

Utah Health Status Update:

Health Disparities and the Social Determinants of Health

March 2013

Health disparities are differences in health outcomes among groups of people. Disparities often affect groups that have systematically experienced obstacles such as poverty and discrimination. The social determinants of health are closely linked to health disparities.

The World Health Organization states: “The social determinants of health are the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status.”¹

Five determinants of population health are generally recognized in the scientific literature:

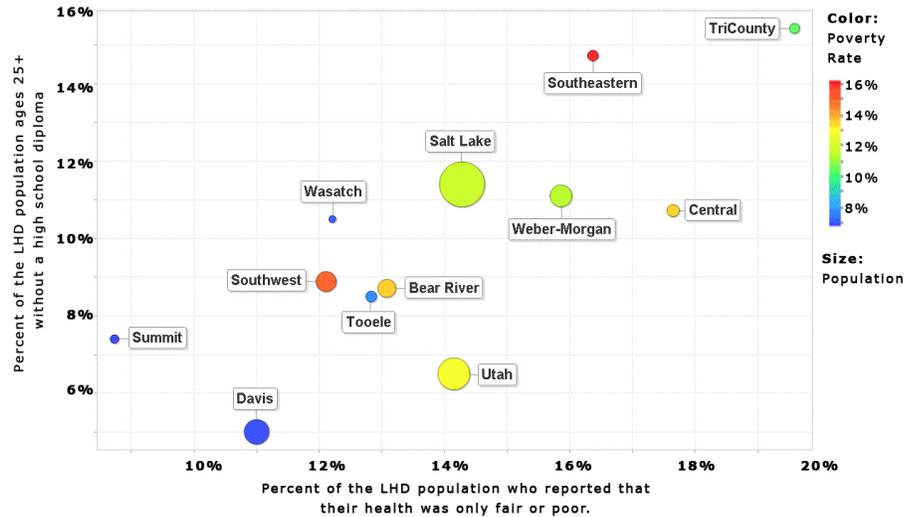
1. Biology and genetics (e.g., age)
2. Individual behavior (e.g., smoking)
3. Social environment (e.g., discrimination, income, education level, marital status)
4. Physical environment (e.g., place of residence)
5. Health services (e.g., access to and quality of care)

The social determinants of health are those included in the latter three categories: social environment, physical environment, and

- In 2011, the TriCounty Health District had the largest proportion of its population reporting that their health was only fair or poor and also had the highest proportion of residents without high school diplomas.
- Hispanics across Utah had the highest rate of fair/poor health and the highest percentage of people without high school diplomas in 2011.
- All racial and ethnic minorities had higher rates of adult diabetes than the non-Hispanic White population in 2011.

Disparities Among Utah Local Health Districts

Figure 1. Education, general health, poverty, and population estimates for each local health district.



Sources: Fair/poor health data: Utah Behavioral Risk Factor Surveillance System, 2011, Age-adjusted; Education, poverty and population data: American Community Survey, 2009-2011 (for counties with populations of 20,000+), 2007-2011 (for counties with populations <20,000).

health services. Social determinants of health are often influenced through policies and environmental factors that cannot be addressed at the individual level.² Biological determinants may not always be preventable, but behavioral and social determinants of health may be modified by policy and program interventions.

Race and ethnicity are based on subjective self-report. When people describe themselves as belonging to a particular race or ethnicity, they may be describing attributes related to any of the biological, behavioral or social determinants of health. “Definitions of race involve descriptions that are embedded in cultural as well as biological factors.”³ In spite of the complexity in defining race and ethnicity, these self-described categories are useful for public health efforts because “both race and ethnicity can be potent predictors for disease risk.”³

These figures demonstrate relationships between health disparities and some social determinants of health. Figure 1 shows disparities by Utah geographies in terms of general health. In 2011, the TriCounty Health District had the largest proportion of its population reporting that their health was only fair or poor, while the Summit County Health District had the lowest proportion reporting only fair/poor health. Not coincidentally, TriCounty Health District also had the highest proportion of residents without high school diplomas and Summit County Health District had the one of the lowest proportions of residents without high school diplomas. Most of the local health districts with good general health also had low poverty rates.

Figure 2 shows the same health indicator by race and ethnicity. Hispanics had the highest rate of fair/poor health and the highest percentage of people without high school diplomas in 2011. All racial and ethnic minority groups had

higher poverty rates than the majority non-Hispanic White population. With the exception of Asians, all Utah racial and ethnic minorities had poorer general health than non-Hispanic Whites.

Figure 3 shows Utah adult diabetes rates by race and ethnicity. All racial and ethnic minorities in Utah had higher rates of adult diabetes than the non-Hispanic White population in 2011. Minority Utahns were also more likely than non-Hispanic Whites to spend a high percentage of their income on housing costs.

According to the Centers for Disease Control and Prevention, “Many of the current approaches to prevention and disease control are focused on individual behavioral risk factors. It is urgent that these be supplemented to address underlying factors, such as poverty, unequal access to health care, incarceration, lack of education, stigma, homophobia, sexism, and racism. We need to go beyond controlling disease on the individual level and address other contributors to disease, including the social and environmental determinants of health.”²²

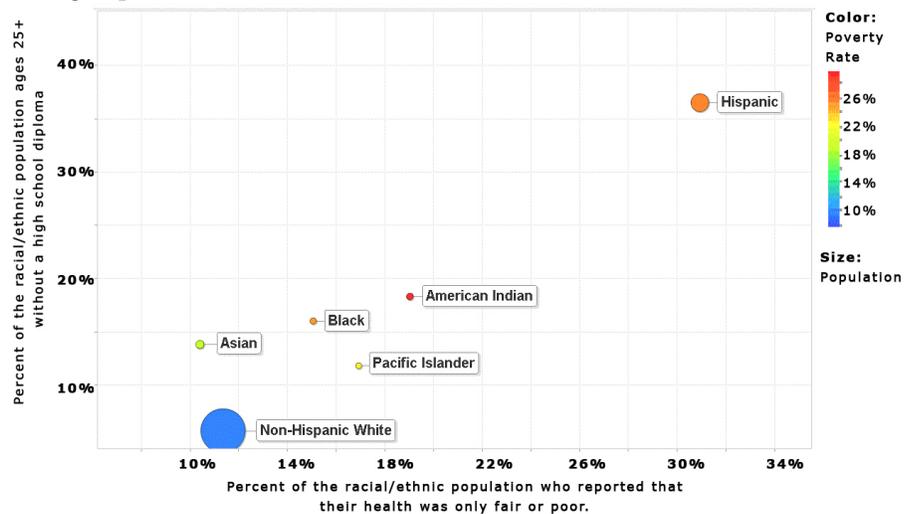
Thank you to Dr. M. Lelinneth B. Novilla and the Social Determinants of Health Research Team of the Brigham Young University, Department of Health Science, for developing the concept of using Google Motion Chart for analysis of Utah social determinants of health and introducing this methodology to Utah Department of Health staff.

References

1. World Health Organization. Social Determinants of Health. Accessed January 24, 2013. http://www.who.int/social_determinants/en/
2. Centers for Disease Control and Prevention. Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; October 2010. Available: <http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf>

Disparities Among Utah Racial/Ethnic Groups

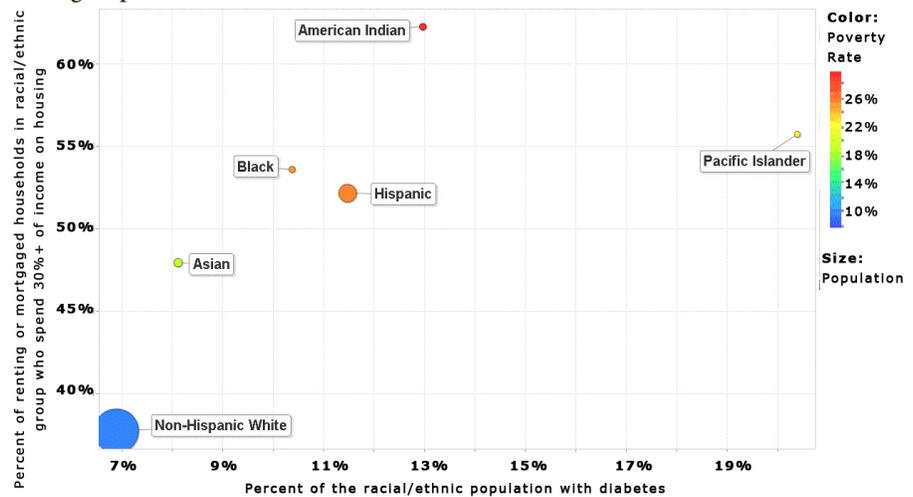
Figure 2. Education, general health, poverty, and population estimates for each racial/ethnic group.



Sources: Fair/poor health data: Utah Behavioral Risk Factor Surveillance System, 2009-2011, Age-adjusted; Education, poverty and population data: American Community Survey, 2009-2011.

Disparities Among Utah Racial/Ethnic Groups

Figure 3. Housing costs, diabetes, poverty, and population estimates for each racial/ethnic group.



Sources: Diabetes data: Utah Behavioral Risk Factor Surveillance System, 2009-2011, Age-adjusted; Education, poverty and population data: American Community Survey, 2009-2011.

3. Genes, Behavior, and the Social Environment: Moving Beyond the Nature/Nurture Debate. Institute of Medicine (US) Committee on Assessing Interactions Among Social, Behavioral, and Genetic Factors in Health; Hernandez LM, Blazer DG, editors. Washington (DC):National Academies Press (US); 2006. Available: <http://www.ncbi.nlm.nih.gov/books/NBK19934/>

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Breaking News, March 2013

Utah's Preferred Drug List (PDL)

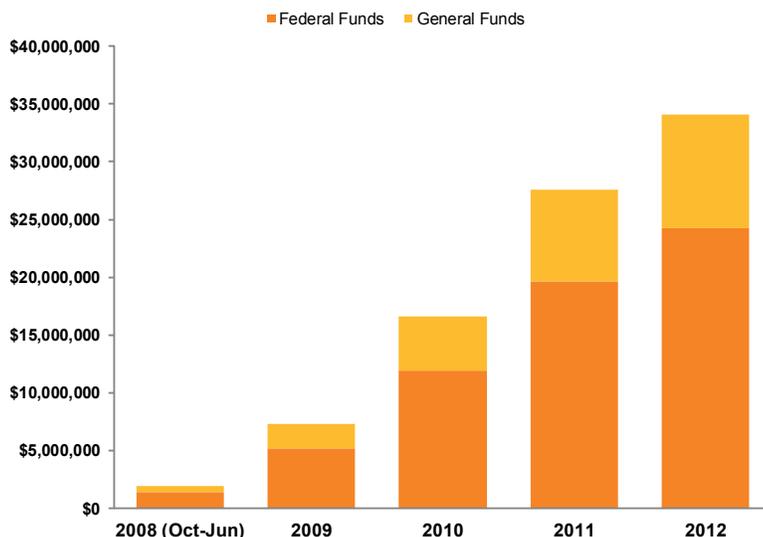
Pharmacy services are a significant expenditure of the overall Medicaid budget, totaling \$182 million in State Fiscal Year (SFY) 2012. To help curtail pharmacy costs, while still providing access to medically necessary medications, Utah implemented a Preferred Drug List (PDL) in 2007 as a tool to apply scientific evidence to pharmacy benefit management.

The PDL identifies preferred drugs that are either therapeutically equivalent or superior to non-preferred drugs. The savings come from having equally effective, but lower cost drugs as preferred drugs. Medicaid clients use these preferred drugs unless they are found to be ineffective and their physician obtains a prior authorization for the non-preferred drugs on the list.

Obtaining secondary rebates from manufacturers wishing to have their (equally safe and effective) version of a drug in a PDL drug class listed as “preferred” is one method of having a lower cost drug.

In SFY 2012, Medicaid added 18 new drug classes to the PDL, for a total of 70 classes. These drug class additions, combined with savings from existing PDL classes, generated annualized PDL savings of approximately \$34.1 million in state and federal funds. Medicaid continues to add drug classes to the PDL, and a new drug class is added at an average rate of one per month.

PDL Savings, Utah, 2008-2012



Community Health Indicators Spotlight, March 2013

New On Line Background Screening System for Licensed Health Care Providers

Within the Utah Department of Health, the Division of Family Health and Preparedness works to protect vulnerable populations. In this division, the Bureau of Health Facility Licensing, Certification and Resident Assessment is responsible for conducting criminal background screenings for workers in health care facilities/agencies in Utah (e.g., nursing homes, home health agencies and other provider types).

In July 2011, the Centers for Medicare and Medicaid Services (CMS) awarded the Bureau a \$3,000,000 grant to develop an automated background screening system. During the 2012 Legislative session, the background screening law was changed to require health facilities to submit names of employees with direct access to patients for background screening. This includes employees with access to medical and/or financial records of patients, not just those with direct care duties.

The Bureau has partnered with the Utah Department of Public Safety to develop a system to assist in protecting Utah's most vulnerable populations; children, the elderly, and the disabled. Along with checking criminal histories, the system is linked to the Certified Nurse Aid Registry, the Division of Occupational and Professional Licensing, the Office of the Inspector General, and the Federal Bureau of Investigation. This system is also designed to perform a nightly check of new arrests and convictions of previously cleared individuals, increasing the ability to protect Utah's vulnerable populations with real-time information.

The initial pilot testing of this system began in January 2013 with approximately 25 health care facilities. Full implementation is anticipated to begin in May 2013.

Monthly Health Indicators Report

(Data Through January 2013)

Monthly Report of Notifiable Diseases, January 2013	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)	24	20.4	24	20.4	1.2
Shiga toxin-producing Escherichia coli (E. coli)	4	3	4	3	1.3
Hepatitis A (infectious hepatitis)	0	1	0	1	0.0
Hepatitis B, acute infections (serum hepatitis)	0	1.2	0	1.2	0.0
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/flu				
Meningococcal Disease	0	0.4	0	0.4	0.0
Pertussis (Whooping Cough)	34	40.8	34	40.8	0.8
Salmonellosis (Salmonella)	9	21.6	9	21.6	0.4
Shigellosis (Shigella)	1	2.4	1	2.4	0.4
Varicella (Chickenpox)	21	61.8	21	61.8	0.3
Quarterly Report of Notifiable Diseases, 4th Qtr 2012	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†	2	29	72	111	0.6
Chlamydia	1,678	1,639	7,474	6,333	1.2
Gonorrhea	133	107	461	445	1.0
Syphilis	14	8	35	31	1.1
Tuberculosis	6	8	37	31	1.2
Medicaid Expenditures (in Millions) for the Month of January 2013	Current Month	Expected/Budgeted‡ for Month	Fiscal YTD	Budgeted‡ Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 10.4	\$ 11.1	\$ 78.4	\$ 77.6	\$ 0.8
Inpatient Hospital	\$ 53.6	\$ 25.9	\$ 178.6	\$ 181.2	\$ (2.5)
Outpatient Hospital	\$ 5.4	\$ 8.0	\$ 39.6	\$ 55.9	\$ (16.3)
Long Term Care	\$ 12.8	\$ 12.8	\$ 92.0	\$ 89.5	\$ 2.5
Pharmacy§	\$ 8.5	\$ 10.8	\$ 91.7	\$ 75.3	\$ 16.4
Physician/Osteo Services	\$ 5.8	\$ 7.7	\$ 50.3	\$ 53.7	\$ (3.5)
TOTAL HCF MEDICAID	\$223.7	\$ 164.5	\$1,140.7	\$1,151.6	\$ (10.9)

Program Enrollment for the Month of January 2013	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	258,866	255,436	+1.3%	251,082	+3.1%
PCN (Primary Care Network)	11,841	11,906	-0.5%	12,658	-6.5%
CHIP (Children's Health Ins. Plan)	35,254	35,417	-0.5%	37,131	-5.1%
Health Care System Measures	Annual Visits			Annual Charges	
	Number of Events	Rate per 100 Population	% Change¶ From Previous Year	Total Charges in Millions	% Change¶ From Previous Year
Overall Hospitalizations (2011)	280,830	9.3%	+0.8%	\$ 5,818.8	+7.4%
Non-maternity Hospitalizations (2011)	175,847	5.7%	+3.8%	\$ 4,909.9	+7.9%
ED Encounters - Not Admitted (2010)	645,962	22.1%	-7.8%	\$ 1,160.9	+7.4%
Outpatient Surgery (2009)	311,442	10.9%	+1.2%	\$ 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+)	2011	472,400	24.4%	+1.3%	12 (2011)
Cigarette Smoking (Adults 18+)	2011	229,300	11.8%	+2.7%	1 (2011)
Influenza Immunization (Adults 65+)	2011	147,400	56.9%	-15.5%	41 (2011)
Health Insurance Coverage (Uninsured)	2011	377,700	13.4%	+26.4%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2010	231	8.1 / 100,000	+0.1%	19 (2009)
Poisoning Deaths	2010	342	12.0 / 100,000	-38.1%	47 (2009)
Suicide Deaths	2010	479	16.8 / 100,000	+5.8%	n/a
Diabetes Prevalence (Adults 18+)	2011	129,600	6.7%	-1.8%	6 (2011)
Poor Mental Health (Adults 18+)	2011	315,300	16.3%	-0.4%	17 (2011)
Coronary Heart Disease Deaths	2010	1,488	52.2 / 100,000	-0.4%	2 (2008)
All Cancer Deaths	2010	2,791	98.0 / 100,000	+7.9%	1 (2008)
Stroke Deaths	2010	736	25.8 / 100,000	-1.4%	13 (2008)
Births to Adolescents (Ages 15-17)	2010	876	14.3 / 1,000	-13.2%	17 (2009)
Early Prenatal Care	2010	38,124	73.1%	+2.1%	n/a
Infant Mortality	2010	251	4.8 / 1,000	-9.0%	3 (2008)
Childhood Immunization (4:3:1:3:3:1)	2010	38,900	70.6%	-7.8%	12 (2010)

† Diagnosed HIV infections, regardless of AIDS diagnosis.

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

§ Includes only 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 2013 season.