Utah Health Status Update

KEY FINDINGS

- **In Utah, on average, ED visits cost more than five and a half times that of an urgent care visit.**

- **While there has been a decrease in ED visits in Utah, there was also a significant increase in the number and percentage of urgent care and telehealth visits.**

- **As healthcare consumers become more familiar with proper ED use, it is expected urgent care and telehealth utilization will increase.**

- **Proper use of the ED will reduce unnecessary medical costs and free up ED resources for the patients who truly need these services.**

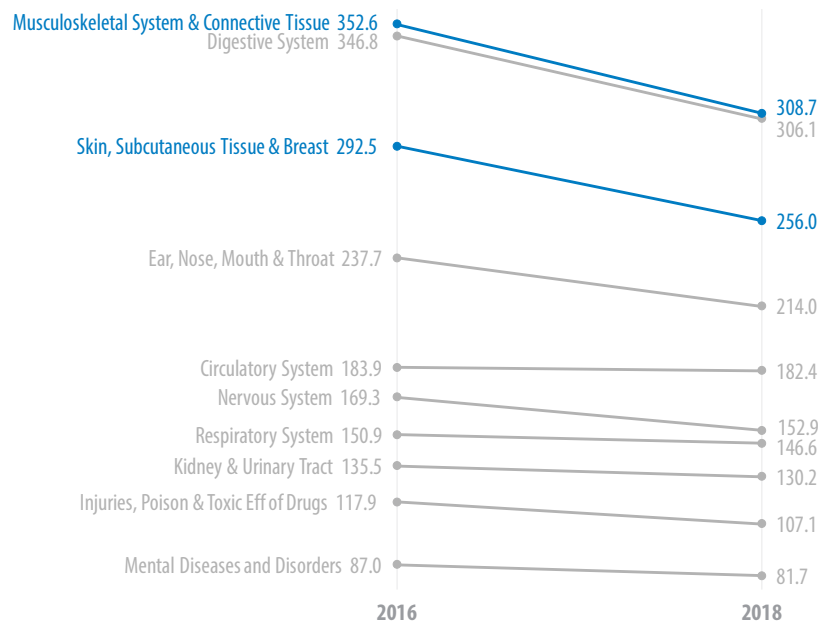## The Rise of Urgent Care Clinics and Telehealth

As healthcare costs balloon around the United States, people often wonder if anything can be done to lower costs and if any progress is being made to reduce healthcare costs. There has been much discussion on reducing the cost by limiting the amount of low-value or unnecessary care that is performed. One of the leading causes of avoidable high medical costs is unnecessary emergency department (ED) visits. In Utah, on average, ED visits cost more than five and a half times that of an urgent care visit. Fortunately, in the last few years there has been a decrease in ED visits.

ED visits can be categorized into 25 mutually exclusive diagnosis groupings called Major Diagnostic Categories (MDC). Figure 1 shows the decrease in ED utilization rates for the top 10 Major Diagnostic Categories from 2016 to 2018.

While there has been a decrease in ED visits in Utah, there was also a significant increase in the number and percentage of urgent care and telehealth visits.

Leading Causes of ED Visits in Utah

Figure 1. ED utilization rates (per 10,000) for the 10 most frequent causes of ED visits all decreased from 2016 to 2018, with Musculoskeletal System and Connective Tissue and Skin, Subcutaneous Tissue, and Breast showing the largest decrease.


	2016	2018
Musculoskeletal System & Connective Tissue	352.6	308.7
Digestive System	346.8	306.1
Skin, Subcutaneous Tissue & Breast	292.5	256.0
Ear, Nose, Mouth & Throat	237.7	214.0
Circulatory System	183.9	182.4
Nervous System	169.3	152.9
Respiratory System	150.9	146.6
Kidney & Urinary Tract	135.5	130.2
Injuries, Poison & Toxic Eff of Drugs	117.9	107.1
Mental Diseases and Disorders	87.0	81.7

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Feature article continued

Figure 2 shows this increase from 2016 to 2018 as a percentage of total emergent care visits.

Urgent Care and Telehealth Utilization Increase

Figure 2. While a decrease was seen in ED visits from 2016 to 2018, there was a significant increase in the percentage of emergent care claims from urgent care and telehealth visits in Utah.

Urgent Care	5.5%
Telehealth	1.8%
Emergency Department	-7.3%
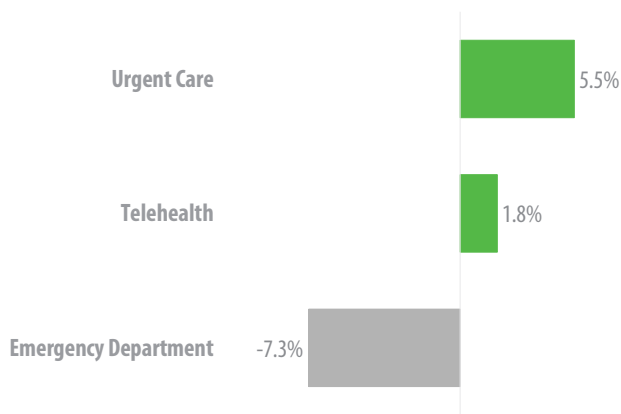
It is important however that people who need to use the ED do so properly. Table 1 displays the ED primary diagnoses decreases for the top three Major Diagnostic Categories. The percentage of decrease column is calculated by dividing the difference in specific

diagnosis cases by the total difference of the number of cases from 2016 to 2018.

While each ED case is unique, these diagnosis descriptions appear, for the most part, to be situations where an urgent care clinic or telehealth visit was a more appropriate use of medical resources.

As healthcare consumers become more familiar with proper ED use, it is expected urgent care and telehealth utilization will increase. Proper use of the ED will reduce unnecessary medical costs and free up ED resources for the patients who truly need these services.

Diagnoses Responsible for the Decrease in ED Visits

Table 1. The largest decrease in ED visits from 2016 to 2018 was for generalized or unspecified abdominal pain.

Major Diagnosis Category	Diagnosis Description	% of Decrease	Cumulative % of Decrease by MDC
Digestive System	Generalized or unspecified abdominal pain	43.1%	43.1%
	Unspecified vomiting	9.4%	52.5%
	Centralized upper abdominal pain	9.2%	61.7%
Musculoskeletal System & Connective Tissue	Lower back pain	14.6%	14.6%
	Strain of lower back or neck	14.1%	28.6%
	Upper back pain	11.4%	40.0%
Skin, Subcutaneous Tissue & Breast	Bacterial skin infection of leg	12.7%	12.7%
	Laceration of the head	4.7%	17.4%
	Laceration of the hand	3.1%	20.5%

Spotlights

**Utah Levels of Neonatal and Maternal Care**

Neonatal and maternal hospital levels of care are determined by assessing site functional capabilities to diagnose, treat, and maintain care for pregnant women and infants. For patients, this means being served in a facility staffed with personnel and equipment that aligns with their risk. For example, pregnant women with severe heart conditions need care at facilities with a full range of specialists available to help care for complex medical conditions. Infants born before 32 weeks gestation should be cared for at facilities with specialized healthcare providers and equipment to care for infants who are born too early or who are critically ill.

The Centers of Disease Control and Prevention (CDC) Levels of Care Assessment Tool determines standardized levels of care and is based on the most recent Levels of Neonatal Care from the American Academy of Pediatrics and the Levels of Maternal Care from the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Hospital levels of care are determined by the services and care provided based on the referenced guidelines, with 1 being the lowest and 4 being the highest level. The results of the assessment tool facilitate the discussion of risk-appropriate care which was developed to improve health outcomes for pregnant women and infants. Understanding levels of care helps to ensure pregnant women and their infants at high risk of complications receive care at a birth facility best prepared to meet their health needs.

Staff with the Utah Department of Health Maternal and Infant Health Program and the CDC conducted the levels of care assessment tool via a web-based survey with each Utah delivering hospital to determine their maternal and neonatal levels of care. The level of care assessment data collection and analysis process provided a snapshot of the 46 Utah delivering hospitals and helps to strategically improve maternal and infant care delivery.

Utah Hospital Levels of Neonatal and Maternal Care Based on CDC Levels of Care Assessment Tool

Figure 1. The majority of Utah hospitals are classifed as Level 1 for both neonatal and maternal care.
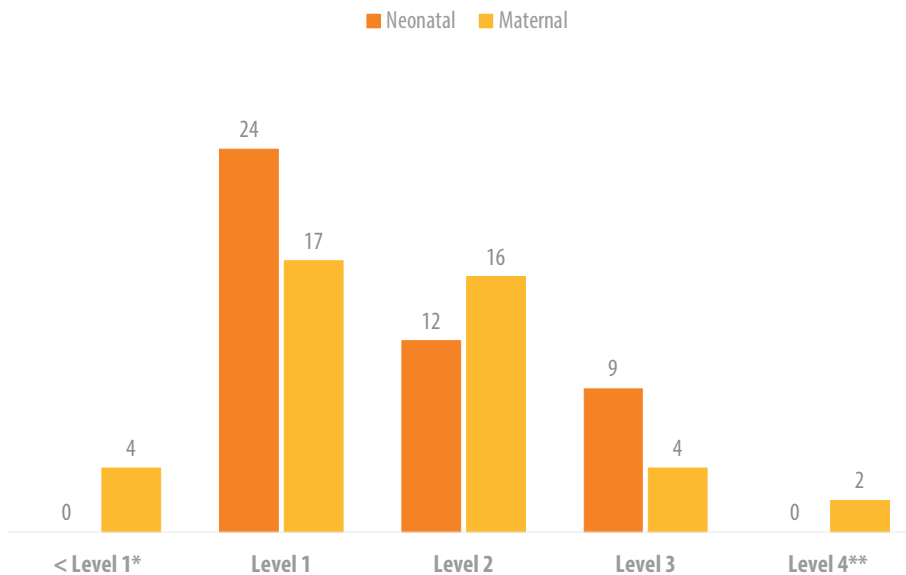
* <Level 1 does not apply to neonatal levels of care.
**There were no Utah delivering hospitals completing the survey which met the Level 4 neonatal care criteria.

Survey Shows How Health Equity Frameworks Redirect Efforts from Short-term Care to Invest in Utah Oral Health Workforce

In 2016, the Utah Department of Health Office of Health Disparities (OHD) began hosting free dental clinics. Aware of this short-term approach to increasing access to care, staff in the OHD applied the National Partnership for Action to End Health Disparities (NPA) framework and endeavored to build the cultural and linguistic skills, awareness, and competence of oral health professional and student volunteers. In May 2019, dental clinic volunteers were surveyed to measure the effectiveness of these strategies.
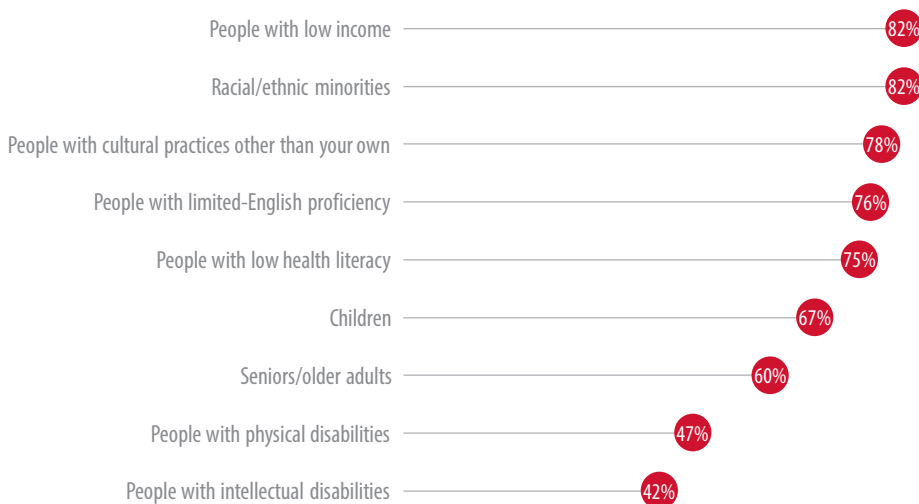
Fifty-five (55) out of 166 volunteers (33%) responded to the survey including dentists, dental hygienists, dental students, and dental hygiene students. Respondents reported volunteering 962 hours among 12 clinics. Nearly all volunteers (98%) interacted with disparate communities and a majority of volunteers (75%) used interpretation services at the clinics (56% of whom said it was their first time using in-person or telephone interpretation).

A majority of volunteers (92–97%) reported the clinics improved their general knowledge of disparate communities, their knowledge of oral health disparities experienced by members of these communities, their communication skills in working with these community members, and their level of comfort when treating patients who are experiencing oral health disparities. Almost every volunteer (91%) said the clinics provided them with opportunities and experiences they would have not received elsewhere. Furthermore, an overwhelming majority of volunteers (92%) said their participation in the clinics increased the likelihood they would accept patients from diverse and vulnerable backgrounds in their current or future clinical practices.

The survey results overall showed some evidence that volunteers were not only engaged in short-term care, but also in activities that invested in sustainable practices aimed at addressing oral health disparities such as building the cultural and linguistic skills of volunteers through a hands-on application of training on cultural considerations and interpretation. These findings encourage partners in and around the oral health community to integrate health equity frameworks into their efforts.

Percentage of Volunteers Reporting Improved Knowledge in Select Areas

Figure 1. A large percentage of volunteers reported improvements in their knowledge about oral health disparities experienced among different population groups.

Category	Percentage
People with low income	82%
Racial/ethnic minorities	82%
People with cultural practices other than your own	78%
People with limited-English proficiency	76%
People with low health literacy	75%
Children	67%
Seniors/older adults	60%
People with physical disabilities	47%
People with intellectual disabilities	42%

Note: These groups are not mutually exclusive.

Monthly Health Indicators

Monthly Report of Notifiable Diseases, September 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)*	48	46	437	422	1.0
Shiga toxin-producing *Escherichia coli (E. coli)*	19	10	141	91	1.6
Hepatitis A (infectious hepatitis)	2	5	18	40	0.5
Hepatitis B, acute infections (serum hepatitis)	0	3	18	13	1.4
Meningococcal Disease	0	0	3	2	1.9
Pertussis (Whooping Cough)	3	27	229	382	0.6
Salmonellosis *(Salmonella)*	24	36	244	308	0.8
Shigellosis *(Shigella)*	8	5	45	37	1.2
Varicella (Chickenpox)	13	17	109	161	0.7
West Nile (Human Cases)	7	9	21	19	1.1

Quarterly Report of Notifiable Diseases, 3rd 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[†]	35	34	95	95	1.0
Chlamydia	2,853	2,380	8,402	7,039	1.2
Gonorrhea	813	577	2,090	1,562	1.3
Syphilis	33	27	99	74	1.3
Tuberculosis	6	7	19	20	1.0

Medicaid Expenditures (in Millions) for the Month of September 2019	Current Month	Expected/ Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance over (under) Budget
Mental Health Services	$ 19.4	$ 18.9	$ 50.2	$ 51.2	$ (1.0)
Inpatient Hospital Services	11.4	11.5	29.9	31.9	(2.1)
Outpatient Hospital Services	3.6	3.7	12.7	13.9	(1.2)
Nursing Home Services	19.4	19.7	48.3	49.9	(1.5)
Pharmacy Services	8.8	8.7	28.5	29.9	(1.4)
Physician/Osteo Services[‡]	3.4	3.4	13.9	14.5	(0.6)
Medicaid Expansion Services	33.3	33.5	93.4	95.1	(1.6)
TOTAL MEDICAID	**251.5**	**246.6**	**760.8**	**764.5**	**(3.6)**

[†] 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

Monthly Health Indicators

Program Enrollment for the Month of September 2019	Current Month	Previous Month	% Change§ From Previous Month	1 Year Ago	% Change§ From 1 Year Ago
Medicaid	286,877	289,287	-0.8%	272,050	+5.5%
CHIP (Children's Health Ins. Plan)	17,265	17,490	-1.3%	18,651	-7.4%

Commercial Insurance Payments#	Current Data Year	Number of Members	Total Payments	Payments per Member per Month (PMPM)	% Change§ From Previous Year
Medical	2018	10,355,207	$ 3,146,492,372	$ 303.86	-0.9%
Pharmacy	2018	8,195,234	543,507,290	66.32	+3.6%

Annual Community Health Measures	Current Data Year	Number Affected	Percent \ Rate	% Change§ From Previous Year	State Rank** (1 is Best)
Obesity (Adults 18+)	2018	618,400	27.8%	+10.1%	13 (2018)
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 (2018)
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 (2018)
Influenza Immunization (Adults 65+)	2018	182,300	52.0%	-7.1%	16 (2018)
Health Insurance Coverage (Uninsured)	2017	304,000	9.8%	+12.6%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2018	239	7.6 / 100,000	-16.2%	14 (2017)
Drug Overdose Deaths Involving Opioids	2017	400	12.9 / 100,000	-7.2%	25 (2017)
Suicide Deaths	2018	665	21.0 / 100,000	-1.5%	46 (2017)
Unintentional Fall Deaths	2018	262	8.3 / 100,000	+14.8%	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%	21 (2018)
Diabetes Prevalence (Adults 18+)	2018	185,900	8.3%	+17.5%	12 (2018)
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%	20 (2018)
Coronary Heart Disease Deaths	2018	1,624	51.4 / 100,000	-5.8%	5 (2017)
All Cancer Deaths	2018	3,262	103.2 / 100,000	+1.3%	1 (2017)
Stroke Deaths	2018	919	29.1 / 100,000	+1.6%	21 (2017)
Births to Adolescents (Ages 15–17)	2018	363	4.9 / 1,000	-15.3%	13 (2017)
Early Prenatal Care	2018	35,975	76.2%	-1.0%	n/a
Infant Mortality	2018	255	5.4 / 1,000	-7.0%	24 (2017)
Childhood Immunization (4:3:1:3:3:1:4)††	2018	36,400	72.0%	+5.9%	22 (2018)

§ 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. †† Data from 2018 NIS for children aged 24 months (birth year 2016).