

Utah Health Status Update: *Utah's Senior Population*

April 2014

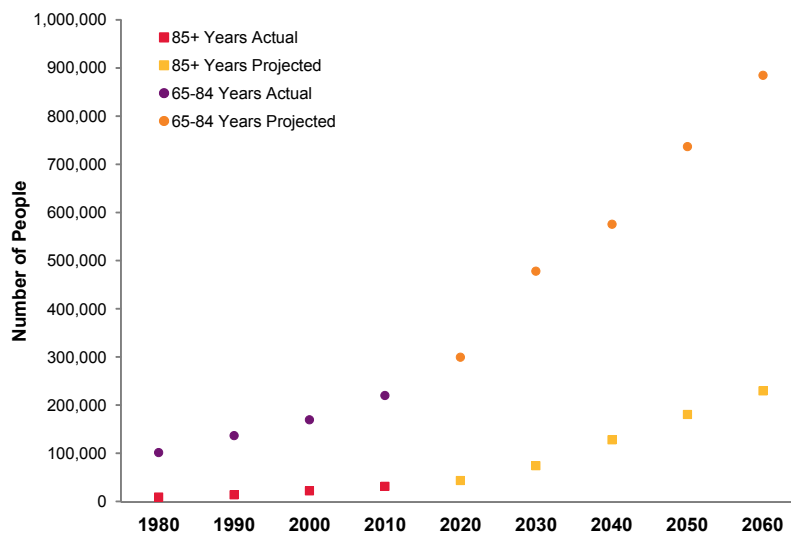
Utah's population is growing older and living longer. The population aged 65 and older has increased from 7.5% of the total state population (110,182 seniors) in 1980 to 9.5% (271,419 seniors) in 2012. According to the Governor's Office of Management and Budget, it is expected to grow to 18.7% (1,115,319 seniors) by 2060 (Figure 1). Additionally, life expectancy at birth for Utah males and females rose from 72.4 years and 78.6 years, respectively, in 1980 to 78.4 and 81.9 in 2011.

Older adults are more likely to be living with chronic medical conditions than adults younger than 65. Nearly 80 percent of seniors have been diagnosed with at least one chronic condition, and half have been diagnosed with at least two.¹ According to data from the Utah Behavioral Risk Factor Surveillance System (BRFSS), Utah adults aged 65 and older are much more likely to report doctor-diagnosed diabetes, arthritis, high blood pressure, and high cholesterol than younger adults (Figure 2). The increase in Utah's senior population, coupled with the rise in chronic disease

- Utah's senior population aged 65+ is expected to grow from 9.5% (271,419) in 2012 to 18.7% (1,115,319) by 2060.
- Utah's seniors are substantially more likely to report having a doctor-diagnosed chronic illness than younger adults in Utah.
- Utah seniors who reported meeting aerobic physical activity guidelines were less likely to report some chronic illnesses.
- Though Utah seniors are less likely to practice some health risk behaviors such as smoking, there is still room to improve in other health risks including obesity and physical inactivity.
- Public health can collaborate with community-based organizations, such as Utah's senior centers, to deliver health promotion and preventive interventions.

Actual/Projected Senior Population

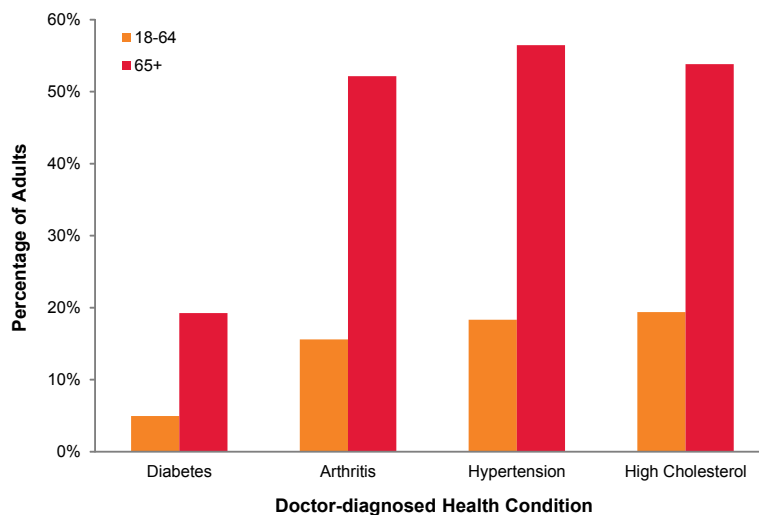
Figure 1. Actual and projected number of older adults by age group, Utah, 1980–2060



Sources: U.S. Bureau of the Census (actual) and Governor's Office of Management and Budget (projected)

Doctor Diagnosed Health Conditions

Figure 2. Percentage of adults who reported each doctor-diagnosed condition by age group, Utah, 2009–2012*



*Diabetes 2009–2012, Arthritis, High Blood Pressure, and High Cholesterol 2009, 2011 and 2012
Source: Utah BRFSS

rates, will strain Utah's health care system. Therefore, it is vital efforts be made to promote the health of our seniors.

There are benefits to health-promoting behaviors that can add healthy years for people who are living longer. The ultimate goal is for older Utah residents to be able to maintain active, independent lifestyles. Practicing healthy behaviors can prevent illness and also better enable people to manage some

existing chronic illnesses. For instance, seniors who meet aerobic physical activity guidelines are less likely to report a number of poor health outcomes (Figure 3). To meet the guidelines, adults had to report 150+ minutes/week of at least moderate intensity aerobic activity or 75+ minutes/week of vigorous intensity or an equivalent combination of aerobic physical activity.

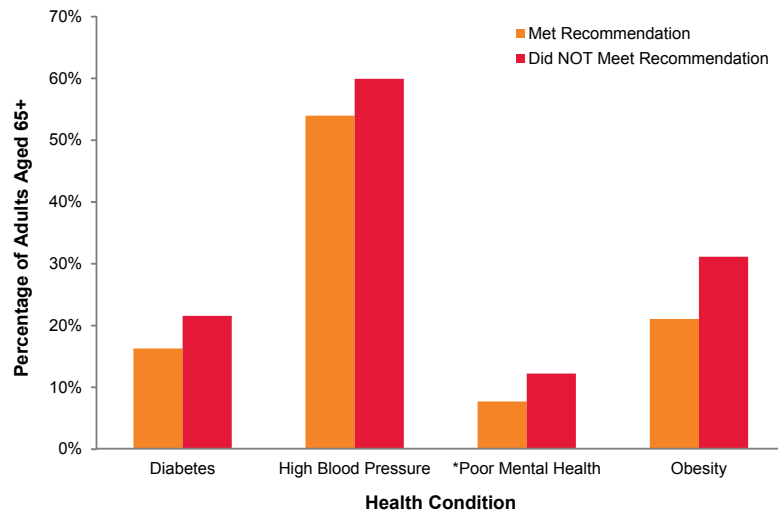
There are also some factors Utah seniors report that can adversely affect their health. Though they are not very likely to report current cigarette smoking or excessive alcohol consumption, a substantial proportion report being overweight, physically inactive, and having had a recent fall (Figure 4). Efforts to decrease these risks are important in preventing poor health outcomes.

A report of 2011 BRFSS data showed that 17.0% of Utah adults aged 60 and over answered affirmatively to the question, “During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?” These seniors often reported associated functional difficulties such as needing assistance with personal care. They were also more likely to report a chronic condition compared to those who did not have cognitive impairment.² Unfortunately, cognitive limitations can affect a person’s ability to practice health-promoting behaviors and to best manage a chronic illness.

The Institute of Medicine (IOM) has recommended enhanced collaboration of public health with community-based organizations, such as senior centers, as a way to produce better prevention and treatment outcomes for people living with chronic disease. The nation’s network of senior centers could become a partner with public health to deliver health promotion and preventive interventions.³ As an example, the Utah Depart-

Health Conditions and Physical Activity

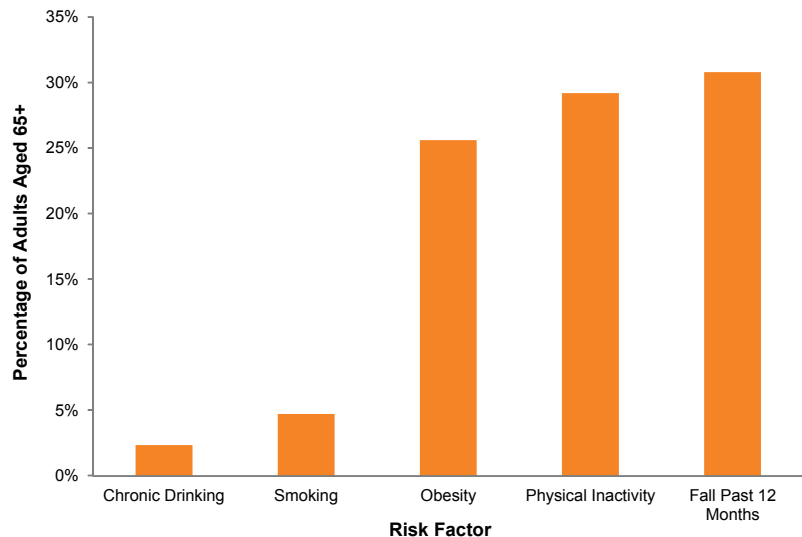
Figure 3. Percentage of adults aged 65+ with selected condition by aerobic physical activity recommendation, Utah, 2011 and 2012



*Poor Mental Health is defined as greater than 7 days mental health not good in past 30 days.
Source: Utah BRFSS

Risk Factors for Poor Health

Figure 4. Percentage of adults aged 65+ with each risk factor for poor health, Utah, 2009–2012



Source: Utah BRFSS

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For additional information about this topic, contact Kathryn Marti, Director, Office of Public Health Assessment, Utah Department of Health, Salt Lake City, UT, (801) 538-6434, email: kmarti@utah.gov, or visit the Office of Public Health Assessment, Utah Department of Health, Box 142101, Salt Lake City, UT 84114-2101, (801) 538-9191, email: chdata@utah.gov

ment of Health has partnered with the Utah Division of Aging and Adult Services (DAAS) to provide Chronic Disease Self-Management classes. The Utah Medicaid Aging Waiver Program allows the DAAS to serve 600 individuals aged 65+ in home and community-based settings as opposed to institutional care. The DAAS contracts with 12 planning and service areas (Area Agencies on Aging) to provide aging programs throughout Utah. Utah’s senior centers can be located on the DAAS website at daas.utah.gov.

References

1. United Health Foundation. *America’s Health Rankings Senior Report*. 2013.
2. Utah Department of Health. *Utah Health Status Update: Perceived Cognitive Impairment*. Salt Lake City: Utah Department of Health, 2013
3. Institute of Medicine. *Living well with chronic illness: A call for public action*. Washington: National Academies Press, 2012.

Breaking News, April 2014

Family Health History and Pregnancy

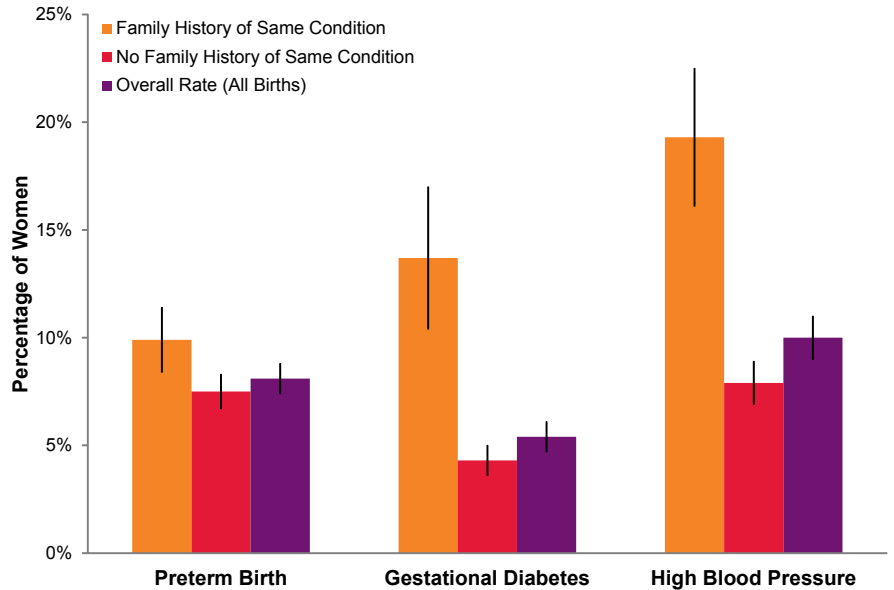
Family history plays a critical role in assessing the risks of adverse pregnancy outcomes¹. For example, a family history of prematurity increases a woman's risk of having a premature baby, and similar risks can be seen for gestational diabetes and hypertension. To assess the impact of family history on adverse birth outcomes, Utah PRAMS (Pregnancy Risk Assessment Monitoring System) asked the question, "Did your mother or any sister who is related to you by blood have any of the following problems during any pregnancy? a) a baby born more than three weeks before the due date; b) gestational diabetes [diabetes that started during pregnancy]; c) high blood pressure during pregnancy." We assessed each of these adverse outcomes by report of a family history of the condition.

The accompanying figure shows the percentage of women with a preterm birth, gestational diabetes, and pregnancy-induced hypertension with and without a family history of that condition. For each outcome, rates were significantly higher if a female blood relative was reported to have had that same condition.

Family history can be an important tool for assessing risks and targeting prevention efforts. Both the American College of Obstetricians and Gynecologists and the American Medical Association recommend a family history evaluation. This screening can be particularly effective when done during routine well-woman checkups and provides an optimal time to plan actions that may reduce future pregnancy risks. Women can facilitate this process by talking with family members and passing on this information to their health care providers.

For more information contact Laurie Baksh, Maternal and Infant Health Program, lbaksh@utah.gov.

Assessment of Adverse Birth Outcomes by Family History



Source: Utah PRAMS (Pregnancy Risk Assessment Monitoring System), 2009-2011

1. American College of Obstetricians and Gynecologists Committee on Genetics. Committee Opinion No. 478: Family history as a risk assessment tool. *Obstet Gynecol.* 2011 Mar;117(3):747-50.

Community Health Indicators Spotlight, April 2014

Utah to Participate in Innovative End-of-Life Care Study

The Utah Office of Vital Records and Statistics has the opportunity to participate in an innovative study led by a researcher at Harvard Medical School. Joel Weissman, Associate Professor of Health Policy in the Center for Surgery and Public Health, is developing a study to examine the end-of-life care of physicians and nurses and compare that to end-of-life care for a cohort of individuals who do not work in the medical or allied health professions.

The goal of the study is to determine if medical professionals have a different end-of-life experience than others who have the same causes of death listed on their death certificates. The research question Dr. Weissman is addressing is "Do medical professionals receive different medical treatment at end of life because they are more familiar with the medical system and therefore better able to navigate through constraints such as insurance limits on care, etc?"

Utah was asked to participate for two reasons—first, Utahns are generally healthier than cohort populations in other states. Second, Utah's rural communities allow the research team to compare access to care issues between rural and urban populations.

The study is dependent on access to Medicare records to determine amount and type of end-of-life care. We look forward to participating and examining the findings of this work.

Monthly Health Indicators Report

(Data Through February 2014)

Monthly Report of Notifiable Diseases, February 2014	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	13	21	31	45	0.7
Shiga toxin-producing Escherichia coli (E. coli)	0	2	2	6	0.3
Hepatitis A (infectious hepatitis)	0	0	0	1	0.0
Hepatitis B, acute infections (serum hepatitis)	1	2	1	3	0.4
Meningococcal Disease	1	1	1	1	1.0
Pertussis (Whooping Cough)	31	60	104	116	0.9
Salmonellosis (Salmonella)	14	16	29	34	0.8
Shigellosis (Shigella)	2	2	6	4	1.4
Varicella (Chickenpox)	9	47	37	90	0.4
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/flu				
Quarterly Report of Notifiable Diseases, 4th Qtr 2013	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV/AIDS†	25	31	118	110	1.1
Chlamydia	1,886	1,667	7,542	6,707	1.1
Gonorrhea	312	94	948	377	2.5
Syphilis	7	10	64	36	1.8
Tuberculosis	7	7	33	31	1.1
Medicaid Expenditures (in Millions) for the Month of February 2014	Current Month	Expected/Budgeted‡ for Month	Fiscal YTD	Budgeted‡ Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 12.1	\$ 11.7	\$ 87.3	\$ 96.5	\$ (9.2)
Inpatient Hospital	\$ 9.7	\$ 12.4	\$ 82.6	\$ 119.4	\$ (36.8)
Outpatient Hospital	\$ 3.8	\$ 6.5	\$ 29.1	\$ 48.9	\$ (19.8)
Long Term Care	\$ 13.3	\$ 13.1	\$ 104.7	\$ 108.3	\$ (3.6)
Pharmacy ‡	\$ 9.1	\$ 14.8	\$ 69.6	\$ 111.1	\$ (41.5)
Physician/Osteo Services §	\$ 4.6	\$ 7.4	\$ 34.9	\$ 60.8	\$ (25.9)
TOTAL HCF MEDICAID	\$184.4	\$ 190.3	\$1,383.8	\$1,390.0	\$ (6.2)

Program Enrollment for the Month of February 2014	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	263,479	257,123	+2.5%	259,786	+1.4%
PCN (Primary Care Network)	13,082	13,453	-2.8%	11,627	+12.5%
CHIP (Children's Health Ins. Plan)	27,152	31,443	-13.6%	35,216	-22.9%
Health Care System Measures	Annual Visits			Annual Charges	
	Number of Events	Rate per 100 Population	% Change¶ From Previous Year	Total Charges in Millions	% Change¶ From Previous Year
Overall Hospitalizations (2012)	281,605	9.2%	-1.2%	\$ 6,146.4	+5.6%
Non-maternity Hospitalizations (2012)	177,753	5.7%	-0.3%	\$ 5,208.7	+6.1%
Emergency Department Encounters (2011)	665,925	22.5%	+1.8%	\$ 1,309.5	+12.8%
Outpatient Surgery (2011)	376,054	12.7%	+2.5%	\$ 1,878.5	+6.5%
Annual Community Health Measures	Current Data Year	Number Affected	Percent/Rate	% Change¶ From Previous Year	State Rank# (1 is best)
Obesity (Adults 18+)	2012	476,400	24.3%	-0.5%	10 (2012)
Cigarette Smoking (Adults 18+)	2012	207,300	10.6%	-10.8%	1 (2012)
Influenza Immunization (Adults 65+)	2012	147,100	56.0%	-1.5%	40 (2012)
Health Insurance Coverage (Uninsured)	2012	376,600	13.2%	-1.5%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2012	205	7.2 / 100,000	-16.8%	19 (2010)
Poisoning Deaths	2012	661	23.1 / 100,000	+15.6%	45 (2010)
Suicide Deaths	2012	545	19.1 / 100,000	+9.3%	45 (2010)
Diabetes Prevalence (Adults 18+)	2012	141,100	7.2%	+7.5%	14 (2012)
Poor Mental Health (Adults 18+)	2012	307,800	15.7%	-3.7%	12 (2012)
Coronary Heart Disease Deaths	2012	1,580	55.3 / 100,000	-3.4%	3 (2010)
All Cancer Deaths	2012	2,861	100.2 / 100,000	+3.3%	1 (2010)
Stroke Deaths	2012	793	27.8 / 100,000	+0.6%	17 (2010)
Births to Adolescents (Ages 15-17)	2012	668	10.4 / 1,000	-6.6%	11 (2011)
Early Prenatal Care	2012	38,829	75.5%	+1.0%	n/a
Infant Mortality	2012	248	4.8 / 1,000	-12.6%	10 (2010)
Childhood Immunization (4:3:1:3:3:1)	2012	40,000	74.9%	+5.3%	15 (2012)

* Influenza activity is minimal in Utah. Influenza-like illness activity is below baseline statewide. As of March 12, 2014, 707 influenza-associated hospitalizations have been reported to the UDOH. More information can be found at <http://health.utah.gov/epi/diseases/flu>.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ Includes only the gross pharmacy costs. Pharmacy Rebate and Pharmacy Part D amounts are excluded from this line item.

§ Physician/Osteo Services - Medicaid payments reported under Physician/Osteo Services does not include enhanced physician payments.

¶ % Change could be due to random variation.

State rank based on age-adjusted rates.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile virus has ended until the 2014 season.