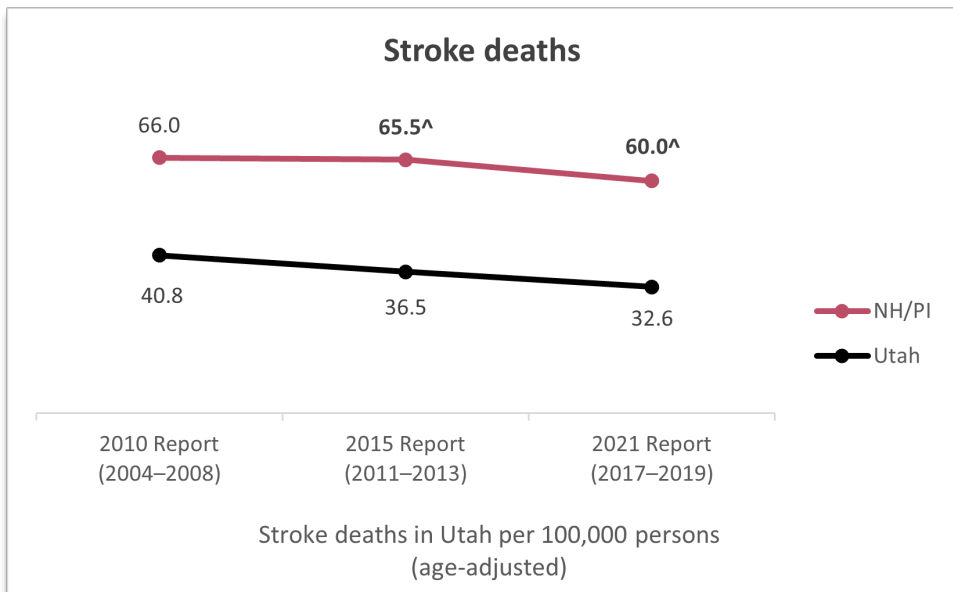
Sources—2010 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2004–2008. UDOH Office of Public Health Assessment, Population Estimates, 2006; 2015 Report: UDOH Office of Vital Records and Statistics, Death Certificate Database, 2009–2013. US Census Bureau, Population Estimates 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 NHPI populations were similar to Utah overall since 2010 reporting. Deaths from coronary heart disease declined among both populations since 2010 reporting.

Sources—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.



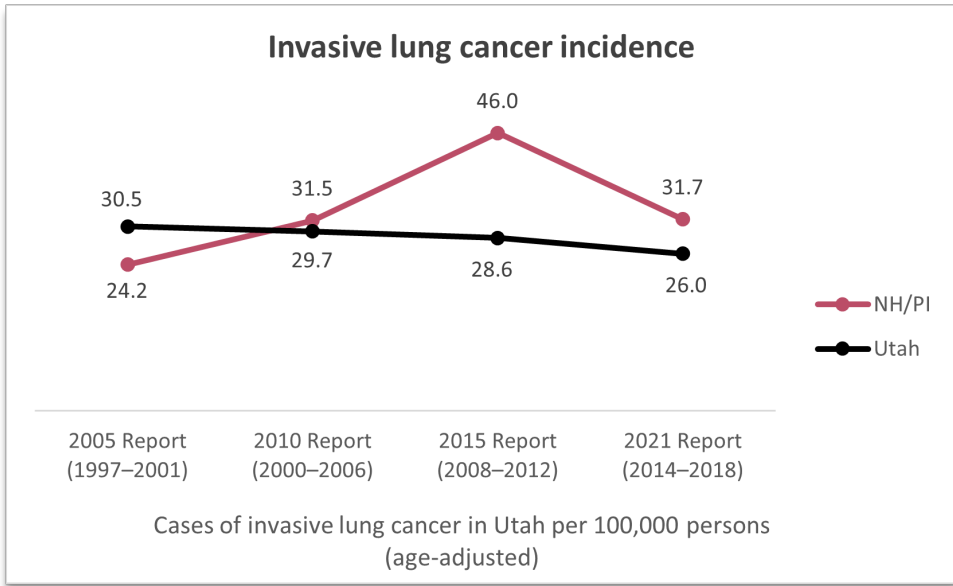
Health disparity: **Yes[^]**
 Disparity ratio: **1.8**
 Health disparity gap: **Persisted**
 Health trend: **Improved**

Stroke death rates among NHPI populations were higher than Utah overall since 2010 reporting. Deaths from stroke declined in both populations since 2010 reporting.

[^]Statistically significantly different than Utah overall

Sources—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.

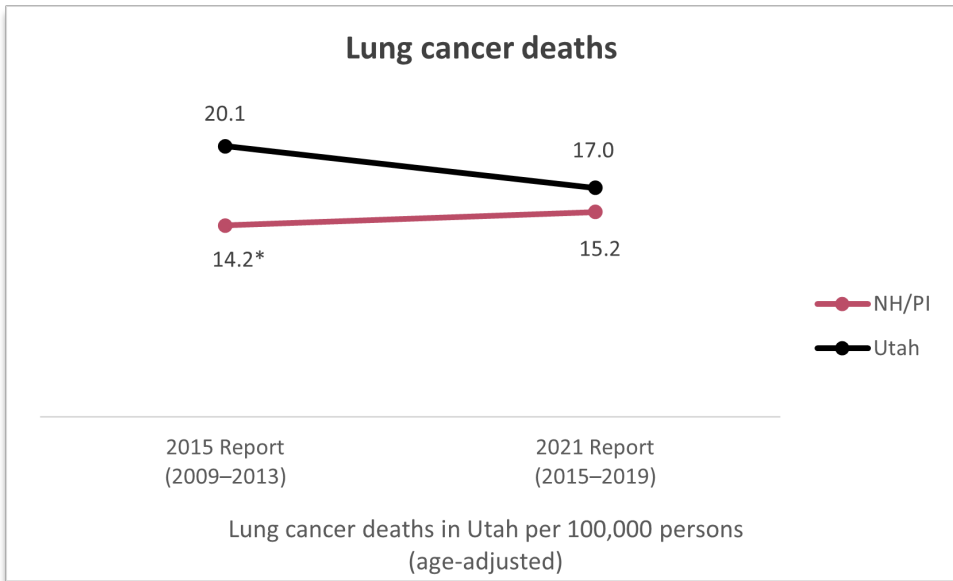
Cancer



Health disparity: **Potential**
 Disparity ratio: **1.2**
 Health disparity gap: **Recently decreased**
 Health trend: **Recently improved**

Lung cancer incidence rates among NHPI populations were higher than Utah overall since 2015 reporting. Lung cancer incidence increased among NHPI populations between 2005 and 2015 reporting, then recently decreased.

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.

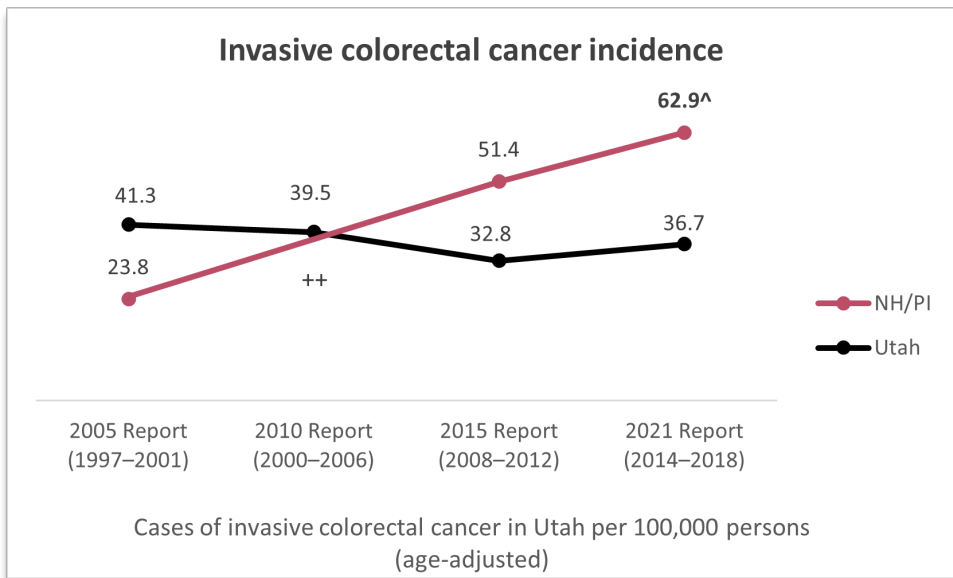


Health disparity: **No**
 Disparity ratio: **0.9**
 Health disparity gap: **N/a**
 Health trend: **N/a**

Lung cancer death rates among NHPI populations were lower than Utah overall since 2015 reporting. Comparing 2015 and 2021 reporting periods, the rate of deaths from lung cancer declined among Utah overall and changed little in NHPI populations.

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

Sources—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.



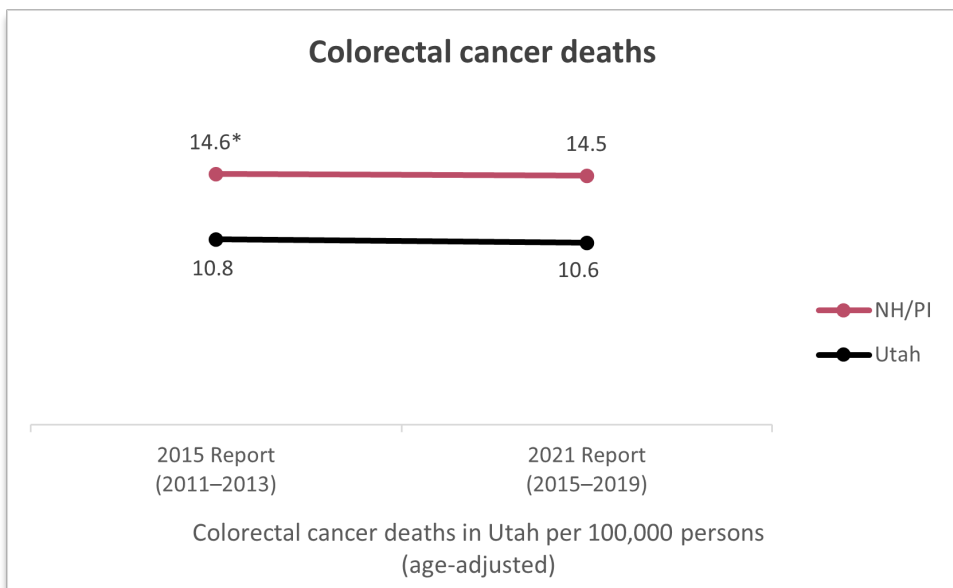
Health disparity: **Yes[^]**
 Disparity ratio: **1.7**
 Health disparity gap: **Increased**
 Health trend: **Worsened**

Colorectal cancer incidence rates among NHPI populations were higher than Utah overall since 2015 reporting. Colorectal cancer incidence among NHPI populations increased since 2005 reporting.

[^]Statistically significantly different than Utah overall

⁺⁺The NHPI population estimate for the 2010 report was combined with the Asian/Asian American population and is not comparable to the NHPI population alone.

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.

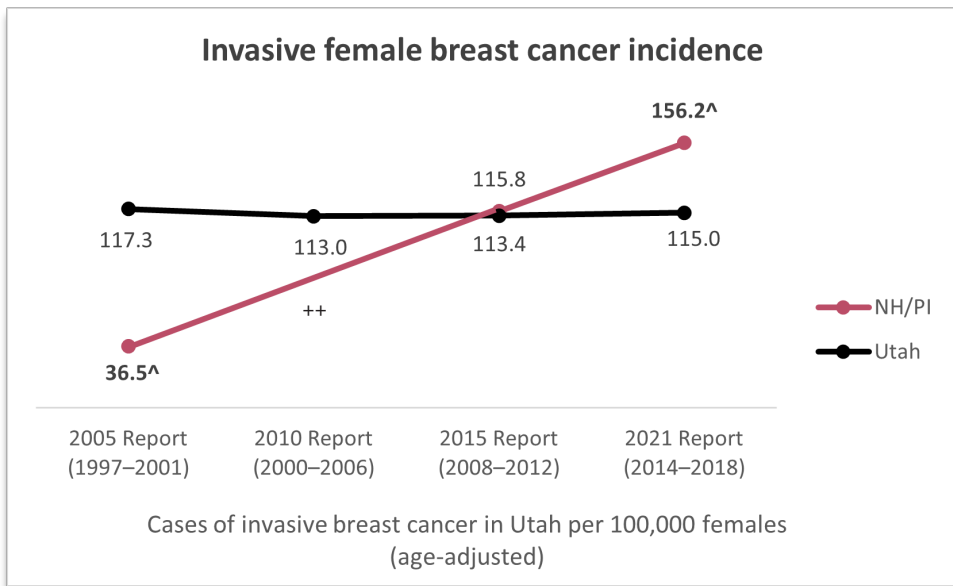


Health disparity: **Potential**
 Disparity ratio: **1.4**
 Health disparity gap: **Persisted**
 Health trend: **N/a**

Colorectal cancer death rates among NHPI populations were higher than Utah overall since 2015 reporting. Comparing 2015 and 2021 reporting periods, the rate of deaths from colorectal cancer changed little in both populations, and a health disparity gap persisted.

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

Sources—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.



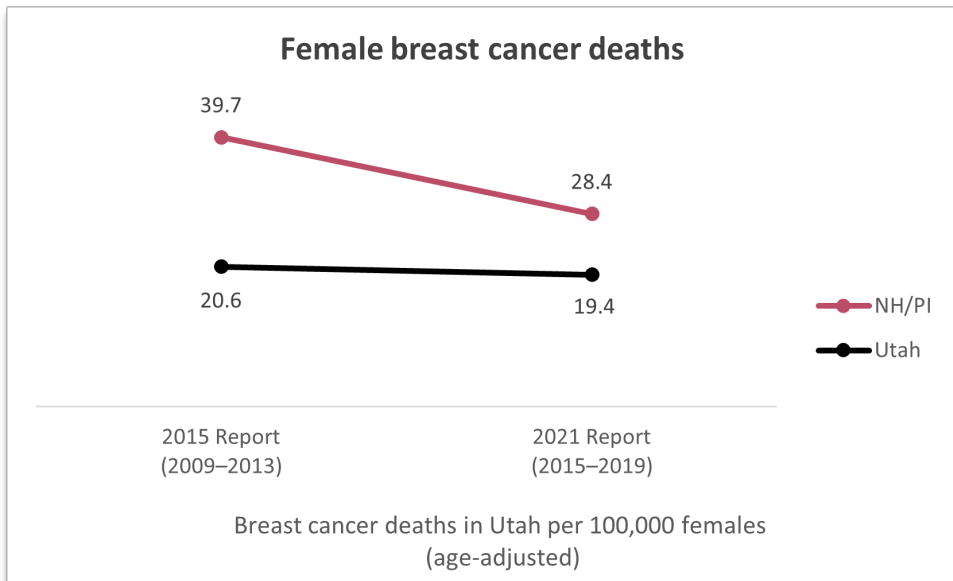
Health disparity: **Yes[^]**
 Disparity ratio: **1.4**
 Health disparity gap: **Emerged**
 Health trend: **Worsened**

Breast cancer incidence rates increased among NHPI females since 2005 reporting. During the same time period, breast cancer incidence among Utah females overall changed little. As of 2021 reporting, breast cancer incidence among NHPI populations was higher than Utah overall and a health disparity emerged.

[^]Statistically significantly different than Utah overall

⁺⁺The NHPI population estimate for the 2010 report was combined with the Asian/Asian American population and is not comparable to the NHPI population alone.

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.

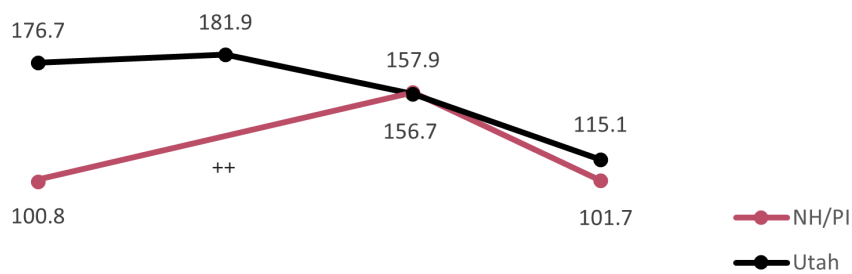


Health disparity: **Potential**
 Disparity ratio: **1.5**
 Health disparity gap: **Decreased**
 Health trend: **N/a**

Breast cancer death rates among NHPI females were higher than Utah females overall at 2015 and 2021 reporting. Comparing 2015 and 2021 reporting periods, the rate of deaths from breast cancer declined among NHPI females and changed little among Utah females overall. Among NHPI populations, breast cancer deaths declined by nearly 30% since 2015 reporting, and the health disparity gap decreased.

Sources—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.

Prostate cancer incidence



2005 Report (1997–2001) 2010 Report (2000–2006) 2015 Report (2008–2012) 2021 Report (2014–2018)

Cases of prostate cancer in Utah per 100,000 males (age-adjusted)

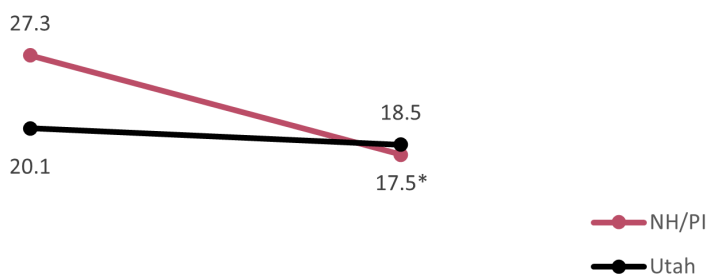
Health disparity: **No**
 Disparity ratio: **0.9**
 Health disparity gap: **N/a**
 Health trend: **Fluctuated**

Prostate cancer incidence rates among NHPI males were lower than Utah males overall. Prostate cancer incidence increased in NHPI populations between 2005 and 2015 reporting, then decreased between 2015 and 2021 reporting.

++The NHPI population estimate for the 2010 report was combined with the Asian/Asian American population and is not comparable to the NHPI population alone.

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.

Prostate cancer deaths



2015 Report (2009–2013) 2021 Report (2015–2019)

Prostate cancer deaths in Utah per 100,000 males (age-adjusted)

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

Prostate cancer death rates among NHPI males were higher than Utah males overall in 2015 reporting. Comparing 2015 and 2021 reporting periods, the rate of deaths from prostate cancer declined* among NHPI males.

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

Sources—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

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

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healthequity.utah.gov/wp-content/uploads/Twenty_Years_BAA.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 trends for Hispanic/Latino communities in Utah
healthequity.utah.gov/wp-content/uploads/Twenty_Years_Hispanic_Latino.pdf

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