UTAH DEPARTMENT OF HEALTH

Utah Health Status Update:

Health Innovation Summit

December 2011

On September 30, 2011, Governor Gary Herbert hosted the Health Innovation Summit in Salt Lake City. Over 500 stakeholders and policy makers came together to map out the principles for the future of health system reform in Utah.

At the summit, speakers highlighted two of the major achievements of Utah's health system reform – the development of the Utah Health Exchange and our new blueprint for a modernized Medicaid program. These reforms are still under development, but we expect them to contribute significantly to the improvement of our health system.

While Utah has received considerable attention for our past efforts, we recognize that there is still a lot of room for future progress. Ultimately, health reform has to be about people. We need to continue to work on reform efforts that will have real, positive effects on real people, saving businesses money, keeping employees insured, and most importantly, helping people to be as healthy possible.

As a result of the summit, stakeholders are now asked to focus on developing a plan to take our system to the next level in nine critical policy areas with a plan that reflects the best possible ideas for change.

Empowering Consumers–We must find a way to provide health care consumers with useful information about cost & quality. We can harness the power of the All Payer Claims Database and other critical sources to put consumers back in the driver's seat. Informed consumers are a critical competitive element to drive innovations and improve outcomes in the marketplace.

- **Critical Policy Areas to Frame Health Reform in Utah include:**
  - **Empowering Consumers**
  - **Healthy Behaviors**
  - **Workforce Capacity**
  - **Payment Reform**
  - **Modernize Medicaid**
  - **Defined Contribution**
  - **Best Practices**
  - **Health IT**
  - **Tort Reform**

CEO Roundtable, L to R - Wes Smith, Salt Lake Chamber; Scott Hymas, RC Willey; Gov. Gary Herbert; Rich McKeown, Leavitt Partners. During the CEO Roundtable, prominent members of the business community discussed how the rising cost of care impacts business and possible solutions.

Healthy Behaviors–We should look for additional incentives to motivate Utah's citizens to engage in healthy behaviors and lifestyles. One of the biggest impediments to addressing costs is to get our citizens to accept responsibility for their own health and choose more wisely when it comes to personal decisions about behavior and lifestyle.

Workforce Capacity–Expanding the supply of health careis another critical competitive element. The key is to create additional capacity for the health care workforce to provide needed health services, which might include increasing the ability of the existing workers to provide services or increasing the size of the health care workforce.

Payment Reform–True reform will require a realignment of financial incentives. One of the most promising aspects of health reform is to start paying for value instead of volume by realigning financial incentives to provide efficient and effective care.

Modernize Medicaid–The state has an opportunity to lead by example. We need to find ways to improve the incentives and outcomes in the Medicaid program, by paying for value instead of volume and motivating the Medicaid population to engage in healthy behaviors.

Defined Contribution–We need to continue to support the small business community by facilitating a defined contribution market for health insurance that focuses on private sector solutions, enhances consumer choice, and helps employers succeed.

Best Practices–As a community, we need to continue to develop, share and implement best practices in the provision of health care, and make sure that providers are motivated and allowed to implement innovative solutions.

Health IT–We need to continue to facilitate and encourage electronic communications among health care providers and insurers, especially in ways that improve care and reduce administration burden and cost.

Tort Reform–Utah has mostly exhausted the possibilities for improving the traditional litigation-based tort system. Now we need to help the private sector implement "2nd generation" approaches to dealing with medical errors.

At the summit, Governor Herbert expressed the need for all stakeholders to engage on these topics. As a state we need to hear ideas of how to make this work. We are also interested in hearing your ideas on what other issues we should be considering, and how we can plan and implement the next generation of healthcare reforms in our state. Please indicate your interest in participating by contacting Dr. David Patton, Executive Director, Utah Department of Health, dpatton@utah.gov.

Plenary Session - Over 500 stakeholders gathered to help frame the discussion for moving Health System Reform forward in the State of Utah.

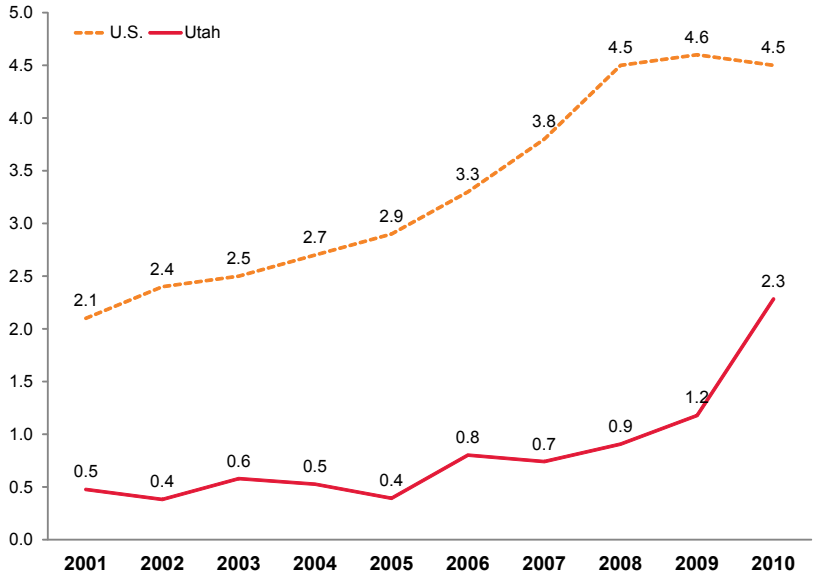
Breaking News, December 2011

Syphilis Resurgence in Utah

Syphilis is a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*. Primary and secondary (P&S) are the first two stages of a syphilis infection; cases are considered infectious and often have overlapping signs and symptoms. In the latency or tertiary stages, these symptoms subside while the bacteria continue to spread; this can lead to severe conditions and death if not treated.

The U.S. rate of P&S syphilis in 2000 was the lowest since reporting began in 1941. From 2001 to 2009, the rate of P&S syphilis increased annually until 2010, when the rate slightly decreased. It is too early to tell whether a declining trend has begun. The Centers for Disease Control and Prevention (CDC) continues to emphasize diligent testing and treatment.

Primary and Secondary Syphilis Rates per 100,000, Utah and U.S., 2001–2010



In Utah, the rate of P&S syphilis infections has increased since 2007 with a significant increase of 92% from 2009 to 2010. During 2010, six of the 12 local health districts reported P&S syphilis cases with the majority residing in Salt Lake County. Hispanics and Whites were equally affected with a rate of 2.3 per 100,000 population. While females accounted for only 3% of cases, their rate slightly increased from previous years. Males aged 35–44 years had the highest rate followed by 20–29 year olds, whose rate has dramatically increased over the last five years. Of those males infected with P&S syphilis, 95% reported male-to-male sexual contact (MSM) as their risk.

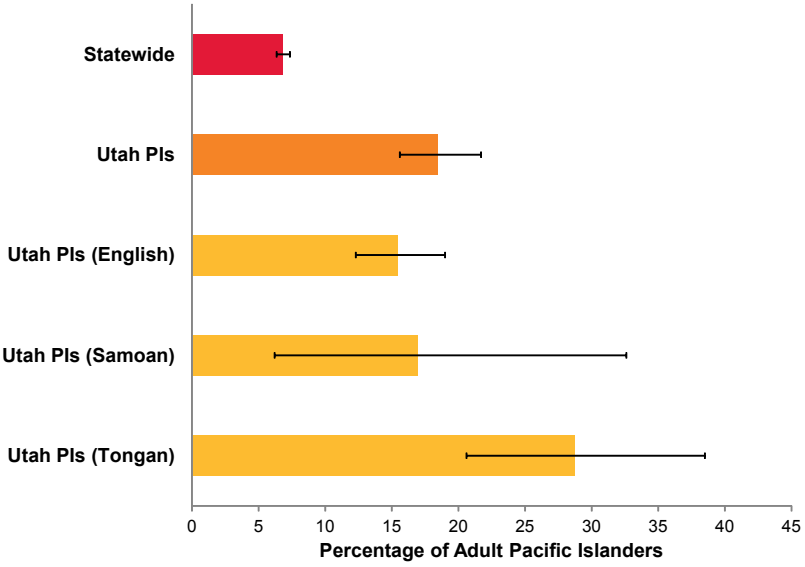
Community Health Indicators Spotlight, December 2011

Utah Pacific Islanders and Diabetes

The Utah Department of Health, Office of Health Disparities Reduction coordinated a survey of adult Utah Pacific Islanders (PIs) in 2011. Of adult PIs surveyed, 13.7% (11.2%–16.6%) reported that they had diabetes. When adjusted for age, the Utah PI adult diabetes rate approximately tripled the statewide rate. The high obesity rate among Utah Pacific Islanders likely contributes to the high diabetes rate.

The Utah adult PI diabetes rate estimated through the Utah Pacific Islander Survey is higher than the Utah adult PI diabetes rate obtained through the Behavioral Risk Factor Surveillance System, 2005–2010 (BRFSS). The Utah BRFSS may underestimate PI disease rates because it is not conducted in Samoan and Tongan. Utah Pacific Islanders interviewed in Tongan were particularly likely to have diabetes.

Age-adjusted Adult Diabetes, Statewide and Among Utah Pacific Islanders (PIs) by Interview Language, 2010 and 2011



Source: Utah Behavioral Risk Factor Surveillance System, 2010 (Statewide Data); Utah Pacific Islander Survey, 2011 (Pacific Islander Data).

Monthly Health Indicators Report

(Data Through October 2011)

Monthly Report of Notifiable Diseases, October 2011	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)	26	21	392	301	1.3
Shiga toxin-producing Escherichia coli (E. coli)	8	9	161	106	1.5
Hepatitis A (infectious hepatitis)	0	1	5	9	0.6
Hepatitis B, acute infections (serum hepatitis)	0	1	7	11	0.6
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/flu				
Meningococcal Disease	0	0	10	6	1.7
Pertussis (Whooping Cough)	0	32	331	318	1.0
Salmonellosis (Salmonella)	14	23	273	280	1.0
Shigellosis (Shigella)	2	6	48	40	1.2
Varicella (Chickenpox)	27	72	301	557	0.5

Quarterly Report of Notifiable Diseases, 3rd Qtr 2011	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†	13	25	57	85	0.7
Chlamydia	1,671	1,516	5,089	4,456	1.1
Gonorrhea	77	137	193	434	0.4
Tuberculosis	6	5	29	22	1.3

Medicaid Expenditures (in Millions) for the Month of October 2011	Current Month	Expected/ Budgeted‡ for Month	Fiscal YTD	Budgeted‡ Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	$ 20.2	$ 23.8	$ 52.1	$ 56.9	$ (4.8)
Inpatient Hospital	$ 61.6	$ 48.7	$ 108.2	$ 105.7	$ 2.5
Outpatient Hospital	$ 8.3	$ 6.0	$ 28.5	$ 29.9	$ (1.5)
Long Term Care	$ 15.3	$ 7.7	$ 48.5	$ 46.4	$ 2.1
Pharmacy§	$ 17.2	$ 6.2	$ 57.4	$ 46.2	$ 11.2
Physician/Osteo Services	$ 8.7	$ 10.8	$ 25.3	$ 28.1	$ (2.8)
TOTAL HCF MEDICAID	$224.9	$ 192.4	$ 550.8	$ 557.0	$ (6.2)

Program Enrollment for the Month of October 2011	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	248,463	245,970	+1.0%	226,998	+9.5%
PCN (Primary Care Network)	14,900	15,336	-2.8%	13,890	+7.3%
CHIP (Children's Health Ins. Plan)	37,563	37,535	+0.1%	38,681	-2.9%

	Annual Visits			Annual Charges	
Health Care System Measures	Number of Events	Rate per 100 Population	% Change¶ From Previous Year	Total Charges in Millions	% Change¶ From Previous Year
Overall Hospitalizations (2010)	274,576	9.0%	-2.6%	$ 5,416.2	+5.9%
Non-maternity Hospitalizations (2010)	167,340	5.3%	-0.9%	$ 4,552.5	+5.9%
Emergency Department Encounters (2009)	684,176	23.3%	-1.1%	$ 1,081.4	+22.9%
Outpatient Surgery (2009)	311,442	10.6%	+1.9%	$ 1,465.7	+14.7%

Annual Community Health Measures	Current Data Year	Number Affected	Percent/ Rate	% Change¶ From Previous Year	State Rank# (1 is best)
Obesity (Adults 18+)	2010	454,700	23.1%	-4.0%	11 (2010)
Cigarette Smoking (Adults 18+)	2010	180,100	9.1%	-6.9%	1 (2010)
Influenza Immunization (Adults 65+)	2010	175,900	68.2%	-0.8%	23 (2010)
Health Insurance Coverage (Uninsured)	2010	301,900	10.6%	-5.6%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2009	227	8.1 / 100,000	-16.6%	15 (2007)
Poisoning Deaths	2009	543	19.4 / 100,000	+7.0%	49 (2007)
Suicide Deaths	2009	445	15.9 / 100,000	+15.3%	n/a
Diabetes Prevalence (Adults 18+)	2010	128,000	6.5%	+0.2%	15 (2010)
Poor Mental Health (Adults 18+)	2010	296,100	15.0%	+6.8%	17 (2010)
Coronary Heart Disease Deaths	2009	1,469	52.5 / 100,000	-4.4%	1 (2007)
All Cancer Deaths	2009	2,543	90.8 / 100,000	+1.1%	1 (2007)
Stroke Deaths	2009	734	26.2 / 100,000	-2.2%	14 (2007)
Births to Adolescents (Ages 15-17)	2009	992	16.5 / 1,000	-10.6%	19 (2008)
Early Prenatal Care	2009	38,562	71.6%	-9.6%	n/a
Infant Mortality	2009	285	5.3 / 1,000	+11.4%	4 (2007)
Childhood Immunization (4:3:1:3:3:1)	2009	41,500	76.6%	+4.1%	16 (2009)

* Influenza activity remains minimal in Utah. Influenza-like illness activity is below baseline statewide. As of November 16, 2011, 1 influenza-associated hospitalization has 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.

‡ Budget has been revised to include supplemental funding from 2011 General Session.

§ Only includes the gross pharmacy costs. Pharmacy Rebate and Pharmacy Part-D amounts are excluded from this line item.

¶ % 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 2012 season.