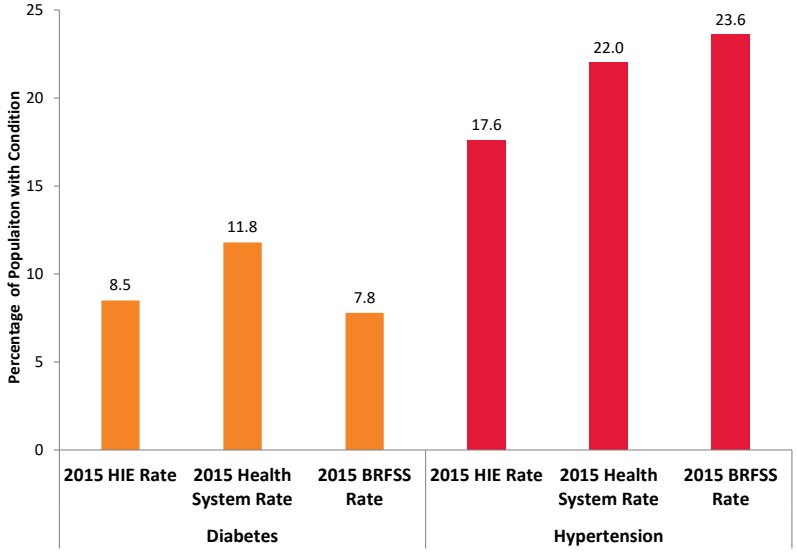
Breaking News, May 2018

Using Clinical Data for Chronic Disease Surveillance

The Utah Department of Health (UDOH) Bureau of Health Promotion is evaluating the potential of using electronic health record (EHR) data to enhance statewide surveillance of chronic diseases. EHR data collected by health information exchanges (HIEs) can complement population-level surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS). HIEs can provide timely data representative of the state and, when used in conjunction with surveys, allow public health to more fully understand chronic disease prevalence, control, and disparities. Focusing on hypertension and diabetes, the Bureau's Clinical Data Team partnered with the statewide HIE (Utah Health Information Network) and a mid-size outpatient health system to pilot clinical data exchange and analysis. Rates of hypertension and diabetes are similar across the three data sets (HIE, health system, and BRFSS). However, each data set uses different methodologies that likely accounts for the differences. The HIE shows promise in its ability to function as hypertension and diabetes surveillance systems. The UDOH is working with the HIE to make the data more useful for chronic disease surveillance by addressing methodologies that may account for the differences in rates and developing strategies that could reduce bias.

Diabetes and Hypertension Rates by Data Source



Community Health Spotlight, May 2018

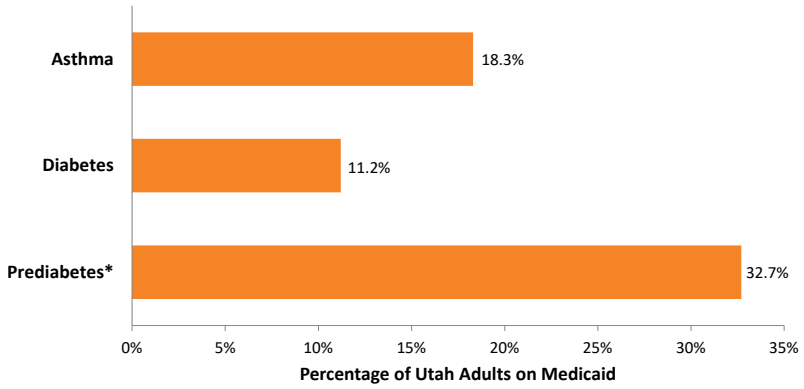
A Partnership with Medicaid to Improve Prediabetes, Diabetes, and Asthma in Utah through the 6|18 Initiative

The 6|18 Initiative: Accelerating Evidence into Action (https://www.cdc.gov/sixeighteen/index.html) is a Centers for Disease Control and Prevention initiative for public health, healthcare providers, purchasers, and payers to improve health and control costs associated with six high-burden, high-cost health conditions with 18 evidence-based interventions.

The Utah Department of Health and the State Office of Medicaid were awarded a grant from the Centers for Health Care Strategies to receive support for collaborative work to reduce costs associated with asthma and diabetes. The goal is to work with Medicaid to provide reimbursement for comprehensive asthma control services and participation in the National Diabetes Prevention Program (National DPP) in order to increase access and ultimately lead to cost savings.

Direct medical and indirect costs for diabetes exceeds $1.5 billion in Utah annually.[1] Programs that promote lifestyle changes, such as the National DPP, can prevent or delay the onset of type 2 diabetes for people with prediabetes. The combined charges for hospital and emergency department visits for asthma exceeded $28 million in Utah in 2014.[2] Comprehensive asthma control services, such as home visits to examine triggers, self-management education, and remediation services referrals, can reduce unnecessary asthma-related hospitalizations.

Percentage of Utah Adults on Medicaid Affected by Asthma, Diabetes, and Prediabetes



*Includes estimated undiagnosed
Source: American Diabetes Association, Utah Behavioral Risk Factor Surveillance Survey

1. American Diabetes Association. http://main.diabetes.org/dorg/PDFs/Advocacy/burden-of-diabetes/utah.pdf
2. Emergency Department Encounter Database, Bureau of Emergency Medical Services, Utah Department of Health