

Utah Health Status Update

KEY FINDINGS

- Rural and urban Utah Small Areas (SA) reported increased telehealth claims from providers in 2020 (Figure 1).
- In 2020, the total average for telehealth claims increased by 1,557% in areas with previous telehealth claims in 2019 (Figure 2).
- Increases in telehealth utilization between 2019 and 2020 were greater for urban areas, with 65% of urban SAs seeing an increase greater than 5,000% versus only 41% of rural areas (Figure 3).
- In 2019, 29% of telehealth claims were rural and 44% of Utah Small Areas with no telehealth claims were rural.⁴

Statewide Telehealth Use Assessment: Changes between 2019 and 2020 and the Impact of the COVID-19 Pandemic

Telehealth is an important tool used to help patients access healthcare services.¹ However, utilization was low prior to the COVID-19 pandemic (Figure 1). Healthcare providers have implemented and utilized telehealth more as the COVID-19 pandemic unfolded to support social distancing, protect healthcare workers, and protect patients who may be particularly vulnerable or at high risk for illness.¹ As the COVID-19 pandemic resulted in a public health emergency, updated and emergency federal and state rule changes made the adoption and use of telehealth easier for patients and providers.²

As part of a statewide Primary Care Needs Assessment, the Utah Department of Health Office of Primary Care and Rural Health, with the support of Comagine Health Analytic Services, assessed how telehealth use across the state changed from 2019 to 2020. The objective of this assessment was to identify areas where telehealth use is low, so further analyses can be performed to identify barriers to telehealth use in those areas, and subsequently undertake initiatives to increase access to telehealth services to the areas in need.

Data

Healthcare insurance claims from the Utah Department of Health [Office of Health Care Statistics All Payer Claims Database](#) were used to collect data. The Utah All Payer Claims Database (APCD) is comprised of medical claims extracted from insurer and major government payer systems. Claims include commercial, Medicaid, and Medicare lines of business but do not represent all Medicare or uninsured patient claims. Payments to healthcare providers outside of these claims systems are not represented in the database such as healthcare paid by charities, some governmental programs (such as Indian Health Services), patients who pay for healthcare out-of-pocket, and some self-funded employer plans. It is estimated the APCD contains data on 65–75% of the population with insurance eligibility for at least part of the year.

Claims from 2019 and 2020 were included in the report with the following telehealth procedure codes in the analysis: 98966, 98967, 98968, 98969, 98970,

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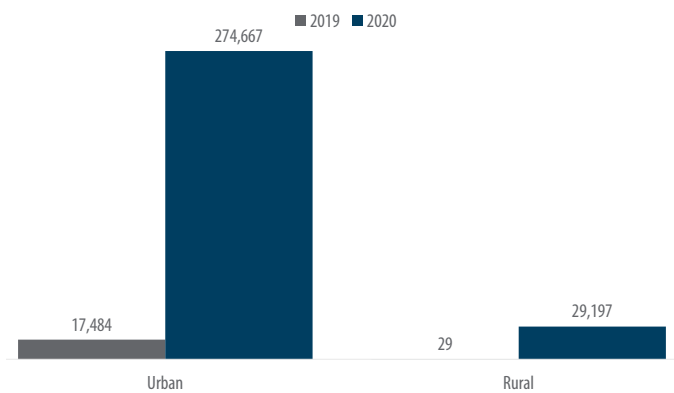
98971, 98972, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99495, 99496, G0071, G0406, G0407, G0408, G0425, G0426, G0427, G2061, G2062, G2063. The ZIP code of the billing provider was used to assign the **Utah Small Area**.³ Data from Utah Small Areas were then collected between rural and urban areas to assess the change between 2019 and 2020.

Assessment of Telehealth Utilization

The 99 Utah Small Areas as defined by the Utah Department of Health, had a drastic increase in telehealth claims from 2019 to 2020.⁴ This aligns with national trends around telehealth utilization. Urban areas including Salt Lake City (Downtown), Murray, Provo/BYU, Taylorsville (East)/Murray (West), Layton/South Weber, and Salt Lake/Glendale reported the most telehealth claims. However, both rural and urban Utah Small Areas reported increased telehealth claims in 2020 (Figure 1).

Telehealth Claims by Rural vs. Urban County Status, Utah Small Areas, 2019–2020

Figure 1. Telehealth claims increased in both rural and urban areas in 2020.



Note: Definitions for rural and urban county classifications include frontier counties with rural telehealth claims. Source: Utah All Payer Claims Database, 2019–2020

In 2020, the total average for telehealth claims increased by 1,557% in areas with previous telehealth claims in 2019 (Figure 2). The Small Areas with the highest increase in telehealth claims were Sandy (Center) V2 (1 to 3,588), Salt Lake City (Foothill/East Bench) (2 to 5,079), Alpine (1 to 803), Ogden (Downtown) (3 to 1,384), and San Juan County (Other) (1 to 341).⁴

Percentage Increase of Telehealth Claims by Utah Small Areas, 2019–2020

Figure 2. Sandy (Center) V2, Salt Lake City (Foothill/East Bench), and Alpine reported the highest percentage increase of telehealth claims between 2019 and 2020.

Utah Small Area	%	Utah Small Area	%
Sandy (Center) V2	358,700	Cottonwood	5,856
Salt Lake City (Foothill/East Bench)	253,850	West Valley (West) V2	5,430
Alpine	80,200	West Jordan (West)/Copperton	5,400
Ogden (Downtown)	46,033	Orem (West) v2	5,333
San Juan County (Other)	34,000	Lehi	5,252
South Jordan V2	32,453	West Jordan (Northeast) V2	5,117
Southwest LHD (Other)	27,633	Riverdale	5,040
Provo/BYU	26,703	Magna	4,950
Delta/Fillmore	25,500	Daggett and Uintah County	4,881
Wasatch County	20,920	Springville	4,809
Payson	20,614	Centerville	4,656
Salt Lake City (Southeast Liberty)	18,609	Syracuse	4,383
Orem (North) v2	18,108	Herriman	4,143
South Ogden	17,481	St. George	3,906
Daybreak	17,455	Ben Lomond	3,898
Sanpete Valley	15,667	Summit County (East)	3,800
Salem City	15,394	Duchesne County	3,712
Salt Lake City (Rose Park)	14,600	Layton/South Weber	3,708
West Jordan (Southeast)	13,234	Emery County	3,600
Eagle Mountain/Cedar Valley	13,022	Richfield/Monroe/Salina	3,515
Provo (West City Center)	12,960	Bountiful	3,287
Kearns V2	12,867	Weber County (East)	3,263
Salt Lake City (Avenues)	12,448	Midvale	2,673
Logan V2	10,533	West Valley (East) V2	2,626
Salt Lake City (Downtown) V2	10,429	South Salt Lake	2,624
Taylorsville (West)	10,268	Millcreek (South)	2,385
Salt Lake City (Sugar House)	9,978	Carbon County	2,354
Draper	9,428	West Valley (Center)	2,253
Cedar City	9,155	Central (Other)	1,953
Farmington	8,924	Sandy (West)	1,828
Riverton/Bluffdale	8,835	Grand County	1,813
Clearfield Area/Hooper	8,192	Roy/Hooper	1,732
North Logan	7,248	Pleasant Grove/Lindon	1,500
Park City	7,213	Washington City	1,500
Kaysville/Fruit Heights	7,156	Utah County (South) V2	1,211
Hurricane/La Verkin	6,625	Spanish Fork	805
Orem (East)	6,500	Tremonton	669
Saratoga Springs	6,247	Taylorsville (East)/Murray (West)	431
Murray	6,184	Brigham City	327
Tooele Valley	6,163	Morgan County	250
American Fork	5,983	Salt Lake City (Glendale) V2	11
Holladay V2	5,956		

Source: Utah All Payer Claims Database, 2019–2020

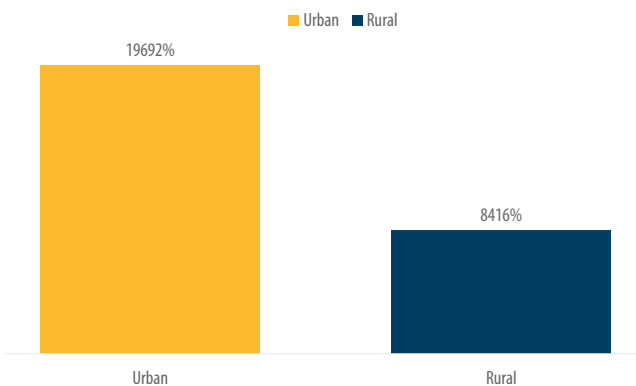
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In 2020, 41% of rural Small Areas had an increase in telehealth utilization greater than 5,000% compared with 65% of urban Small Areas, indicating rural areas had a disproportionately lower rate of telehealth increase compared with their higher populated urban counterparts (Figure 2).

While Utah Small Areas reported more telehealth claims in 2020, urban areas demonstrated a higher increase (19,692%) overall, compared with rural areas (8,416%) (Figure 3). Twenty-nine percent of 2019 telehealth claims were in rural Small Areas and 44% of Small Areas with zero telehealth claims in 2019 were rural. Urban Small Areas supported and utilized telehealth more than rural areas. Prior to the COVID-19 pandemic and the emergency expansion of telehealth rules, rural areas disproportionately provided fewer telehealth services.

Percentage Increase of Telehealth Claims by Rural vs. Urban County Status, Utah Small Areas, 2019–2020

Figure 3. Telehealth utilization increased in both rural and urban counties resulting in all 99 Utah Small Areas with telehealth claims in 2020.



Note: Definitions for rural and urban county classifications include frontier counties with rural telehealth claims. Source: Utah All Payer Claims Database, 2019-2020

Resources:

- Utah Department of Health [Telehealth & Office Visit Trends: A Snapshot from Utah’s All Payer Claims Database](#), [Preliminary COVID-19 Healthcare Trends: A Snapshot from Utah’s All Payer Claims Database & Healthcare Facility Database](#)

- For additional information on Utah rural health please visit: <https://ruralhealth.health.utah.gov/>.
- For additional analyses of healthcare claims please contact: healthcarestat@utah.gov.

1. Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic [Internet]. [cited 24 Aug 2021]. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html>
2. Utah Medicaid Guidance: Telehealth Q&A for COVID-19 Emergency [Internet]. [cited 11 Aug 2021]. Available from: https://medicaid.utah.gov/Documents/pdfs/covid/COVID-19_TelehealthFAQ1.21.pdf
3. Utah Department of Health Utah Small Area Boundary Definition. [cited 16 Dec 2021] <https://ibis.health.utah.gov/ibisph-view/pdf/resource/UtahSmallAreaInfo.pdf>
4. Utah Department of Health Utah’s All Payer Claims Database. [cited 16 Dec 2021] <https://stats.health.utah.gov/about-the-data/apcd/>

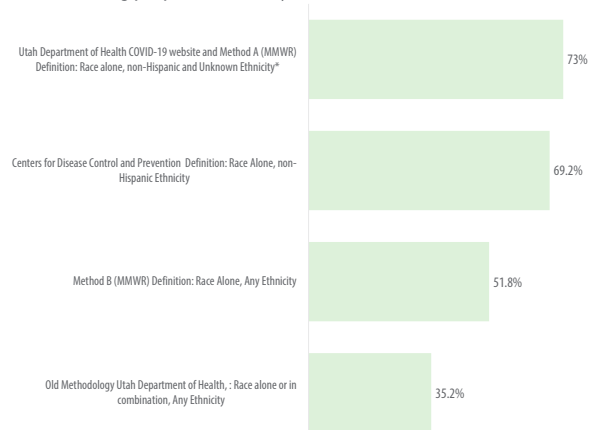
American Indian/Alaska Native Population Vaccine Coverage: Differences in Measurement and Reporting

Racial groups are defined by the federal Office of Management and Budget¹ with race and ethnicity data collected using a combination of ethnicity and single or multiple racial identities.² Data collection systems may allow recording of only one race, all races that apply, or a recording of two or more races. Ethnicity is recorded as non-Hispanic, Hispanic, or unknown/refused. Variations in how data are collected and reported may influence numbers and percentages reported for various race/ethnicity combinations. The terms American Indian and Alaska Native (AI/AN) in data collection typically describe race without the legal status of enrollment in a federally recognized tribe.³ Inconsistent racial definitions of the American Indian/Alaska Native race, within and between agencies, can paint dramatically different pictures of health statuses.²

As of 11/17/2021, the [Utah Department of Health](#) reports racial data, including people who identify as American Indian/Alaska Native, as race alone, non-Hispanic and unknown ethnicity for COVID-19 vaccine analysis to better represent data across all racial and ethnic minority populations.⁴ The [Centers for Disease Control and Prevention \(CDC\)](#) reports race alone, non-Hispanic.⁵ On August 12, 2021, the CDC Morbidity and Mortality Weekly Report (MMWR) mentioned two alternative methods for race and ethnicity groupings—Method A: American Indian/Alaska Native race alone, non-Hispanic and unknown ethnicity, and Method B: American Indian/Alaska Native race alone, any ethnicity.⁶ Each of these methods captures a slightly different American Indian/Alaska Native population, which are not directly comparable (Figure 1).

Percentage of Eligible Utah American Indian and Alaska Native Population Who Received at Least One Dose of COVID-19 Vaccine by Different Race/Ethnicity Measurement Methods, Utah, 12/01/2020–12/31/2021

Figure 1. The current Utah Department of Health and Centers for Disease Control and Prevention racial group definitions reported the highest percentages of at least one COVID-19 vaccine dose received among people who identify as American Indian and Alaska Native.



* Race & Ethnicity: As of 11/17/2021, UDOH updated the race/ethnicity population definition to more closely align with the data being collected. Racial groupings include people who are reported with a single race alone and have not indicated Hispanic ethnicity. This update resulted in higher rates of testing, cases, hospitalization, deaths, and vaccination across all racial and ethnic minority populations.⁴

Note: Population estimates based on 2020 data for ages 5 and older.

Source: The Utah Department of Health [Public Health Indicator Based Information System \(IBIS\)](#) website, The Utah Department of Health [Bureau of Epidemiology Disease Control and Prevention](#)

While some racial groupings of American Indian/Alaska Native more closely represent the race and ethnicity makeup of the population in Utah, none exclusively capture the tribally enrolled population.⁷ For more resources regarding tribe-focused interventions, reports, and discussions contact armerrill@utah.gov.

1. Office of Management and Budget (OMB) DIRECTIVE NO. 15 Race and Ethnic Standards for Federal Statistics and Administrative Reporting <https://wonder.cdc.gov/wonder/help/populations/bridged-race/directive15.html>

2. Best Practices for American Indian and Alaska Native Data Collection. 26 Aug. 2020. www.uihi.org/resources/best-practices-for-american-indian-and-alaska-native-data-collection/. <https://www.bia.gov/frequently-asked-questions>

3. Public Affairs, A guide to tracing American Indian & Alaska native ancestry (n.d.). Washington, D.C.

4. Utah Department of Health COVID-19 website Case counts: Coronavirus (n.d.). Retrieved October 15, 2021, from <https://coronavirus.utah.gov/case-counts/>.

5. Centers for Disease Control and Prevention. (n.d.). Reporting covid-19 vaccination demographic data. Centers for Disease Control and Prevention. Retrieved October 19, 2021, from <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/distributing/demographics-vaccination-data.html>.

6. Yoon, P., Hall, J., Fuld, J., Mattocks, L., Lyons, B. C., Bhatkoti, R., Henley, J., McNaghten, A. D., Daskalakis, D., & Pillai, S. K. (2021, August 12). Alternative methods for grouping race and ethnicity to monitor covid-19 outcomes and vaccination coverage. Centers for Disease Control and Prevention. Retrieved October 20, 2021, from <https://www.cdc.gov/mmwr/volumes/70/wr/mm7032a2.htm>.

7. Norris, Tina, et al. "The American Indian and Alaska Native Population: 2010." 2010 Census Briefs, United States Census Bureau, Jan. 2012, www.census.gov/history/pdf/c2010br-10.pdf.

Monthly Health Indicators

Monthly Report of Notifiable Diseases, November 2021	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (<i>Campylobacter</i>)	53	58	339	378	0.9
COVID-19 (SARS-CoV-2)	Cases updated at https://coronavirus.utah.gov/case-counts/ .				
Shiga toxin-producing <i>Escherichia coli</i> (<i>E. coli</i>)	37	23	165	106	1.6
Hepatitis A (infectious hepatitis)	1	4	5	38	0.1
Hepatitis B, acute infections (serum hepatitis)	1	2	10	12	0.8
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/influenza .				
Meningococcal Disease	0	1	1	2	0.6
Pertussis (Whooping Cough)	0	41	48	249	0.2
Salmonellosis (<i>Salmonella</i>)	38	38	214	258	0.8
Shigellosis (<i>Shigella</i>)	6	7	39	37	1.0
Varicella (Chickenpox)	9	11	42	121	0.3
Quarterly Report of Notifiable Diseases, 3rd Qtr 2021	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†	28	27	50	61	0.8
Chlamydia	2,776	2,442	5,752	5,081	1.1
Gonorrhea	839	624	1,752	1,239	1.4
Syphilis	53	32	100	63	1.6
Tuberculosis	5	5	7	18	0.4
Medicaid Expenditures (in Millions) for the Month of November 2021	Current Month	Expected/ Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance over (under) Budget
Mental Health Services	\$17	\$17	\$101	\$102	(\$1.3)
Inpatient Hospital Services	\$21	\$21	\$79	\$80	(\$1.0)
Outpatient Hospital Services	\$4	\$4	\$15	\$16	(\$1.3)
Nursing Home Services	\$18	\$18	\$94	\$95	(\$1.5)
Pharmacy Services	\$11	\$11	\$58	\$59	(\$1.8)
Physician/Osteo Services‡	\$12	\$12	\$29	\$30	(\$1.2)
Medicaid Expansion Services	\$88	\$89	\$454	\$457	(\$2.9)
***TOTAL MEDICAID	\$361	\$362	\$1,825	\$1,827	(\$1.8)

|| 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 November	Current Month	Previous Month	% Change [§] From Previous Month	1 Year Ago	% Change [§] From 1 Year Ago
Medicaid	445,195	440,675	+1.0%	372,975	+19.4%
CHIP (Children's Health Insurance Plan)	8,458	8,751	-3.3%	15,932	-46.9%
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	651	20.0 / 100,000	-1.9%	40 (2019)
Asthma Prevalence (Adults 18+)	2020	250,600	10.8%	+9.1%	29 (2019)
Poor Mental Health (Adults 18+)	2020	540,700	23.3%	+7.9%	28 (2019)
Drug Overdose Deaths Involving Opioids	2020	432	13.3 / 100,000	+7.3%	20 (2019)
Unintentional Fall Deaths	2020	651	20.0 / 100,000	-1.9%	17 (2019)
Infant Mortality	2020	366	11.3 / 100,000	+4.6%	17 (2018)
Traumatic Brain Injury Deaths	2020	2,272	69.9 / 100,000	+6.1%	15 (2019)
Obesity (Adults 18+)	2020	663,700	28.6%	-2.1%	15 (2019)
Diabetes Prevalence (Adults 18+)	2020	188,000	8.1%	+1.3%	13 (2018)
Births to Adolescents (Ages 15-17)	2020	318	4.1 / 1,000	+7.7%	10 (2018)
Childhood Immunization (4:3:1:3:3:1:4)††	2019	49,400	80.0%	+17.6%	7 (2019)
Motor Vehicle Traffic Crash Injury Deaths	2020	299	9.2 / 100,000	+27.6%	7 (2019)
High Blood Pressure (Adults 18+)	2020	598,700	25.8%	+5.7%	7 (2019)
Cigarette Smoking (Adults 18+)	2020	206,500	8.9%	+1.1%	1 (2019)
Binge Drinking (Adults 18+)	2020	264,500	11.4%	+0.9%	1 (2019)
Coronary Heart Disease Deaths	2020	1,853	57.0 / 100,000	+12.0%	1 (2019)
All Cancer Deaths	2020	3,459	106.4 / 100,000	+3.7%	1 (2019)
Stroke Deaths	2020	916	28.2 / 100,000	-1.0%	1 (2019)
Influenza Immunization (Adults 65+)	2020	261,400	68.5%	+7.2%	22 (2019)
Child Obesity (Grade School Children)	2018	38,100	10.6%	+11.6%	n/a
Vaping, Current Use (Grades 8, 10, 12)	2019	37,100	12.4%	+11.3%	n/a
Health Insurance Coverage (Uninsured)	2020	383,500	11.8%	-6.3%	n/a
Early Prenatal Care	2020	34,716	75.9%	-0.0%	n/a

[§] Relative percentage change. Percentage 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 2019 NIS for children aged 24 month (birth year 2017).