UTAH DEPARTMENT OF HEALTH

Utah Health Status Update: *Current Marijuana Use in Utah*

January 2019

Since 2001, marijuana use data for Utah adolescents has been collected using the Prevention Needs Assessment (PNA) survey; however, data regarding adult marijuana use has never been collected until 2017. During 2017, the Utah Department of Health and the Utah Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) partnered to collect the first statewide adult marijuana use data using the Behavior Risk Factor Surveillance Survey (BRFSS). Below, are the preliminary findings for these data that will help establish baseline use rates and patterns for public health surveillance, policy impact, and policy analysis.

Past 30-day Use

Overall, 6.1% of Utah adults reported current use of marijuana. Current use is defined as use within the past 30 days. The age group with the highest rate of current use (10.2%) was adults aged 18–34. Adult use rates for aged 35+ ranged between 5% to 1% of users. Males (7.7%) had higher rates than females (4.6%). Among youth in grades 8, 10, and 12, 8.2% reported marijuana use within the past 30 days. Adults in Summit County (10.5%) and Salt Lake County (8.2%) local health districts had 30-day use rates higher than the state rate. Adults in Utah County Health District (2.6%) had rates lower than the state rate. Current use was higher among adults reporting seven or more poor mental health days during the past month (11.3%) and those with chronic pain (9.4%). Current use was lower among veterans (3.8%). There were no differences in 30-day use by race, ethnicity, education, or income.

KEY FINDINGS

- **During 2017, 6.1% of Utah adults reported current use of marijuana.**
- **Marijuana usage rates were high for adults aged 18–34 (10.2%) and among high school students (8.2%). Rates were also higher for males (7.7%).**
- **Adults in Summit County (10.5%) and Salt Lake County (8.2%) had higher rates of current marijuana use; Utah County (2.6%) had a lower rate.**
- **Adults reporting poor mental health and chronic pain had higher rates of current marijuana use.**
- **Most adults used marijuana for recreational purposes, but of those with poor mental health and chronic pain, more users reported medical reasons for using marijuana.**
- **Women and older adults reported a higher perceived risk of harm from marijuana than men and younger adults.**

Reasons for Use

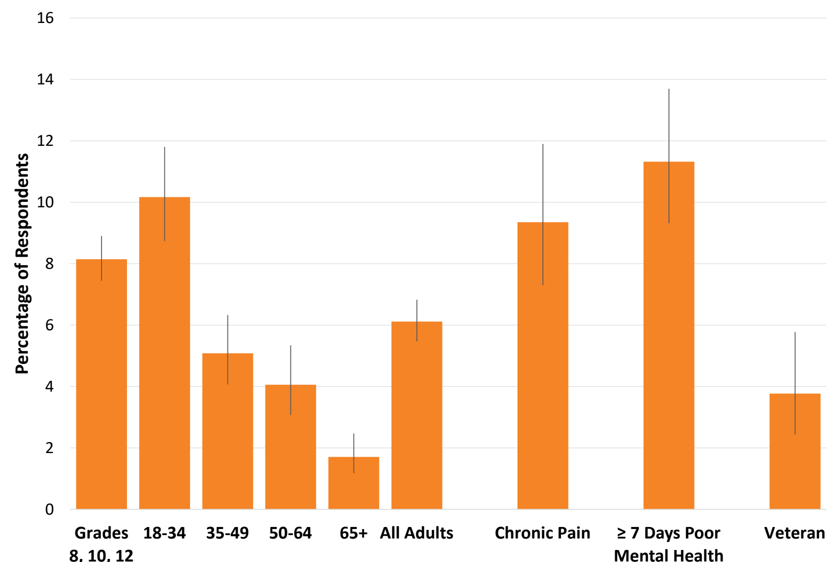
Among adults who used marijuana during the past 30 days, 42.3% used only for non-medical reasons, while 30.8% used for both medical and non-medical reasons, and 26.9% used marijuana only for medical reasons. There were no statistical differences in reason for use by age or sex, although the percentage reporting medical use only was 34.2% among adult females compared with 22.4% among adult males. However, the reason for using marijuana varied distinctly for those who also reported chronic pain, arthritis, or 7+ days of poor mental health within the past month. Users who reported chronic pain and users with arthritis mostly used marijuana only for medical reasons (56.2% and 48.0%). Users who reported seven or more poor mental health days during the past month reported use more evenly across all categories.

Perception of Risk of Harm

Utah adults had varying rates of perceived risk of harming themselves physically and in other ways when they smoked marijuana 1–2 times per

Past 30-day Use

Figure 1. Percentage of adolescents, adults, veterans, and those reporting chronic pain and poor mental health who reported using marijuana one or more times in the past 30 days, Utah, 2017



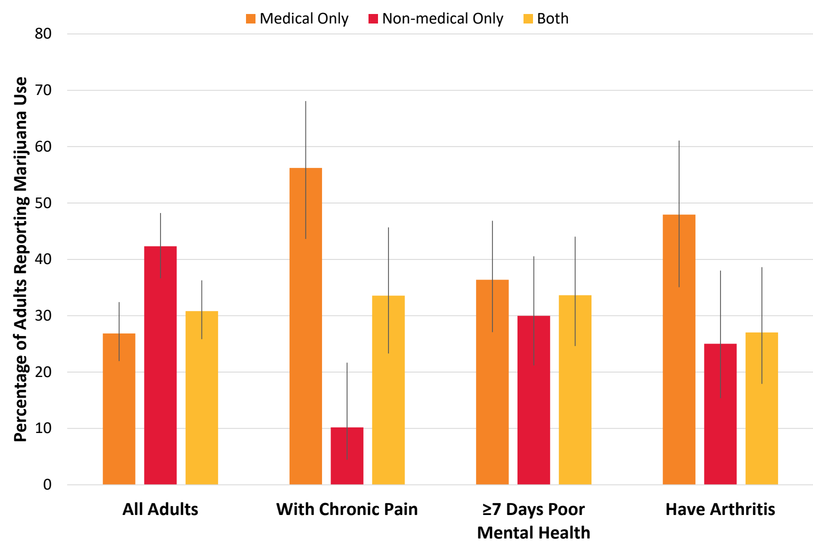
Grades 8, 10, and 12 from the Utah Prevention Needs Assessment Survey
Adult data from the Utah Behavioral Risk Factor Surveillance System

week. More females (46.9%) reported moderate to great perceived risk of harm smoking marijuana than males (38.1%). Younger age groups also reported minimal perceived risk of harm related to smoking marijuana one or two times per week. Two-thirds (68.2%) of 18- to 34-year-olds reported no or slight perceived risk of harm related to smoking marijuana. The perceived risk of harm was opposite for adults aged 65 and older where 63.2% of these adults reported moderate to great perceived risk of harm. The only age group with similar perceived risk across both categories was adults ages 50 to 64. About half (51.4%) of these adults reported no or slight perceived risk of harm, and 48.6% reported moderate to great perceived risk.

These data are the first snapshot of adult marijuana use in Utah and provide insights into overall adult use and use by age, sex, and reasons for use by various self-reported characteristics. To better establish patterns of use and how these patterns change, there is a need for regular data collection regarding marijuana use. As laws governing the use of marijuana and the state criminal penalties for possession of marijuana are changing in Utah and surrounding states, these data will provide insights for public health surveillance as well as a baseline for measuring policy impact and analysis.

Reasons for Use

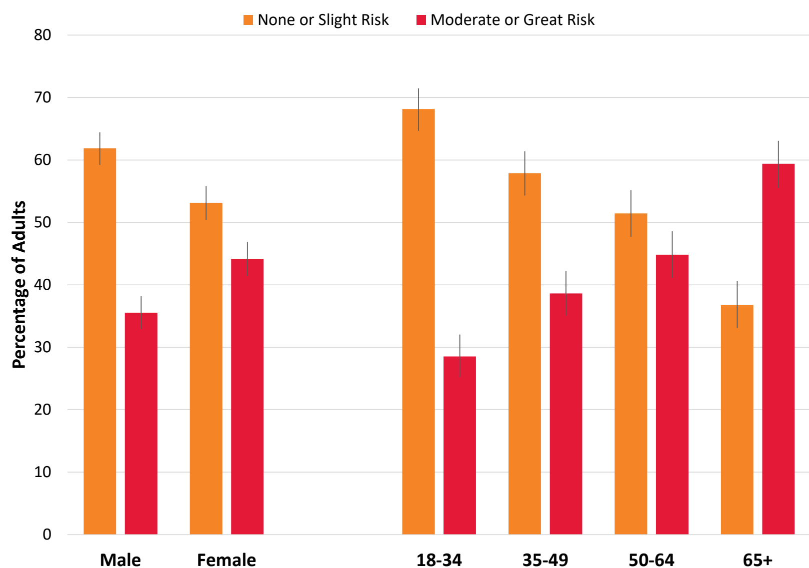
Figure 2. Percentage of adults reporting reason for using marijuana within the past 30 days by selected characteristics, Utah, 2017



Source: Utah Behavioral Risk Factor Surveillance System

Perception of Risk of Harm

Figure 3. Percentage of adults reporting none or slight risk versus moderate or great risk of harm from using marijuana 1–2 times per week by age and sex, Utah, 2017



Source: Utah Behavioral Risk Factor Surveillance System

UDOH ANNOUNCEMENT:

Many environmental health rules in Title R392 have been revised this last year, including new food truck and general sanitation rules. New rules were created in cooperation with Utah local health departments and to come into compliance with statutory requirements. Some rules hadn't been changed since 1990 and needed to be updated. The school rule had a minor update to come in line with building codes, while the pool rule was changed to accommodate instructional pools. All of these rules can be found at https://rules.utah.gov/publicat/code/r392/r392.htm.

For additional information about this topic, contact Mike Friedrichs, 801-538-6244, mfriedrichs@utah.gov; or the Office of Public Health Assessment, Utah Department of Health, (801) 538-9191, chdata@utah.gov.

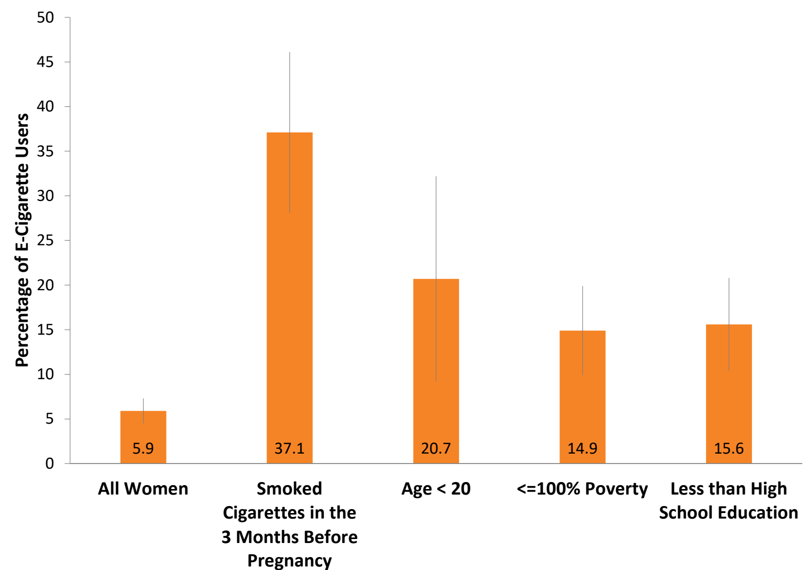
Breaking News, January 2019

E-cigarette Use Among Pregnant Women

Although research is emerging around e-cigarettes in general, there continues to be a lack of scientific evidence regarding the safety and risks of e-cigarette use on maternal and fetal health. A common misconception is that e-cigarettes are a safer and healthier alternative (for mother and baby) compared to traditional cigarettes.[1] However, most e-cigarettes contain nicotine and the adverse health effects of nicotine on maternal and fetal outcomes have been well documented.

In 2016, the Pregnancy Risk Assessment Monitoring System (PRAMS) found 5.9% of women with a recent live birth reported using e-cigarettes in the three months before pregnancy. Additionally, significantly higher rates of e-cigarette use were found among specific groups of women when compared to the rate of e-cigarette use by all women just prior to pregnancy (see figure). Preconception and prenatal screening for tobacco use should address e-cigarette use, and healthcare providers should refer women using these products to the Utah Tobacco Quit Line https://www.quitnow.net/Utah/.

E-cigarette Use in the Three Months Before Pregnancy Among Women With a Recent Live Birth, Utah, 2016



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

1. McCubbin, A.; Fallin-Bennett, A. et al. Perceptions and use of electronic cigarettes in pregnancy. *Health Education Research* 2017; 32:22-32.

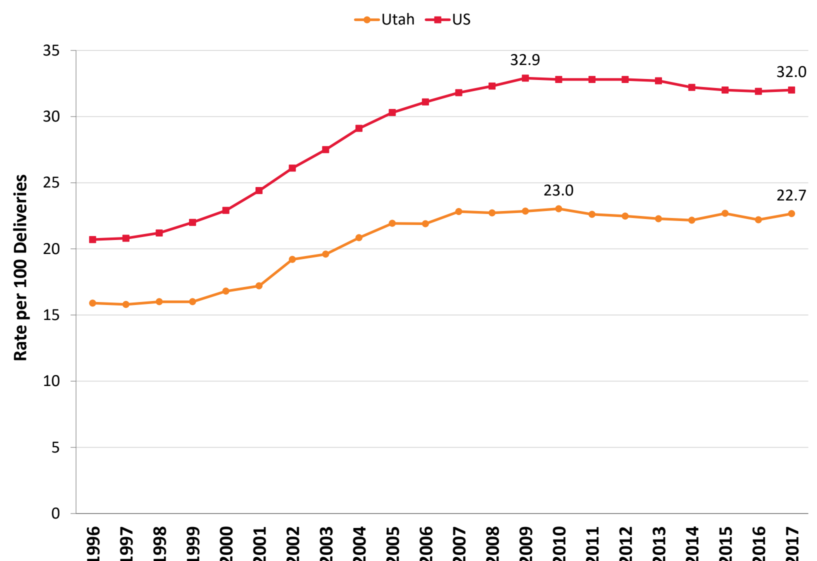
Community Health Spotlight, January 2019

Trend in Overall Cesarean Rate

In 2017, close to one-third of all births in the U.S. were from Cesarean deliveries (C-section). Although C-sections can be a valuable intervention, overuse of this procedure is associated with excess health problems. For more than 13 consecutive years (1996–2009), the C-section rate in the U.S. has increased, topping out at 32.9%; following a plateau, the national rate has continued to decline since 2013 (32.0% in 2017). While the C-section rate in Utah is consistently lower than the rate in the U.S. as a whole, the rate increased from 1997 to 2010, maxing at 23.0%, and remaining stable since 2011 at 22.7%.

C-section rates include all C-section deliveries: primary C-sections (C-sections among women whom this is their first C-section) and women with repeat C-sections. However, an important rate to consider is the number of women with a vaginal birth after cesarean (VBAC). Unfortunately, data have not been available for comparison of national rates of primary C-section and VBAC. Although there is a national recommendation for VBAC reporting on birth certificates, this recommendation was not adopted by all states until 2016. In 2017, however,the primary C-section rate in Utah (11.9%) was well below the national rate of 21.9%. Compared to 22.5% in Utah, nationally, only 12.8% of deliveries were VBAC. This high rate of VBAC in Utah may be a contributing factor to the state's ranking for the last three years as the lowest in the nation for C-sections.

Rate of Cesarean Deliveries, Utah and U.S., 1996–2017



Sources: Utah Birth Certificate Database and National Center for Health Statistics

Monthly Health Indicators Report

(Data Through November 2018)

Monthly Report of Notifiable Diseases, November 2018	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*)	28	33	509	498	1.0
Shiga toxin-producing *Escherichia coli* (*E. coli*)	12	7	189	94	2.0
Hepatitis A (infectious hepatitis)	1	7	134	30	4.5
Hepatitis B, acute infections (serum hepatitis)	1	1	31	9	3.3
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/influenza				
Meningococcal Disease	0	0	3	3	1.0
Pertussis (Whooping Cough)	7	50	291	650	0.4
Salmonellosis (*Salmonella*)	23	25	336	353	1.0
Shigellosis (*Shigella*)	4	5	57	42	1.4
Varicella (Chickenpox)	9	19	141	210	0.7

Quarterly Report of Notifiable Diseases, 3rd Qtr 2018	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†	35	30	99	91	1.1
Chlamydia	2,688	2,099	7,905	4,354	1.8
Gonorrhea	764	387	2,169	770	2.8
Syphilis	46	22	111	42	2.7
Tuberculosis	5	8	15	22	0.7

Medicaid Expenditures (in Millions) for the Month of November 2018‡	Current Month	Expected/ Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Mental Health Services§	$ 7.4	$ 7.6	$ 64.4	$ 65.6	$ (1.2)
Inpatient Hospital Services	$ 25.8	$ 26.1	$ 72.6	$ 74.6	$ (2.1)
Outpatient Hospital Services	$ 5.0	$ 5.0	$ 16.1	$ 16.9	$ (0.8)
Nursing Home Services	$ 32.8	$ 32.8	$ 97.2	$ 98.5	$ (1.3)
Pharmacy Services	$ 10.1	$ 9.9	$ 51.8	$ 53.4	$ (1.6)
Physician/Osteo Services	$ 3.9	$ 3.9	$ 22.9	$ 23.2	$ (0.3)
Medicaid Expansion Services	$ 8.2	$ 8.2	$ 37.0	$ 38.8	$ (1.9)
TOTAL MEDICAID#	$ 168.3	$ 168.1	$ 953.5	$ 958.5	$ (5.0)

* Influenza activity was low in November 2018. 18 influenza-associated hospitalizations have been confirmed from September 30, 2018 to November 30, 2018. Active influenza surveillance has begun for the 2018/19 influenza season. More information and weekly reports can be found at http://health.utah.gov/epi/diseases/influenza/surveillance/2018-2019/Utah_Weekly_Influenza_Report.html.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

Program Enrollment for the Month of November 2018	Current Month	Previous Month	% Change** From Previous Month	1 Year Ago	% Change** From 1 Year Ago
Medicaid	269,388	271,384	-0.7%	280,202	-3.9%
PCN (Primary Care Network)	16,807	15,149	+10.9%	13,779	+22.0%
CHIP (Children's Health Ins. Plan)	18,388	18,564	-0.9%	19,334	-4.9%

Health Care System Measures (Year)	Annual Visits			Annual Charges	
	Number of Events	Visits per 1,000 Utahns	% Change** From Previous Year	Total Charges in Millions	% Change** From Previous Year
Overall Hospitalizations (2016)	297,106	97.4	+3.0%	$ 8,638.0	+8.4%
Non-maternity Hospitalizations (2016)	198,257	65.0	+2.0%	$ 7,466.1	+9.2%
Emergency Department Encounters†† (2016)	756,376	247.9	+7.6%	$ 2,286.3	+21.7%
Outpatient Surgery (2016)	491,566	161.1	+4.9%	$ 3,000.6	-0.3%

Annual Community Health Measures	Current Data Year	Number Affected	Percent/ Rate	% Change** From Previous Year	State Rank‡‡ (1 is best)
Obesity (Adults 18+)	2017	548,100	25.2%	-0.4%	7 (2017)
Cigarette Smoking (Adults 18+)	2017	193,600	8.9%	+1.1%	1 (2017)
Influenza Immunization (Adults 65+)	2017	187,900	56.0%	+2.0%	40 (2017)
Health Insurance Coverage (Uninsured)	2017	304,000	9.8%	+12.6%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2017	280	9.0 / 100,000	+6.9%	16 (2016)
Poisoning Deaths	2017	714	23.0 / 100,000	-0.3%	33 (2016)
Suicide Deaths	2017	663	21.4 / 100,000	+6.3%	47 (2016)
Diabetes Prevalence (Adults 18+)	2017	154,400	7.1%	-1.4%	6 (2017)
Poor Mental Health (Adults 18+)	2017	395,900	18.2%	+7.1%	22 (2017)
Coronary Heart Disease Deaths	2017	1,692	54.5 / 100,000	+1.8%	5 (2017)
All Cancer Deaths	2017	3,160	101.9 / 100,000	-0.4%	1 (2017)
Stroke Deaths	2017	888	28.6 / 100,000	-6.0%	21 (2017)
Births to Adolescents (Ages 15-17)	2017	420	5.8 / 1,000	-7.6%	13 (2017)
Early Prenatal Care	2017	37,395	77.0%	+2.3%	n/a
Infant Mortality	2017	282	5.8 / 1,000	+7.0%	15 (2016)
Childhood Immunization (4:3:1:3:3:1)	2017	35,600	70.2%	-4.6%	46 (2017)

‡ This state fiscal year (SFY) 2018 report includes supplemental payments to better match the SFY 2018 Medicaid Forecast Budget which costs have not been included in previous years.

§ The SFY 2018 Medicaid Forecast Budget includes Mental Health and Substance Abuse services together while this report only accounts for Mental Health services. This is to stay consistent with the previous years reports.

Medicaid Espansion Services was added to the Medicaid program in SFY 2018. Total Medicaid costs exclude the Prism Project.

** Relative percent change. Percent change could be due to random variation.

†† Treat and release only.

‡‡ State rank based on age-adjusted rates where applicable.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile Virus will start in June for the 2019 season.