

Utah health status update

Key findings

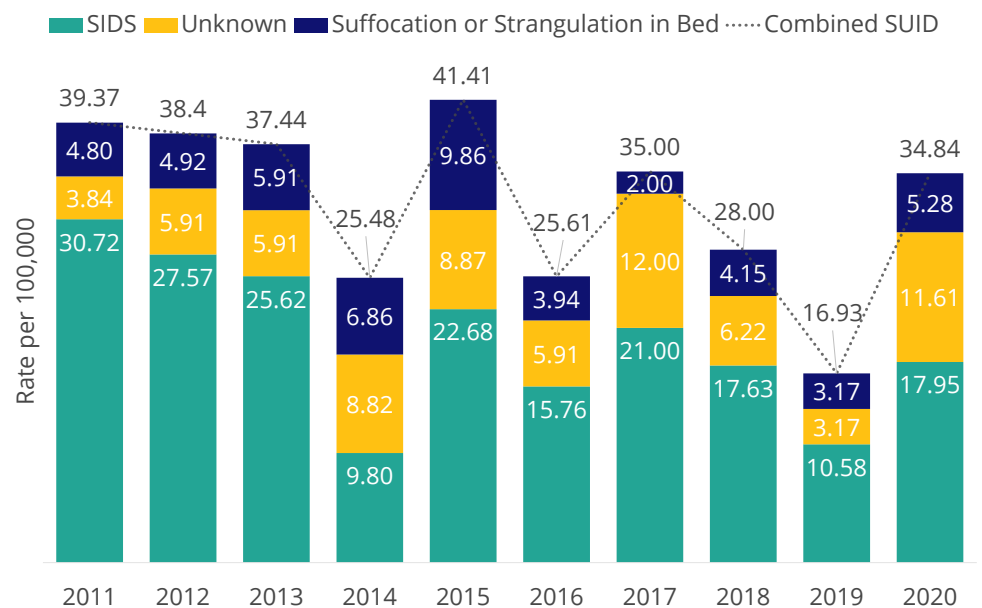
- In 2020, the rate of sudden unexpected infant deaths (SUID) cases in Utah from sudden infant death syndrome (SIDS) was 17.95 per 100,000 population (figure 1).
- In 2020, 78.8% of the 33 SUID cases in Utah had unexplained unsafe sleep factors present (figure 2).

Sudden unexpected infant deaths in Utah, 2020

October is Sudden Infant Death Syndrome (SIDS) Awareness month in the United States and in many parts of the world. In Utah, an average of nearly 20 infants died each year from SIDS from 2011–2020 (a rate of 32.4 per 100,000 infants).¹ SIDS is the highest reported death within the broad category of Sudden Unexpected Infant Deaths (SUID).² There is no immediately obvious cause of SUID, but causes are commonly captured on death certificates as SUID, unknown cause, and unintentional suffocation or strangulation in bed. In 2020, a total of 33 SUID cases were reported in Utah with 17 categorized as SIDS, 11 categorized with an unknown cause, and 5 categorized as accidental suffocation or strangulation in bed.¹ These cases accounted for 13.1% (or ~1 in 8) of the 251 Utah infant deaths in 2020.¹ The rate of SUID cases from SIDS was 17.95 per 100,000 population in 2020, an increase from 2018 and 2019 (figure 1).

Sudden unexpected infant deaths rates per 100,000 population by manner of documented death, Utah, 2011–2020

Figure 1. While the rate of sudden infant death syndrome was the most documented cause of sudden unexpected infant deaths, overall SUID remained constant from 2011–2020.



Source: Utah Department of Health and Human Services Utah Death Certificate Database.



Feature article continued

While the rate of SUID in Utah and in the United States has remained a constant for decades now, more efforts are in the works and research is underway to better understand and prevent future SUID cases.^{1,2} The Utah Department of Health and Human Services (DHHS) works with community partners in conjunction with the Child Fatality Review Committee (CFRC) to review every child death in the state, including SUID cases. The review process confirms the cause and manner of death and works to identify opportunities for prevention. See the recent publication of the 2020 Child Fatality Review Committee (CFRC) Annual report at <https://vipp.health.utah.gov/wp-content/uploads/Child-Fatality-Report-2022-Approved.pdf>.

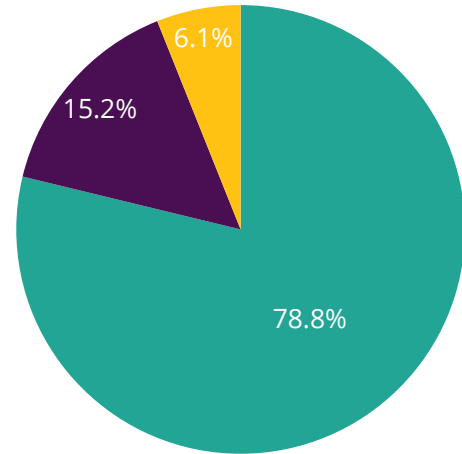
After the Utah CFRC reviews SUID cases, the cases are sent for an advanced clinical review with a specialized group of pediatric medical experts including neurologists, forensic pathologists, cardiologists, and geneticists/genetic counselors who review each case to help recognize or identify specific pathologies or genetic issues related to the deaths. Utah DHHS also takes part in the Centers for Disease Control and Prevention SUID and Sudden Death in the Young (SDY) case registry with the initial child death review process. The case registry guides teams who review these deaths in the United States to further categorize sudden and unexpected child deaths and gather additional information in research and prevention efforts.³ In-depth detailed categorization of SUID cases from the case registry helps us better understand potential risk factors for SUID.

The top risk factor for SUID is unsafe sleep practices.³ In 2020, 78.8% of the 33 SUID cases in Utah had unexplained unsafe sleep factors present (figure 2). In 2019, 100% of SUID cases included unsafe sleep factors with 80% completed case information.⁴

Percentage of Sudden Unexpected Infant Deaths, by explained or unexplained case documentation of death, Utah, 2020

Figure 2. Unsafe sleep factors were present in 78.8% of the 33 SUID cases reviewed.

- Explained and unexplained deaths with unsafe sleep factors
- Unexplained deaths with Safe Sleep Environment
- Unexplained deaths with incomplete case information



Source: Utah Department of Health and Human Services Utah Death Certificate Database.

As more is done to understand genetic factors of SUID, continued work is needed to assure parents and caretakers have the support and education they need to provide a safe sleep environment for every infant. In July 2022 the American Academy of Pediatrics (AAP) released updated recommendations to reduce the risk for sleep-related infant death. Those updated recommendations can be found at <https://www.aap.org/en/patient-care/safe-sleep/>.

1. Centers for Disease Control and Prevention. (2022, June 21). Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, Data. Retrieved from <https://www.cdc.gov/sids/data.htm>.

2. Utah Department of Health and Human Services Death Certificate Database. Retrieved on June 8, 2022 from Utah's Indicator-Based Information System for Public Health website: <http://ibis.health.utah.gov/>.

3. Centers for Disease Control and Prevention. (2022, March 1). Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, SUID and SDY Case Registry. Retrieved from <https://www.cdc.gov/sids/case-registry.htm>.

4. Utah Department of Health and Human Services Violence and Injury Prevention Program. (2022). National Child Fatality Review Case Reporting System Database, Utah Data.

Key findings

- The Utah Department of Health and Human Services Office of Health Equity developed 6 standards for race and ethnicity data collection in Utah (figure 1).
- The Utah Department of Health and Human Services Office of Health Equity developed a set of best practices for how race and ethnicity information should be collected by health and public health practitioners in Utah (figure 2).

Guidelines for data collection on race and ethnicity in Utah

In June 2022, the Utah Department of Health and Human Services (DHHS) Office of Health Equity (OHE) published Guidelines for data collection on race and ethnicity. These guidelines provide a set of state-specific standards to promote consistent and comparable data collection on race and ethnicity in Utah. Uniform data collection improves data integrity and quality so relevant and reliable data is available for decision-making. Standards enhance the ability to report, track, and identify opportunities to address racial and ethnic health disparities.

The race and ethnicity data collection guidelines were developed and adapted specifically for Utah following federal guidelines from the Office of Management and Budget's (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, and the U.S. Department of Health and Human Services Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. The guidelines development process included:

- Use of federal data collection standards on race and ethnicity as the starting point for creating Utah-specific standards.
- Research conducted by the U.S. Census Bureau on various dimensions of race and ethnicity data collection.
- Examination of census data as it pertains to Utah.
- Consultation with experienced subject matter experts in collection and analysis of demographic data throughout DHHS offices and programs.
- Engagement with community-based partners who serve racial and ethnic minority communities in Utah.

DHHS OHE developed 6 standards for race and ethnicity data collection in Utah (figure 1). These standards were created in consideration of federal guidelines while implementing adaptations for Utah. Substantial consideration was given for how to best represent racial and ethnic



minority populations in Utah and to embrace diversity in data collection efforts. More detailed explanations of each standard can be found in the [Guidelines for data collection on race and ethnicity](#).

DHHS Office of Health Equity 6 standards to develop race and ethnicity guidelines

Figure 1. The 6 standards of race/ethnicity data collection.

- 1. Self-identification: An individual identifies their own race and ethnicity**
- 2. Minimum categories: The minimum race categories are American Indian/Alaska Native, Asian/Asian American, Black/African American, Native Hawaiian/Pacific Islander, and White. The minimum ethnicity categories are Hispanic/Latino/a/x* and not Hispanic/Latino/a/x.***
- 3. Question format: Race and ethnicity data should be collected in a combined format, which presents the 6 minimum race and ethnicity categories together.**
- 4. Multi-racial heritage: Respondents should be offered the option to select 1 or more races to identify their multi-racial heritage. Recommended instructions which accompany the race/ethnicity question include "mark all that apply" and "select all that apply." There is no "multi-racial" category.**
- 5. Additional granularity: Collecting additional granularity in race and ethnicity data is encouraged where it is supported by sample size and the additional detail can be aggregated back to the 6 minimum categories.**
- 6. Write-in option of "other:" An optional write-in category option of "some other race/ethnicity" or "other" can be added to surveys with an open-ended request to specify. This respondent-specified race must then be coded to the minimum race/ ethnicity categories before results are reported.**

*The Utah Department of Health and Human Services Office of Health Equity implemented "Hispanic/Latino/a/x" to acknowledge the use of the terms "Latino," "Latina," and "Latinx" within different segments of the ethnic population.

The [Guidelines for data collection on race and ethnicity](#) provide a sample data collection template with the use of the 6 standards for collecting race/ ethnicity data (figure 2).

New DHHS Office of Health Equity race and ethnicity data collection template

Figure 2. The new race and ethnicity standards in this template were developed to identify opportunities to address racial and ethnic health disparities in Utah.

The form is titled "Race and ethnicity data collection template" and includes the Utah Department of Health & Human Services logo. A teal banner at the top states: "These questions are optional and your answers are confidential. We would like you to tell us your race and ethnicity so that we can identify and address health differences." The form contains three numbered questions:

- How do you identify your **race, ethnicity, country of origin, or ancestry?**
- Which of the following describes your **racial or ethnic identity?** Please check **all** that apply.
 - American Indian/Alaska Native**
 - American Indian/Alaska Native
 - Indigenous Mexican, Central American, or South American
 - Canadian Inuit, Metis, or First Nation
 - Some other American Indian/Alaska Native (specify below): _____
 - Asian/Asian American**
 - Asian Indian
 - Chinese
 - Filipino/a
 - Japanese
 - Korean
 - Vietnamese
 - Some other Asian/Asian American (specify below): _____
 - Black/African American**
 - African American
 - Black African
 - Black Caribbean
 - Some other Black (specify below): _____
 - Hispanic/Latino/a/x***
 - Central American
 - Mexican, Mexican American, Chicano/a
 - South American
 - Spanish/Spainiard
 - Some other Hispanic/Latino/a/x (specify below): _____
 - Native Hawaiian/Pacific Islander**
 - Chamorro
 - Native Hawaiian
 - Samoan
 - Tongan
 - Some other Pacific Islander (specify below): _____
 - White**
 - White European
 - Middle Eastern/North African
 - Some other White (specify below): _____
 - Other responses**
 - Some other Race/Ethnicity (specify below): _____
 - Prefer not to answer
- If you picked **more than one** category to identify your race/ethnicity, is there **one** you think of as your **primary** racial or ethnic identity?
 - Yes. Please circle your primary racial or ethnic identity above.
 - I do not have just one primary racial or ethnic identity
 - N/A. I only selected one from the available options
 - Don't know
 - Prefer not to answer

A teal banner at the bottom states: "This template has been adapted from the Oregon Health Authority's *Repairing REAL Data on COVID-19 Encounters: Implementation Guide for Health Systems/Providers*"

In June 2022, the chief statistician of the United States announced [the federal government plans to renew and revise the federal standards for collecting race and ethnicity data](#). As the race and ethnicity guidelines are a work-in-progress, additional standards may be forthcoming.

For more updates from the Utah Department of Health and Human Services Office of Health Equity visit <https://healthequity.utah.gov/data-and-reports/>.

Influenza vaccination coverage during pregnancy in Utah, **PRAMS** 2016–2020

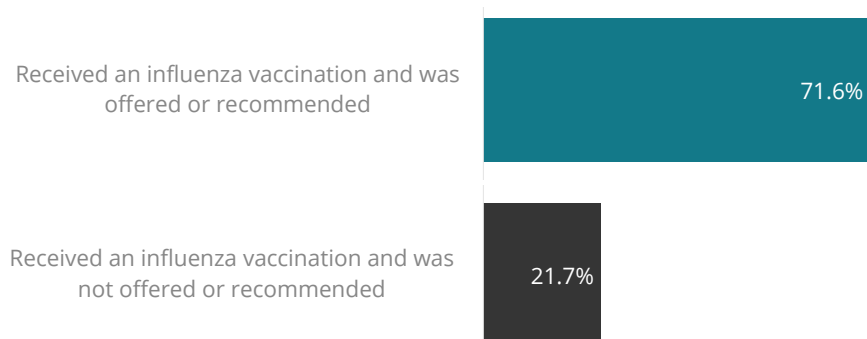
People who are pregnant are at higher risk of severe complications following influenza infection compared with the general population.¹ Influenza vaccination during pregnancy can protect and provide passive immunity to infants up to 6 months of age via maternal antibodies.² The Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP) and American College of Obstetricians and Gynecologists (ACOG) recommend all people who are or will be pregnant during influenza (flu) season receive an inactivated influenza vaccine as soon as it is available.

During 2016–2020, 85.1% of people who gave birth reported an influenza vaccination was offered or recommended to them by a doctor or other healthcare professional in the 12 months before the delivery of their infant and 63.7% reported receiving an influenza vaccination during that period. An increase in influenza vaccination rates was observed in 2020 (67.6%) compared with the average rate during the previous 4 years (62.8%).³ Although reasons for not receiving an influenza vaccination are not collected through the Utah Pregnancy Risk Assessment Monitoring System (PRAMS), data shows influenza vaccination rates were significantly higher (71.6%) among those whose health-care providers offered or recommended one (figure 1).³ Influenza vaccination is a crucial component of preconception and prenatal care. It is important for healthcare providers and public health officials to continue efforts to improve the rate of influenza vaccination during pregnancy.

Additional recommendations can be found on the American College of Obstetricians and Gynecologists website: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/04/influenza-vaccination-during-pregnancy>.

Percentage of people who gave birth and received an influenza vaccination in the 12 months before delivery of an infant, by healthcare provider offer or recommendation status, 2016–2020

Figure 1. The percentage of people who gave birth and reported receiving an influenza vaccination before delivery was higher among those whose healthcare provider offered or recommended an influenza vaccination when compared with those whose healthcare provider did not offer or recommend an influenza vaccination.



1. Macias AE, McElhane JE, Chaves SS, Nealon J, Nunes MC, Samson SI, Seet BT, Weinke T, Yu H. The disease burden of influenza beyond respiratory illness. *Vaccine*. 2021 Mar 15;39 Suppl 1:A6-A14.

2. Zaman K, Roy E, Arifeen SE, Rahman M, Raqib R, Wilson E, Omer SB, Shahid NS, Breiman RF, Steinhoff MC. Effectiveness of maternal influenza immunization in mothers and infants. *N Engl J Med*. 2008 Oct 9;359(15):1555-64.

3. Utah Department of Health and Human Services [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#), 2016–2020.

Source: Utah Department of Health and Human Services Pregnancy Risk Assessment Monitoring System (PRAMS).

Monthly health indicators

Monthly report of notifiable diseases, September 2022	Current month # cases	Current month # expected cases (5-yr average)	# cases YTD	# expected cases YTD (5-yr average)	YTD standard morbidity Ratio (obs/exp)
COVID-19 (SARS-CoV-2)	Weekly updates at https://coronavirus.utah.gov/case-counts/				
Influenza*	Updates at http://health.utah.gov/epi/diseases/influenza				
Campylobacteriosis (Campylobacter)	52	61	399	380	1.0
Salmonellosis (Salmonella)	34	39	268	251	1.1
Shiga toxin-producing Escherichia coli (E. coli)	33	28	167	127	1.3
Pertussis (Whooping Cough)	3	28	73	209	0.3
Varicella (Chickenpox)	3	11	48	95	0.5
Shigellosis (Shigella)	9	6	60	34	1.7
Hepatitis A (infectious hepatitis)	0	2	7	27	0.3
Hepatitis B, acute infections (serum hepatitis)	0	2	0	9	0.0
Meningococcal Disease	0	0	0	1	0.0
West Nile (Human cases)	1	12	1	14	0.1
Quarterly report of notifiable diseases, 2nd quarter 2022	Current quarter # cases	Current quarter # expected cases (5-yr average)	# cases YTD	# expected cases YTD (5-yr average)	YTD standard morbidity ratio (obs/exp)
HIV/AIDS†	24	28	52	59	0.9
Chlamydia (Q4 2021)	3,118	2,614	11,206	10,342	1.1
Gonorrhea (Q4 2021)	1,078	728	3,620	2,699	1.3
Syphilis (Q4 2021)	52	32	212	130	1.6
Tuberculosis	14	<5	18	12	1.6
Medicaid expenditures (in millions) for the month of September 2022	Current month	Expected/budgeted for month	Fiscal YTD	Budgeted fiscal YTD	Variance over (under) budget
Mental health services	\$2	\$2	\$215	\$216	(\$0.9)
Inpatient hospital services	\$9	\$8	\$247	\$248	(\$1.1)
Outpatient hospital services	\$2	\$1	\$40	\$40	(\$0.8)
Nursing home services	\$53	\$52	\$375	\$376	(\$1.0)
Pharmacy services	\$3	\$4	\$152	\$154	(\$1.9)
Physician/osteo services‡	\$3	\$3	\$87	\$88	(\$0.9)
Medicaid expansion services	\$45	\$45	\$1,142	\$1,144	(\$1.6)
***Total Medicaid	\$156	\$156	\$4,484	\$4,484	(\$0.4)

|| Comparisons include previous data year 2020. Updates for COVID-19 can be found at <https://coronavirus.utah.gov>. This includes case counts, deaths, number of Utahns tested for disease, and latest information about statewide public health measures to limit the spread of COVID-19 in Utah.

* More information and weekly reports for influenza can be found at <http://health.utah.gov/epi/diseases/influenza>.

† 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.

‡ Medicaid payments reported under physician/osteo Services do not include enhanced physician payments.

***The Total Medicaid program costs do not include costs for the PRISM project.

Monthly health indicators

Program enrollment for the month of September	Current month	Previous month	% change [§] from previous month	1 year ago	% change [§] from 1 year ago
Medicaid	482,605	476,965	+1.2%	430,690	+12.1%
CHIP (Children's Health Insurance Plan)	6,213	6,365	-2.4%	9,297	-33.2%
Commercial insurance payments [#]	Current data year	Number of members	Total payments	Payments per member per month (PMPM)	% change [§] from previous year
Dental	2020	5,667,256	\$ 154,748,044	\$27.31	N/A
Medical	2020	11,631,161	\$ 3,365,207,356	\$289.33	-3.8%
Pharmacy	2020	10,845,512	\$ 889,492,538	\$82.01	+9.4%
Annual community health measures	Current data year	Number affected	Percent\rate	% change from previous year	State rank ^{**} (1 is best)
Suicide deaths	2020	2,272	69.9 / 100,000	6.10%	40 (2019)
Asthma prevalence (adults 18+)	2020	250,600	10.80%	9.10%	39 (2020)
Poor mental health (adults 18+)	2020	540,700	23.30%	7.90%	37 (2020)
Influenza immunization (adults 65+)	2020	261,400	68.50%	7.20%	23 (2020)
Drug overdose deaths involving opioids	2020	432	13.3 / 100,000	7.30%	20 (2019)
Unintentional fall deaths	2020	651	20.0 / 100,000	-1.90%	17 (2019)
Infant mortality	2020	366	11.3 / 100,000	4.60%	17 (2018)
Traumatic brain injury deaths	2020	2,272	69.9 / 100,000	6.10%	15 (2019)
Obesity (adults 18+)	2020	663,700	28.60%	-2.10%	13 (2020)
Diabetes prevalence (adults 18+)	2020	188,000	8.10%	1.30%	17 (2020)
Births to adolescents (ages 15-17)	2020	318	4.1 / 1,000	7.70%	10 (2018)
Childhood immunization (4:3:1:3:3:1:4)††	2020	47,970	74.6%	-2.5%	19 (2020)
Motor vehicle traffic crash injury deaths	2020	299	9.2 / 100,000	27.60%	7 (2019)
High blood pressure (adults 18+)	2020	598,700	25.80%	5.70%	7 (2019)
Cigarette smoking (adults 18+)	2020	206,500	8.90%	1.10%	1 (2020)
Binge drinking (adults 18+)	2020	264,500	11.40%	0.90%	1 (2020)
Coronary heart disease deaths	2020	1,853	57.0 / 100,000	12.00%	1 (2020)
All cancer deaths	2020	3,459	106.4 / 100,000	3.70%	1 (2020)
Stroke deaths	2020	916	28.2 / 100,000	-1.00%	1 (2020)
Child obesity (grade school children)	2018	38,100	10.60%	11.60%	n/a
Vaping, current use (grades 8, 10, 12)	2019	37,100	12.40%	11.30%	n/a
Health insurance coverage (uninsured)	2020	383,500	11.80%	-6.30%	n/a
Early prenatal care	2020	34,716	75.90%	0.00%	n/a

[§] Relative percent change. Percent change could be due to random variation.

[#] Figures subject to revision as new data is processed.

^{**} State rank in the United States based on age-adjusted rates where applicable.

^{††} Data from 2020 NIS for children aged 24 month (birth year 2018).