Utah Health Status Update:

Intimate Partner Violence Among Women in Utah

October 2009 | Utah Department of Health

Intimate partner violence (IPV) is a silent public health problem that is often hidden behind closed doors. To estimate the lifetime prevalence of IPV in Utah, women 18 years or older (n=2,876) were anonymously asked specific questions about their experience with abuse. Among the women who were in a safe place to answer the questions (98%, n=2,821), 14.2% (n=448) reported that an intimate partner had ever hit, slapped, pushed, kicked, or hurt them in any way.

The percentage of women who reported ever experiencing IPV increased with age, with the exception of women who were 65 years or older. See Figure 1.

There was an inverse relationship between IPV and the level of maternal education. Nearly, 23% of women with less than a high school education reported IPV, while only 10.3% of women who graduated from college did so. Women whose annual income was less than $20,000 reported higher rates of IPV (23%) compared to those with an annual income of $50,000 or more (12.7%).

There was a slight disparity when looking at IPV rates by race, although statistically insignificant. Nearly, 17% of non-White women reported IPV, compared to 14% of White women.

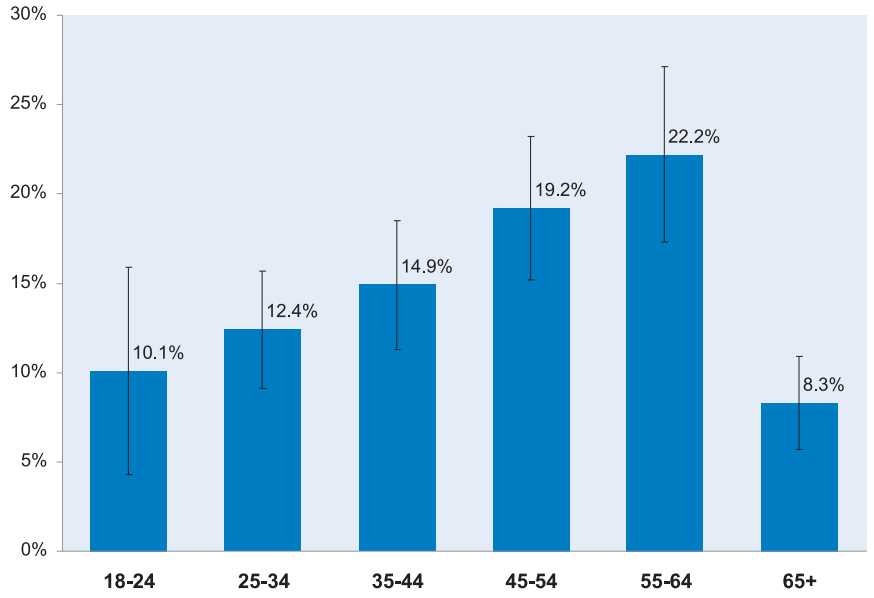
Divorced or separated women reported the highest rates of ever having experienced IPV (42.1%), when analyzing the data by marital status. See Figure 2.

Women who reported IPV were asked about their relationship to the perpetrator at the time of the most recent incident. Approximately, 39% said that the perpetrator was their husband or a male live-in partner. Slightly more than 22% reported the perpetrator to be a former husband or former live-in partner, and 26.7% indicated a former boyfriend as the abuser.

Researchers have found that women in their childbearing years are at the greatest risk of IPV. IPV during the perinatal time period is of particular concern because research indicates that women who are abused are more likely to have poorer birth outcomes including low birth weight infants, preterm labor, and fetal death. They are also more likely to be involved with high risk behavior such as smoking, drinking, and delaying prenatal care.

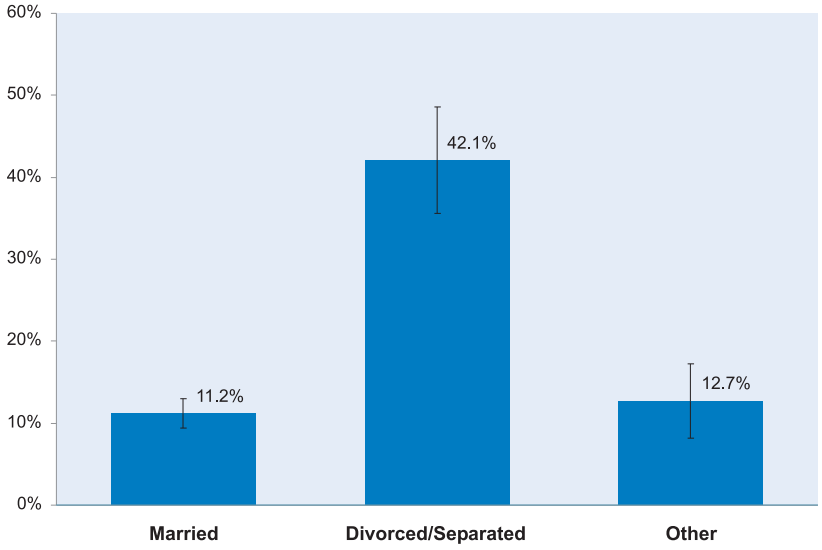
Intimate Partner Violence by Age

Figure 1. Percentage of women who reported physical abuse ever by an intimate partner by age, Utah BRFSS, 2008



Intimate Partner Violence by Marital Status

Figure 2. Percentage of women who reported physical abuse ever by an intimate partner by martial status, Utah BRFSS, 2008



Among the women who reported ever experiencing IPV in their lifetime, 7.8% indicated that they were victims of IPV within the past twelve months. Among these women, none reported being pregnant at the time of the survey; however, nearly 80% were of childbearing age.

In a different survey, Utah women who recently gave birth to a live born infant were asked about their experience with abuse during the perinatal time period. Slightly more than 8% of women reported experiencing physical, emotional, or sexual abuse. The abuse occurred during the 12 months before pregnancy, or during pregnancy. See Figure 3.

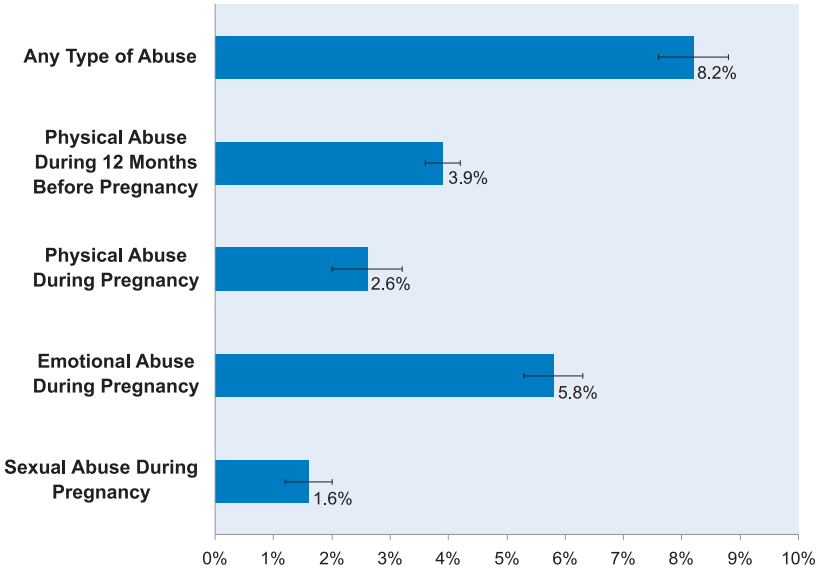
Earlier it was noted that the percentage of women who had ever experienced IPV in their lifetime increased with age. This trend is reversed when looking only at childbearing women who report abuse during the perinatal time period. See Figure 4.

Figure 4 illustrates the percentage of women who report any type of abuse. The same pattern follows across the age groups when looking at each type of abuse separately, as well. It is important to note that emotional abuse is the most commonly reported type of abuse in each age group, and is often a precursor to physical abuse.

The Utah Department of Health, in conjunction with the Utah Domestic Violence Council, works to raise awareness of available IPV resources and advocates for routine screening of IPV in all health care settings. Also, they provide training to health care professionals on IPV assessment, referral, and reporting. Raising awareness of IPV enhances opportunities for successful intervention in disrupting the cycle of abuse, and helping to make Utah women safer.

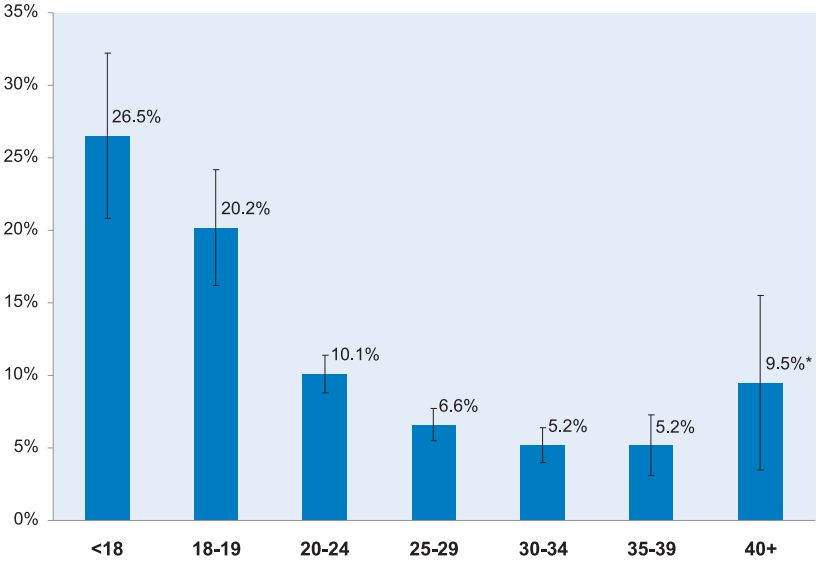
Abuse During Perinatal Period by Type of Abuse

Figure 3. Percentage of women who delivered a live born infant who reported abuse during the perinatal time period by type, Utah PRAMS, 2004–2007



Abuse During Perinatal Period by Age

Figure 4. Percentage of women who delivered a live infant who reported any type of abuse (physical, emotional, or sexual) during the perinatal time period by age, Utah PRAMS, 2004–2007



* Use caution in interpreting, the estimate has a relative standard error greater than 30% and does not meet UDOH standards for reliability.

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For additional information about this topic, contact Joanne McGarry, Reproductive Health Program, Utah Department of Health, Box 142001, Salt Lake City, UT 84114-2001, (801) 538-6077, email: jmcgarry@utah.gov, or the Office of Public Health Assessment, Utah Department of Health, Box 142101, Salt Lake City, UT 84114-2101, (801) 538-9191, email: chdata@utah.gov

Breaking News, September 2009

New Stroke Protocols

Early in 2010 a new rule will be instituted through the Bureau of Emergency Medical Services (BEMS) requiring EMS to transport possible stroke patients to a Stroke Receiving Hospital (SRH) or a Primary Stroke Center. Utah has four primary stroke centers, McKay Dee Hospital, University of Utah Hospital, Intermountain Medical Center, and Utah Valley Regional Medical Center. Any hospital will be able to apply to become a SRH. This rule will increase the number of hospitals that can give ischemic stroke patients the clot busting drug within the required timeframe which will make the treatment available statewide.

EMS will use standardized pre-hospital treatment protocol for the suspected stroke patients, and notify hospitals that a suspected stroke is on the way. The SRH will be able to alert the stroke team and be ready for the patient upon arrival.

Stroke remains the third leading cause of death in the United States as well as in Utah. Time is important to the preservation of brain tissue. Sooner treatment means less damage to the brain. A standardized treatment and transport system in the state will save time and improve overall care of stroke patients.

The Heart Disease and Stroke Prevention Program (HDSPP) and BEMS have prepared a toolkit for hospitals and will help hospitals build infrastructure to become a SRH. Additionally, HDSPP also pays for a quality assurance tool (Get With The Guidelines) for hospitals who are interested in treating stroke patients. For more information contact Nancy Thacker at nancythacker@utah.gov.

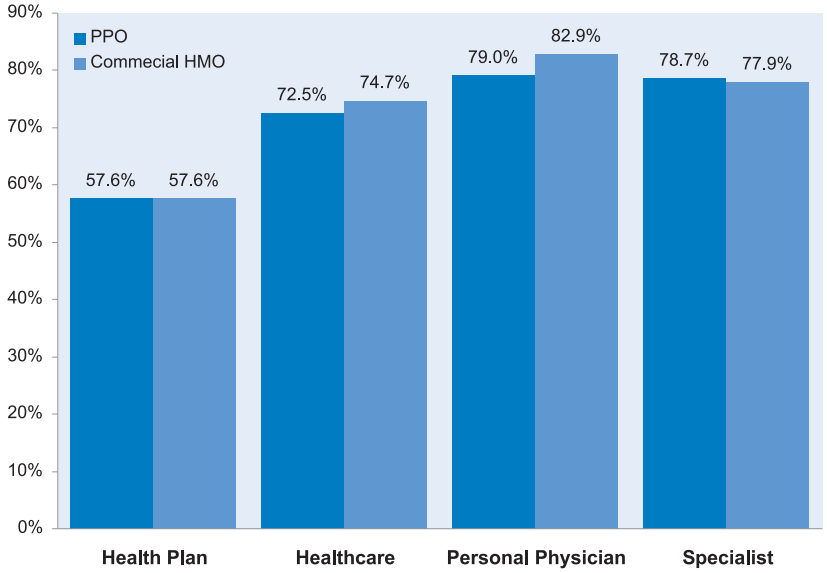
Community Health Indicators Spotlight, September 2009

PPO Consumer Satisfaction

The Utah Health Data Committee (HDC) is committed to provide information that is important to consumers in order to make informed decisions regarding their healthcare. In 2009, the HDC recommended that PPOs (Preferred Provider Organizations) be included with the CAHPS surveys (Consumer Assessment of Healthcare Providers and Systems). In total, six PPOs participated in the survey. The survey results contain eight different scores, four for general ratings (health plan, healthcare, physician, and specialist) and four for composites (getting care quickly, doctor's communication, getting needed care, and customer service). The data in this report was collected between January and May of 2009.

Since this is the first year the data has been collected in Utah, previous scores cannot be compared, but a comparison can be made with data from the health plans that also participated in the survey. The following graph indicates the different scores on the rating scales between the commercial HMOs (Health Maintenance Organizations) and PPOs. There were no significant differences between the commercial HMO scores and the PPO scores. The largest difference between the commercial HMOs and the PPOs was 3.9%. While the PPOs still have room for improvement, the survey does suggest that Utahns are just as satisfied with their PPO performance as they are with their HMO performance.

Percentage of Respondents That Gave a Rating of 8, 9, or 10, PPOs vs. Commercial HMOs, Utah, 2009



Monthly Health Indicators Report

(Data Through August 2009)

Monthly Report of Notifiable Diseases, August 2009	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)	34	32	209	226	0.9
Enterotoxigenic Escherichia coli (E. coli)	20	5	63	65	1.0
Hepatitis A (infectious hepatitis)	0	1	4	15	0.3
Hepatitis B (serum hepatitis)	0	2	16	18	0.9
Measles (Rubeola, Hard Measles)	0	0	0	0	--
Meningococcal Diseases	0	1	1	7	0.1
Norovirus	1	3	8	12	0.7
Pertussis (Whooping Cough)	7	17	172	285	0.6
Salmonellosis (Salmonella)	9	8	235	219	1.1
Shigellosis (Shigella)	0	2	17	29	0.6
Varicella (Chickenpox)	0	3	334	472	0.7
Viral Meningitis	4	9	27	76	0.4
West Nile (human cases)	0	2	1	26	0.0
Notifiable Diseases Reported Quarterly, 2nd Qtr 2009	**Current Quarter # Cases**	**Current Quarter # Expected Cases (5-yr average)**	**# Cases YTD**	**# Expected YTD (5-yr average)**	**YTD Standard Morbidity Ratio (obs/exp)**
HIV	17	23	39	42	0.9
AIDS	10	10	23	23	1.0
Chlamydia	1,545	1,221	3,281	2,488	1.3
Gonorrhea	84	175	180	354	0.5
Tuberculosis	9	8	20	17	1.2
Program Enrollment for the Month of August 2009	**Current Month**	**Previous Month**	**% Change§ From Previous Month**	**1 Year Ago**	**% Change§ From 1 Year Ago**
Medicaid	198,188	197,248	+0.5%	167,293	+18.5%
PCN (Primary Care Network)	21,673	23,438	-7.5%	20,177	+7.4%
CHIP (Children's Health Ins. Plan)	40,219	40,131	+0.2%	34,762	+15.7%

Medicaid Expenditures (in Millions) for the Month of August 2009†	Current Month	Expected/ Budgeted for Month✗	Fiscal YTD	Budgeted Fiscal YTD✗	Variance - over (under) budget✗
Capitated Mental Health	$ 13.0	N/A	$ 14.1	N/A	N/A
Inpatient Hospital	$ 18.1	N/A	$ 25.4	N/A	N/A
Outpatient Hospital	$ 9.8	N/A	$ 14.0	N/A	N/A
Long Term Care	$ 15.1	N/A	$ 22.5	N/A	N/A
Pharmacy	$ 10.9	N/A	$ 22.2	N/A	N/A
Physician/Osteo Services‡	$ 6.9	N/A	$ 9.9	N/A	N/A
TOTAL HCF MEDICAID	$ 116.8	N/A	$ 173.5	N/A	N/A
Health Care System Measures	**Number of Events**	**Rate per 100 Population**	**% Change§ From Previous Year**	**Total Charges in Millions**	**% Change§ From Previous Year**
Overall Hospitalizations (2007)	278,952	9.7%	-0.7%	$ 4,265.9	+10.1%
Non-maternity Hospitalizations (2007)	164,659	5.6%	-0.9%	$ 3,554.6	+9.9%
Emergency Department Encounters (2007)	682,122	24.0%	-1.3%	$ 781.0	+17.1%
Outpatient Surgery (2007)	296,596	10.5%	-5.7%	$ 1,109.0	+8.6%
Annual Community Health Measures	**Current Data Year**	**Population at Risk**	**Number Affected**	**Percent/ Rate**	**% Change§ From Previous Year**
Overweight and Obesity (Adults 18+)	2008	1,924,274	1,119,500	58.2%	+0.5%
Cigarette Smoking (Adults 18+)	2008	1,924,274	179,200	9.3%	-20.4%
Influenza Immunization (Adults 65+)	2008	237,275	173,900	73.3%	-3.8%
Health Insurance Coverage (Uninsured)	2008	2,781,954	298,200	10.7%	+0.7%
Motor Vehicle Crash Injury Deaths	2008	2,781,954	268	9.6 / 100,000	-3.3%
Suicide Deaths	2008	2,781,954	384	13.8 / 100,000	+1.3%
Diabetes Prevalence	2008	2,781,954	129,500	4.7%	-1.0%
Coronary Heart Disease Deaths	2008	2,781,954	1,514	54.4 / 100,000	-4.0%
All Cancer Deaths	2008	2,781,954	2,478	89.1 / 100,000	-5.6%
Births to Adolescents (Ages 15-17)	2008	61,727	1,122	18.2 / 1,000	-2.0%
Early Prenatal Care	2008	55,605	43,997	79.1%	-0.4%
Infant Mortality	2008	55,605	264	4.7 / 1,000	-7.9%
Childhood Immunization (4:3:1:3:3:1)	2008	53,525	39,400	73.6%	-5.8%

§ % Change could be due to random variation.
† The final Medicaid July old adjustment expendiures have not been posted and are not included in this report. The Medicaid service expenditures reported here are the most current as of the release date of this report.
✗ Determination on tier 1 and tier 2 unemployment enhancements and the ARRA rate differentials for the the school districts are still being decided. For these two reasons the total Medicaid Budget amounts are not ready to be released.
‡ Medicaid payments reported under Physician/Osteo Services do not include enhanced physician payments.
Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for influenza has ended until the 2009 season.