Utah Health Status Update

KEY FINDINGS

- One hot spot of elevated blood lead levels was found in Salt Lake County from 2008–2017.
- Childhood lead exposure can be prevented. Whenever a parent or guardian, or health care provider suspects that a child is at risk for lead exposure, a blood lead test should be performed.
- Find additional blood lead resources for the general public and health care providers at https://epht.health.utah.gov/epht-view/topic/ChildhoodBloodLead.html.

Investigation of Elevated Childhood Blood Lead Levels in Salt Lake County, 2008–2017

Introduction

Childhood lead exposure continues to be a public health concern. Lead plays no biological function in the human body and can harm a child's intellectual and cognitive development. While there are many possible routes of lead exposure (including drinking water and air emissions), the primary source of concern continues to be lead-based paint in older residential homes.

The Environmental Epidemiology Program at the Utah Department of Health partnered with the Salt Lake County Health Department to conduct a hot spot investigation to identify elevated childhood blood levels in the county and focus education and outreach efforts.

Methods

Data were collected on all blood lead test results conducted in Salt Lake County from 2008 to 2017 among children from birth to age five. Test results were classified as "elevated" if they met the current recommended level of concern, which is ≥ 5 micrograms per deciliter of blood. Patient addresses were used as part of the hot spot scanning method. This allowed for more precise hot spot areas to be found. A total of 15,815 blood lead tests were used, of which 386 (2.4%) were elevated.

Results

The investigation found one hot spot of elevated blood lead tests. The hot spot area is almost exclusively situated in Salt Lake City. Figure 1 shows a map of the hot spot area in Salt Lake County and Figure 2 shows a more detailed view of the area. Blood lead tests conducted in this area were 2.5 times as likely to have an elevated test result, compared to the rest of the county (2.1–3.1, 95% CI).

Discussion

The location of the hot spot is primarily situated in the area of Salt Lake County that has the highest ratios of pre-1950 housing, and thus, lead-based paint in residential housing. This confirms what was already believed to be the high-

Feature Article Continued

Identified Cluster of Elevated Childhood Blood Lead Levels in Salt Lake County, 2008–2017

Figure 1. The investigation found one hot spot of elevated blood lead tests in the northern part of Salt Lake County.

risk areas for elevated blood lead levels in Salt Lake County. Individuals who are concerned about lead exposure should speak with their health care provider.

What Can You Do to Prevent Childhood Lead Exposure?

Childhood lead exposure can be prevented. If you are a parent or guardian to young children, consider these ways to reduce and prevent lead exposure:

- Have your child tested for lead.
- If your child lives in or frequently visits a house built before 1978, have the paint tested for lead. This includes a facility like a home daycare center or a babysitter's home.
- Wash your child's hands and toys often.
- Wear gloves and use soap and water to clean floors, windowsills, and other surfaces regularly.
- Have your child eat foods high in iron, calcium, vitamin C, and low in fats.
- If your work involves lead, wash up and change your clothes before coming home.

Detailed View of Identified Cluster of Elevated Childhood Blood Lead Levels in Salt Lake County, 2008–2017

Figure 2. The hot spot of elevated blood lead tests included parts of Rose Park, the Avenues, Glendale, Downtown Salt Lake City, South Salt Lake, Southeast Liberty, and Foothill.

Find the full investigation report at http://health.utah.gov/enviroepi/healthyhomes/epht/SLC_EBLL_2019.pdf.

Spotlights

Misapplication of the CDC Guidelines on Prescribing Opioids[1]

The New England Journal of Medicine (NEJM) presented the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain (Guideline), and provides advice against misapplication of the Guideline. Misapplication of the Guideline can risk patient health, safety, and wellbeing.

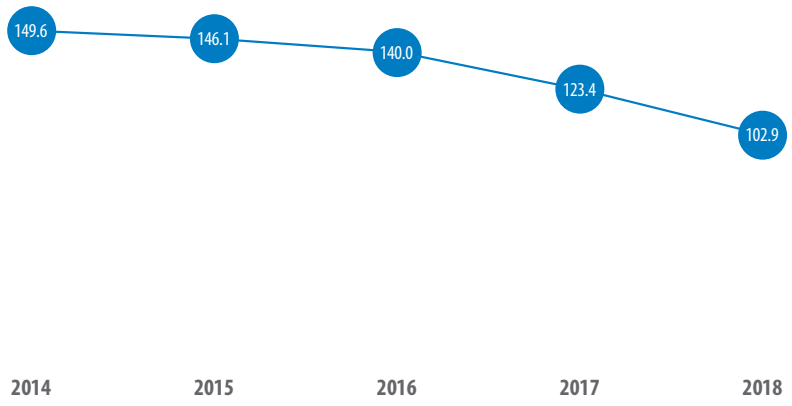
The CDC is raising awareness about the following issues that could put patients at risk:

- **Misapplication of recommendations to populations outside of the Guideline's scope.** The Guideline is intended for primary care clinicians treating chronic pain for patients 18 and older. Examples of misapplication include applying the Guideline to patients in active cancer treatment, patients experiencing acute sickle cell crises, or patients experiencing post-surgical pain.
- **Misapplication of the Guideline's dosage recommendation that results in hard limits or "cutting off" opioids.** The Guideline states, "When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should… avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." The recommendation statement does not suggest discontinuation of opioids already prescribed at higher dosages.
- **The Guideline does not support abrupt tapering or sudden discontinuation of opioids.** These practices can result in severe opioid withdrawal symptoms including pain and psychological distress, and some patients might seek other sources of opioids. In addition, policies that mandate hard limits conflict with the Guideline's emphasis on individualized assessment of the benefits and risks of opioids given the specific circumstances and unique needs of each patient.
- **Misapplication of the Guideline's dosage recommendation to patients receiving or starting medication-assisted treatment for opioid use disorder.** The Guideline's recommendation about dosage applies to use of opioids in the management of chronic pain, not to the use of medication-assisted treatment for opioid use disorder. The Guideline strongly recommends offering medication-assisted treatment for patients with opioid use disorder.

From 2014 to 2018, there was a decrease in the rate of high dose opioid prescriptions dispensed per 1,000 Utahns (see Figure). In order to protect Utahns, is it vital that misapplication of the Guideline be prevented when prescribing opioids.

Rate of high dose opioid prescriptions (>90 MME) dispensed per 1,000 population, Utah, 2004–2018

Figure 1. The number of high dose opioid prescriptions dispensed decreased by 30% since 2014 in Utah.



1. This information is copied and slightly reworded from: https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html.

Spotlights

Opioid Crisis Planning

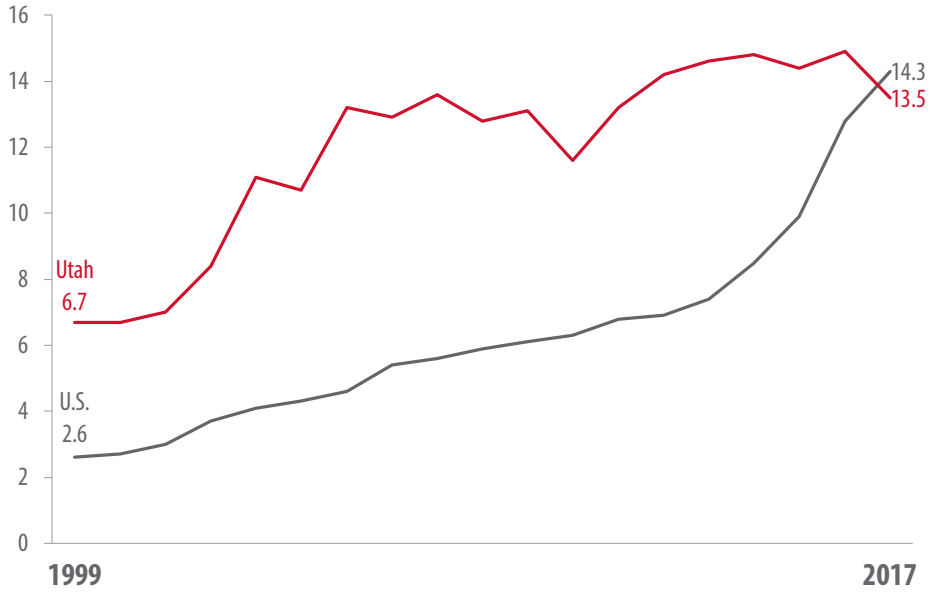
In August 2016, there were 26 people who overdosed in a 4-hour span in Huntington, West Virginia. Most happened in one neighborhood where heroin was laced with fentanyl. What is the role of public health in something like this? Does Utah have the right partnerships in place now to be able to respond? What can community partners do to make sure there is a coordinated and effective response when this happens?

Overdoses due to opioids continue to be a problem in Utah. The opioid overdose death rate in Utah has been significantly higher than the national rate for more than a decade. The national rate surpassed the Utah rate in 2017 (see Figure). On average, 34 Utahns die every month from an opioid overdose.

In Utah, staff at each local health department along with the Utah Department of Health have worked with partners over the last year to put together an opioid crisis response plan. These plans were developed to identify when and how local communities would respond to an opioid crisis, which could also be thought of as an overdose outbreak or cluster. While many public health interventions are focused on primary prevention or preventing the event from occurring, the crisis plans are focused on tertiary prevention or managing overdoses after the crisis occurs and softening the impact of the crisis. The development of the plans has provided successful networking opportunities for a diverse group of community partners (public health, healthcare professionals, first responders, pharmacists, drug task force members, and behavioral health agencies) addressing the opioid problem. For more information about state or local opioid crisis response plans, please contact Gary Mower at gdmower@utah.gov.

Opioid deaths per 100,000 population, Utah and U.S., 1999–2017

Figure 1. The opioid overdose death rate in Utah has been significantly higher than the national rate for more than a decade. In 2017, the national rate surpassed the Utah rate.



Monthly Health Indicators

Monthly Report of Notifiable Diseases, July 2019	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*)	53	65	316	320	1.0
Shiga toxin-producing *Escherichia coli (E. coli)*	13	19	84	64	1.3
Hepatitis A (infectious hepatitis)	2	4	14	31	0.4
Hepatitis B, acute infections (serum hepatitis)	0	2	13	14	0.9
Meningococcal Disease	1	0	2	1	1.4
Pertussis (Whooping Cough)	8	42	161	316	0.5
Salmonellosis (*Salmonella*)	36	41	175	222	0.8
Shigellosis (*Shigella*)	4	4	29	27	1.1
Varicella (Chickenpox)	2	9	82	133	0.6
West Nile (Human cases)	0	1	0	1	0.0
Quarterly Report of Notifiable Diseases, 2nd Qtr 2019	**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	29	51	62	0.8
Chlamydia	2,759	2,248	5,529	4,659	1.2
Gonorrhea	616	498	1,271	985	1.3
Syphilis	89	62	187	125	1.5
Tuberculosis	7	6	13	13	1.0
Medicaid Expenditures (in Millions) for the Month of July 2019	**Current Month**	**# Expected (5-yr average)**	**Fiscal YTD**	**Budgeted Fiscal YTD**	**Variance over (under) Budget**
Mental Health Services	$ 2.7	$ 2.6	$ 167.9	$ 169.1	$ (1.3)
Inpatient Hospital Services	6.8	6.6	233.3	234.8	(1.5)
Outpatient Hospital Services	1.9	1.9	44.3	45.5	(1.2)
Nursing Home Services	8.7	7.8	290.0	290.5	(0.6)
Pharmacy Services	0.9	1.7	130.7	132.5	(1.8)
Physician/Osteo Services‡	1.8	1.7	67.2	67.5	(0.3)
Medicaid Expansion Services	8.6	7.6	156.9	157.4	(0.5)
TOTAL MEDICAID	**(18.4)**	**(20.0)**	**2,835.6**	**2,836.4**	**(0.8)**

† Diagnosed HIV infections, regardless of AIDS diagnosis.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance has ended for influenza until the 2019–2020 season.

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

UTAH DEPARTMENT OF HEALTH

DATA THROUGH JULY 2019

Monthly Health Indicators

Program Enrollment for the Month of July 2019	Current Month	Previous Month	% Change§ From Previous Month	1 Year Ago	% Change§ From 1 Year Ago
Medicaid	287,849	287,141	+0.2%	273,946	+5.1%
CHIP (Children's Health Ins. Plan)	17,512	17,528	-0.1%	18,959	-7.6%
Commercial Insurance Payments#	**Current Data Year**	**Number of Members**	**Total Payments**	**Payments per Member per Month (PMPM)**	**% Change§ From Previous Year**
Medical	2017	8,347,707	$ 2,558,930,212	$ 306.54	new measure
Pharmacy	2017	7,551,975	483,316,448	64.00	new measure
Annual Community Health Measures	**Current Data Year**	**Number Afflicted**	**Percent \ Rate**	**% Change§ From Previous Year**	**State Rank** (1 is Best)**
Obesity (Adults 18+)	2018	618,400	27.8%	+10.1%	7 (2017)
Child Obesity (Grade School Children)	2018	38,100	10.6%	+11.6%	n/a
Cigarette Smoking (Adults 18+)	2018	200,100	9.0%	+0.9%	1 (2017)
Vaping, Current Use (Grades 8, 10, 12)	2017	32,000	11.1%	+6.3%	n/a
Binge Drinking (Adults 18+)	2018	236,700	10.6%	-7.7%	1 (2017)
Influenza Immunization (Adults 65+)	2018	182,300	52.0%	-7.1%	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%	14 (2017)
Drug Overdose Deaths Involving Opioids	2017	400	12.9 / 100,000	-7.2%	25 (2017)
Suicide Deaths	2017	663	21.4 / 100,000	+6.3%	46 (2017)
Unintentional Fall Deaths	2017	224	7.2 / 100,000	+7.2%	20 (2017)
Traumatic Brain Injury Deaths	2017	634	20.4 / 100,000	-8.4%	32 (2017)
Asthma Prevalence (Adults 18+)	2018	205,500	9.2%	+3.6%	15 (2017)
Diabetes Prevalence (Adults 18+)	2018	185,900	8.3%	+17.5%	6 (2017)
High Blood Pressure (Adults 18+)	2017	532,900	24.5%	+3.8%	3 (2017)
Poor Mental Health (Adults 18+)	2018	418,300	18.8%	+3.1%	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%	24 (2017)
Childhood Immunization (4:3:1:3:3:1)	2017	35,600	70.2%	-4.6%	46 (2017)

§ Relative percent change. Percent change could be due to random variation.
# Figures subject to revision as new data is processed.
** State rank based on age-adjusted rates where applicable.