UTAH DEPARTMENT OF HEALTH

Utah Health Status Update:

Positive Attitude and Behavioral Changes among WIC Participants

October 2013

Introduction

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves low-income pregnant, postpartum and breastfeeding women, and infants and children up to age five. WIC is administered by the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA). The benefits consist of nutritious supplemental foods, nutrition education and counseling, and referrals to health care and social services. In Utah, the WIC program is administered by the Utah Department of Health, Division of Family Health and Preparedness, and implemented within the boundaries of 12 designated local health departments.

Purpose

The purpose of the 2012 Participant Satisfaction Survey was to determine the level of satisfaction among recipients of Utah WIC services. The survey also examined the patterns of service awareness and utilization, nutrition education and behavioral change, breastfeeding practices, food packages and voucher use, healthy diet, tobacco use, and oral health care practices.

Methods

The survey was designed to collect cross-sectional data from a sample of WIC clinic participants during the months of June through August 2012. The survey was printed in both English and Spanish. Analyses for this study included descriptive statistics including frequencies, chi squares, and multivariate logistic regression.

- **A Participant Satisfaction Survey was administered to determine the level of satisfaction among recipients of Utah WIC services.**
- **When asked to rate the services received from WIC, the majority of respondents described the services as excellent.**
- **When asked about types of behavioral changes the family has made, the majority of respondents indicated that they now eat more fruits and vegetables since starting the WIC program.**
- **Analysis showed that those who rated the nutrition education as excellent were more likely to have modified their behavior toward a healthier lifestyle.**

Demographic Characteristics

Table 1. Percentage of WIC particpants with specific demographic characteristics, Utah, 2012

Characteristic	Count	%	95% Confidence Intervals Lower	Upper
Age				
Under 18	182	5.2	4.5	6.0
18-24	1,086	31.1	29.6	32.6
25-34	1,609	46.1	44.4	47.7
35-49	597	17.1	15.8	17.1
50-64	19	0.5	0.3	0.8
Education				
8th grade or less	291	8.4	7.5	9.3
9th grade - 11th grade	711	20.5	19.2	21.9
High school graduate	962	27.7	24.3	29.2
Some college	887	25.6	24.1	27.0
Associate degree	279	8.0	7.1	9.0
College graduate	338	9.8	8.8	10.7
Time in WIC Program				
Less than 6 months	566	16.2	15.0	17.5
6-12 months	701	20.1	18.8	21.4
1-2 years	994	28.5	27.0	30.0
3-5 years	768	22.0	20.7	23.4
More than 5 years	458	13.1	12.0	14.3
Type of Participant				
Pregnant	580	15.6	14.4	16.7
Breastfeeding	590	15.8	14.7	17.0
Postpartum	309	8.3	7.4	9.2
Parent and/or guardian of an infant on WIC	1,235	33.1	31.6	34.7
Parent and/or guardian of a child on WIC	1,699	45.6	44.0	47.2

Source: Utah 2012 WIC Participant Satisfaction Survey

Results

The overall survey response rate was 91.8%, with a total of 3,727 participants completing the survey. Overall, the majority of survey respondents (77.2%) were between 18 and 34 years of age (Table 1), and parents/caretakers of an infant/child on WIC (78.7%). The majority (71.0%) of respondents had a high school education or more. More than one-third (36.3%) of survey participants indicated that they have been on WIC for less than a year. A similar percentage (35.1%) had been on WIC for three or more years.

Nutrition Education and Behavioral Changes

Nutrition education plays a critical role in the WIC program and is intended to influence participants' nutrition and health-related knowledge, attitudes, and behaviors. Federal WIC regulations require all local WIC

clinics to offer participants, at no cost, at least two nutrition education sessions during each certification period. FNS has set two major goals of WIC nutrition education: 1) to emphasize the relationship between nutrition, physical activity, and health; and 2) to assist the individual who is at nutritional risk in achieving a positive change in dietary and physical activity habits, resulting in improved nutritional status and in the prevention of nutrition-related problems through optimal use of the supplemental foods and other nutritious foods. These classes are provided in individual counseling sessions or through group classes or via online sessions. Federal rules require that WIC agencies must spend at least one-sixth of their administrative budget on nutrition education.

When asked about preferred methods of receiving nutrition education (where participants were allowed to select more than one preference), the top three preferred methods included: taking a packet of information home to read (44.0%); completing an Internet class (33.4%); and attending WIC classes in the clinic (28.3%). More than a quarter (27.2%) were interested in checking out nutrition books and videos to use at home.

When asked to rate the services received from WIC, the majority of respondents (70.7%) described the services as excellent. One in four participants (27.3%) indicated that the services they received were good (Table 2). More than half of respondents (54.1%) rated the nutrition education assessment process as excellent.

When asked about types of behavioral changes the family has made, the majority (71.0%) of respondents indicated that they now eat more fruits and vegetables since starting the WIC program. More than half (52.9%) reported eating more whole-grain foods. Close to one in three reported an increase in eating more low-fat foods (30.9%) and engaging in physical activities (30.4%) as a result of their participation in the WIC program.

Logistic regression was performed to examine the effect of participants' rating of nutrition education on reported behavioral or lifestyle changes made since participating in the WIC program. The analysis showed that those who rated the nutrition education as excellent were more likely to have modified their behavior toward a healthier lifestyle (Table 3). They were significantly more likely to have had their children immunized (OR=2.4), to breastfeed their infants longer (OR=2.2), and to spend more time eating as a family (OR=2.3) compared to those who reported they made no changes in their behavior.

WIC Services and Nutrition Education Ratings

Table 2. Ratings by survey participants, Utah, 2012

	All, %	English Version, %	Spanish Version, %	P value
WIC Service Ratings				
Excellent	70.7	70.2	72.2	0.5294
Good	27.3	27.9	25.9	
Fair	1.9	1.9	2.0	
Poor	0.1	0.1	0.0	
Nutrition Education Ratings				
Excellent	54.1	51.3	61.4	<.0001
Good	42.3	44.8	35.5	
Fair	3.5	3.6	3.1	
Poor	0.2	0.3	0.0	

Source: Utah 2012 WIC Participant Satisfaction Survey

Effects of Nutrition Education Assessment on Behavior Modification

Table 3. Ratings by survey participants of behavior modification, Utah, 2012

Behavior Modification	Count	Odds Ratio	95% Confidence Interval
Eat more whole grains	1,971	1.39	0.97-1.99
Spend more time eating with your family	1,019	2.34	1.76-3.10
Physical activity	1,134	1.31	0.79-2.18
Begin feeding solid foods to my baby at 6 months	793	2.19	1.67-2.88
Breastfeed my baby longer	749	2.17	1.56-3.04
Drink less soda and sweetened drinks	1,530	1.43	1.03-1.98
Eat more fruit	2,647	1.47	1.06-2.05
Eat more iron-rich foods	1,214	2.32	1.60-3.34
Eat more low-fat foods	1,151	2.19	1.60-2.99
Immunize my children	781	2.42	1.10-5.32

Source: Utah 2012 WIC Participant Satisfaction Survey

Conclusion

The results of the Participant Satisfaction Survey suggest that the large majority of respondents rated WIC services as excellent and were highly satisfied. The findings also suggest that participants are learning about nutrition and applying this information to promote positive changes in their food habits and other lifestyle choices.

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Breaking News, October 2013

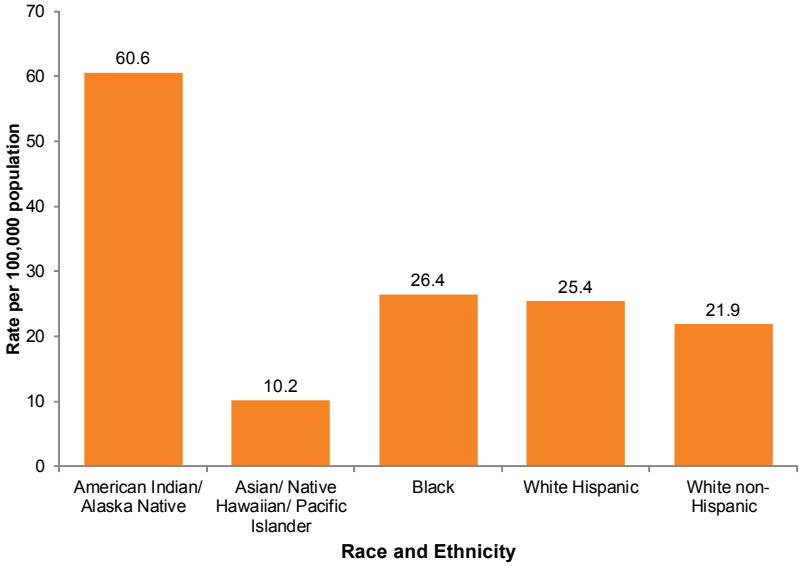
Alcohol-Attributable Deaths in Utah, 2006–2010

Excessive alcohol consumption is a leading preventable cause of death. On average, 80,000 deaths are attributed to alcohol use in the United States each year.[1]

Utah-specific estimates of alcohol-attributable deaths and years of potential life lost were calculated using information from death certificates and the Behavioral Risk Factor Surveillance System (BRFSS) for the years 2006–2010.

On average there were 513 alcohol-attributable deaths in Utah each year (22.4 per 100,000 population), and 15,760 years of potential life lost as a result of these deaths (634 per 100,000). Males were more than twice as likely as females to die as a result of excessive alcohol consumption (31 vs. 14 deaths per 100,000), and made up the majority of both alcohol-attributable deaths (73%) and years of potential life lost (83%) in working-age adults (20–64 years).

Alcohol-Attributable Death Rates by Race and Ethnicity, Utah, 2006–2010



Source: Utah Vital Records and Behavioral Risk Factor Surveillance System , 2006-2011

The alcohol-attributable death rate among the American Indian/Alaska Native population (60.6 per 100,000) was almost six times the rate among the Asian/Native Hawaiian/Pacific Islander population (10.2 per 100,000).

Even though alcohol consumption in Utah is relatively low compared with other states, 11.2% of Utah adults report binge drinking compared with the US average of 16.9%, a reduction in excessive alcohol consumption could make a significant contribution to reducing preventable and premature deaths.

1. Alcohol and Public Health. Alcohol-Related Disease Impact (ARDI) Software. www.cdc.gov/alcohol/ardi.htm

Community Health Indicators Spotlight, October 2013

Autism Waiver Program

The Autism Waiver Program was funded as a 2-year pilot project during the 2012 legislative session for the state's Medicaid program. The program was funded to provide treatment for approximately 250 children, ages two through six, who are clinically diagnosed with an Autism Spectrum Disorder (ASD). The program provides intensive individual support for children with ASD, as well as respite care for families. Data has shown that early, intensive treatment gives children with ASD the best chance to reach their full potential.

The program, which launched late last year, has already received feedback from grateful parents recognizing the successes of their young children. "Our family feels so blessed to be part of the Autism Waiver Program," said one Utah mother. "Our son, who is almost six years old, has been receiving behavioral services since February and we are so happy with the progress he has made. The doors that have been opened in his brain have built his confidence tremendously."

Currently, 69 girls and 254 boys are enrolled in the program. New applicants are selected only during an open enrollment period, when funding and openings are made available. In addition, progress evaluations for children enrolled in the program are completed on a semi-annual basis, with formal reports due to the Legislature in the fall of 2013 and 2014.

For more information on the Utah Autism Waiver Program please visit: http://health.utah.gov/autismwaiver/, or go to http://health.utah.gov/autismwaiver/Listserv.html to join the Autism Waiver Listserve.

Monthly Health Indicators Report

(Data Through August 2013)

Monthly Report of Notifiable Diseases, August 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)	50	49	347	300	1.2
Shiga toxin-producing Escherichia coli (E. coli)	14	36	83	85	1.0
Hepatitis A (infectious hepatitis)	0	1	9	6	1.6
Hepatitis B, acute infections (serum hepatitis)	0	1	1	8	0.1
Meningococcal Disease	1	0	7	4	1.8
Pertussis (Whooping Cough)	39	54	736	383	1.9
Salmonellosis (Salmonella)	33	34	216	227	1.0
Shigellosis (Shigella)	3	6	16	26	0.6
Varicella (Chickenpox)	2	11	135	314	0.4
West Nile (Human Cases)	3	3	3	5	0.6
Quarterly Report of Notifiable Diseases, 2nd Qtr 2013	**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†	15	25	25	102	0.2
Chlamydia	1,830	1,623	3,708	3,361	1.1
Gonorrhea	166	91	320	184	1.7
Syphilis	21	10	37	16	2.3
Tuberculosis	10	9	18	18	1.0
Medicaid Expenditures (in Millions) for the Month of August 2013	**Current Month**	**Expected/ Budgeted‡ for Month**	**Fiscal YTD**	**Budgeted‡ Fiscal YTD**	**Variance - over (under) budget**
Capitated Mental Health	$ 18.5	$ 14.6	$ 22.7	$ 20.5	$ 2.3
Inpatient Hospital	$ 17.5	$ 29.8	$ 18.8	$ 31.6	$ (12.8)
Outpatient Hospital	$ 5.2	$ 8.1	$ 6.4	$ 11.4	$ (5.1)
Long Term Care	$ 16.3	$ 16.4	$ 23.0	$ 23.0	$ 0.1
Pharmacy ‡	$ 10.1	$ 17.6	$ 16.8	$ 24.6	$ (7.8)
Physician/Osteo Services §	$ 5.3	$ 9.2	$ 6.7	$ 12.9	$ (6.2)
TOTAL HCF MEDICAID	$251.2	$ 239.6	$ 361.1	$ 351.3	$ 9.8

Program Enrollment for the Month of August 2013	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	260,344	259,684	+0.3%	253,188	+2.8%
PCN (Primary Care Network)	15,807	16,117	-1.9%	15,919	-0.7%
CHIP (Children's Health Ins. Plan)	34,278	34,823	-1.6%	36,232	-5.4%
	Annual Visits			Annual Charges	
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 (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%
Emergency Department Encounters (2011)	665,925	22.4%	+1.7%	$ 1,309.5	+12.8%
Outpatient Surgery (2011)	376,054	12.6%	+2.4%	$ 1,878.5	+6.5%
Annual Community Health Measures	**Current Data Year**	**Number Affected**	**Percent/ Rate**	**% Change¶ From Previous Year**	**State Rank# (1 is best)**
Obesity (Adults 18+)	2012	476,400	24.3%	-0.5%	10 (2012)
Cigarette Smoking (Adults 18+)	2012	207,300	10.6%	-10.8%	1 (2012)
Influenza Immunization (Adults 65+)	2012	147,100	56.0%	-1.5%	40 (2012)
Health Insurance Coverage (Uninsured)	2012	376,600	13.2%	-1.5%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2011	242	8.6 / 100,000	+3.2%	19 (2010)
Poisoning Deaths	2011	554	19.7 / 100,000	+12.8%	45 (2010)
Suicide Deaths	2011	503	17.9 / 100,000	+5.2%	n/a
Diabetes Prevalence (Adults 18+)	2012	141,100	7.2%	+7.5%	14 (2012)
Poor Mental Health (Adults 18+)	2012	307,800	15.7%	-3.7%	12 (2012)
Coronary Heart Disease Deaths	2011	1,612	57.2 / 100,000	+6.7%	3 (2010)
All Cancer Deaths	2011	2,733	97.0 / 100,000	-3.5%	1 (2010)
Stroke Deaths	2011	778	27.6 / 100,000	+5.6%	17 (2010)
Births to Adolescents (Ages 15-17)	2011	706	11.2 / 1,000	-20.3%	11 (2011)
Early Prenatal Care	2011	38,228	74.7%	+2.3%	n/a
Infant Mortality	2011	282	5.5 / 1,000	+14.6%	10 (2010)
Childhood Immunization (4:3:1:3:3:1)	2011	37,400	71.1%	+0.7%	42 (2010)

† Diagnosed HIV infections, regardless of AIDS diagnosis.
‡ Includes only the gross pharmacy costs. Pharmacy Rebate and Pharmacy Part D amounts are excluded from this line item.
§ Physician/Osteo Services - Medicaid payments reported under Physician/Osteo Services does not include enhanced physician payments.
¶ % 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 influenza virus has ended until the 2013-2014 season.