

Utah Health Status Update:

It Takes a Village: Addressing Infant Mortality Disparities by Giving Utah Pacific Islander Babies the Best Chance

April 2018

Introduction

Utah Native Hawaiians/Pacific Islanders (NHPI) experience significantly higher rates of infant mortality compared to the Utah population overall. However, no health promotion interventions exist in Utah or the U.S. tailored to Pacific Islanders to address this and other birth outcome disparities.

Since 2014, the Utah Department of Health Office of Health Disparities (OHD) in collaboration with health care professionals and community partners have been working to address this issue. The final product of these efforts is the *It Takes a Village: Giving Our Babies the Best Chance* (ITAV) Project. The ITAV Project raises awareness and addresses birth outcomes disparities in the context of Pacific Islander cultural beliefs and practices. From May 2017 to February 2018, the OHD conducted the final implementation and evaluation of the ITAV Project.

Methods

Based on U.S. Census data (to accurately reflect the diversity of Utah NHPI communities) and Utah vital records data (to accurately reflect the NHPI communities most affected), the OHD selected and trained a representative sample

of NHPI community facilitators. Facilitators then recruited English-speaking NHPI adults aged 18 and older for the project. While adults and couples of reproductive age were preferred for the project, a variety of genders, generations, and marital statuses participated.

Facilitators delivered four two-hour workshops to seven groups of participants. Pre- and post-intervention questionnaires were administered to assess awareness, knowledge, and self-efficacy along with a post-intervention project evaluation.

Results

In the final implementation phase, all 63 participants completed evaluation questionnaires. The majority of participants were female (76%), married (64%), and had a high school degree (35%) or some college (33%), with the average age being 35 years.

Stages of Behavior Change

The project successfully moved almost one-fourth of participants out of the pre-contemplation stage (not identifying infant mortality as a health issue affecting their community) and 80% of participants forward at least one stage. A majority of participants (75%) ended in the preparation stage (felt they had the tools to do something).

Awareness

By the end of the intervention, all participants were aware of infant mortality disparities in their community; an improvement from only half of participants (54%) pre-intervention.

Knowledge

After the project, participants demonstrated substantial improvements in their knowledge of the definition of infant mortality, the leading cause of infant mortality among Utah NHPI communities, the definition of preconception health, and birth spacing recommendations (all of which participants were least familiar with pre-intervention). The project also improved knowledge about prenatal care and when it should start.

Self-efficacy

By the end of the project, participants felt more confident talking to community members, coaching family members, and coaching community members about pregnancy and birth-related issues (all of which participants were least confident about pre-intervention). The project also helped participants feel more confident talking to family members about these topics and finding trusted information and resources.

Project Evaluation

All participants agreed the project was culturally appropriate for NHPI communities. The project structure and content was well received overall with only a third of participants suggesting minor improvements.

Conclusion

Results demonstrate the cultural appropriateness of the ITAV Project effectively raised awareness, improved knowledge, and increased self-efficacy. The results establish the project's need and promote widespread

KEY FINDINGS

- **The *It Takes a Village: Giving Our Babies the Best Chance* (ITAV) Project raises awareness and addresses birth outcomes disparities in the context of Pacific Islander cultural beliefs and practices.**
- **By the end of the intervention, all participants were aware of infant mortality disparities in their community, an improvement from only half of participants (54%) pre-intervention.**
- **Results demonstrate the cultural appropriateness of the ITAV Project effectively raised awareness, improved knowledge, and increased self-efficacy.**

dissemination and appropriate adaptation among organizations working with the Utah NHPI communities and for NHPI communities across the nation. Finalized project content will be released online in April 2018 during Minority Health Month.

Program Results

Table 1. Pre- and post-intervention participant responses for stages of behavior change, awareness, knowledge, self-efficacy, and program evaluation by Utah Native Hawaiian/Pacific Islander community

Variable N (%)	Participants 63 (100%)		Native Hawaiian 11 (17%)		Micronesian 10 (16%)		Samoan 19 (30%)		Tongan 26 (41%)	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Stages of Behavior Change										
Precontemplation (Infant mortality is not a problem for NHPI communities.)	16 (25%)	1 (2%)	2 (18%)	0 (0%)	2 (20%)	0 (0%)	4 (21%)	0 (0%)	9 (35%)	1 (4%)
Contemplation (Infant mortality is a problem for NHPI communities and/or I do not know what to do.)	46 (73%)	15 (24%)	9 (82%)	0 (0%)	8 (80%)	6 (60%)	15 (79%)	7 (37%)	16 (61%)	5 (20%)
Preparation (Infant mortality is a problem for NHPI communities and I have the tools to do something about it.)	1 (2%)	47 (75%)	0 (0%)	11 (100%)	0 (0%)	4 (40%)	2 (11%)	12 (63%)	1 (4%)	20 (77%)
No progress	11 (18%)		0 (0%)		4 (40%)		4 (21%)		4 (15%)	
Backward progress	2 (3%)		0 (0%)		1 (10%)		0 (0%)		1 (4%)	
Forward progress	50 (80%)		11 (100%)		5 (50%)		15 (79%)		21 (81%)	
Awareness										
NHPIs are one of the groups with the highest infant mortality rate in Utah.	34 (54%)	63 (100%)	8 (73%)	11 (100%)	5 (50%)	10 (100%)	8 (42%)	19 (100%)	13 (50%)	26 (100%)
Knowledge										
Correctly defined infant mortality	13 (21%)	62 (98%)	4 (36%)	11 (100%)	2 (20%)	9 (90%)	5 (26%)	19 (100%)	2 (8%)	26 (100%)
Identified the leading cause of infant mortality among Utah NHPI communities	3 (5%)	52 (83%)	0 (0%)	9 (82%)	1 (10%)	8 (80%)	1 (5%)	17 (90%)	1 (4%)	20 (77%)
Correctly defined preconception health	26 (41%)	39 (62%)	8 (73%)	8 (73%)	6 (60%)	5 (50%)	6 (32%)	13 (68%)	6 (23%)	14 (54%)
Correctly defined prenatal care	45 (71%)	59 (94%)	8 (73%)	11 (100%)	9 (90%)	10 (100%)	13 (68%)	18 (95%)	15 (54%)	23 (89%)
Identified when a woman should initiate prenatal care	55 (87%)	63 (100%)	11 (100%)	11 (100%)	10 (100%)	10 (100%)	16 (84%)	19 (100%)	19 (73%)	26 (100%)
Identified the recommendation for birth spacing	15 (24%)	62 (98%)	2 (18%)	11 (100%)	5 (50%)	10 (100%)	3 (16%)	18 (95%)	5 (19%)	25 (96%)
Self-efficacy Single Point Scales (1-5)										
Mean										
Confidence talking to family members about pregnancy and birth-related issues	3.8	4.7	3.8	5.0	4.7	4.9	3.4	4.5	3.4	4.5
Confidence talking to community members about pregnancy and birth-related issues	3.1	4.5	2.8	4.4	4.3	4.7	3.3	4.4	2.8	4.4
Confidence finding trusted information and resources for before, during, and after pregnancy	3.8	4.6	3.7	4.8	4.2	4.7	3.9	4.5	3.5	4.6
Confidence coaching (providing advice and guidance to) family members about steps that could be taken to have healthy babies	3.2	4.5	3.1	4.6	4.5	4.7	3.3	4.4	2.7	4.4
Confidence coaching (providing advice and guidance to) community members about steps that could be taken to have healthy babies	3.0	4.4	2.7	4.1	4.3	4.7	3.1	4.3	2.5	4.4
Program Evaluation Single Point Scales (1-5)										
Mean										
The usefulness of the information received in the training	4.9		5.0		4.9		4.8		5.0	
The structure of the training session(s)	4.8		4.9		4.9		4.8		4.6	
The pace of the training session(s)	4.7		4.5		4.9		4.7		4.5	
The convenience of the training schedule	4.4		4.0		4.8		4.4		4.4	
The convenience of the training location	4.6		4.3		4.9		4.4		4.6	
The usefulness of the training materials	4.8		4.7		5.0		4.7		4.9	
The usefulness of the training activities	4.8		4.7		5.0		4.7		4.8	
Was this training culturally appropriate for PI/HN communities?	63 (100%)		11 (100%)		10 (100%)		19 (100%)		26 (100%)	
Was this training appropriate for your level of experience in this area?	62 (98%)		11 (100%)		10 (100%)		18 (95%)		26 (100%)	
Do you think this training could be improved?	22 (36%)		2 (18%)		4 (40%)		7 (39%)		10 (40%)	

For additional information about this topic, contact Brittney Okada, 801-538-6779, bokada@utah.gov; or the Office of Public Health Assessment, Utah Department of Health, (801) 538-9191, chdata@utah.gov.

Breaking News, April 2018

Developmental Screening Practices in Utah

According to the 2011–12 National Survey of Children’s Health, nearly 15% of children two- to eight-years-old have a developmental, behavioral, or mental disorder. Opportunities for appropriate and effective intervention rely on early detection, which is why the American Academy of Pediatrics (AAP) recommends that all infants and young children be screened for developmental delays using a validated, standardized screening tool at the 9, 18, and 30 (or 24) month well-child visit. Policy also recommends that developmental monitoring or surveillance be incorporated into every pediatric preventive care visit between birth and five years.

The 2017 Developmental Screening Survey was developed collaboratively by the Utah Department of Health Data Resources and the Early Childhood Utah Programs as a follow-up to a previous survey conducted in 2013. The purpose of the survey was to examine the trends in routine developmental screening and surveillance done by pediatric healthcare professionals during well-child visits. The survey was conducted online using Survey Monkey between May 2017 and October 2017. Physicians were identified using the Utah Division of Occupational and Professional Licensing database and were invited to participate in the survey via an emailed invitation. A total of 323 physicians responded to the survey invitation. For this report, however, analysis was restricted to those who indicated seeing children six-years-old and younger in their practice (n=108).

Overall, 62.9% identified their specialty as “family practice” and the remaining 37.1% identified their specialty as “pediatrics.” More than half (53.4%) indicated having been in practice for 11 or more years. An overwhelming majority (97.1%) reported performing developmental surveillance at any well-child visits. Routine use of standardized developmental screening tools was reported by 71.0% of surveyed physicians. This figure is much higher than the 2009 national average (47.7%) reported by the AAP. The Ages and Stages Questionnaire (ASQ) was used by the majority of physicians (59.2%). Those who reported routine use of standardized screening tools were also significantly more likely to communicate the developmental screening results “always/almost always” with parents as compared to those physicians who reported not routinely using standardized screening tools (75.4% vs 29.6%, $p < .001$). It is encouraging that a majority (71.0%) of physicians reported using standardized developmental screening tools; however, almost one-third (29.0%) reported they did not using them in their practice.

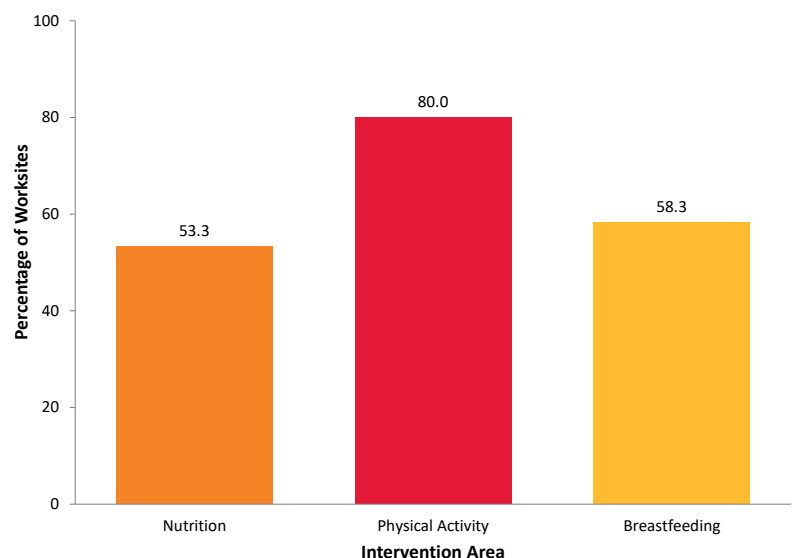
Community Health Spotlight, April 2018

Efforts to Improve Worksite Wellness

On average, full-time employees spend a significant amount of time each week at their place of employment. Nationally, overweight and obese full-time employees with chronic health problems miss 450 million more days of work each year than healthy workers. Productivity losses from missed work cost employers \$225.8 billion, or \$1,685 per employee each year and bear about 58% of total employee medical cost.¹ Employers should be interested in increasing healthy behavior to reduce costs of chronic disease.

The Utah Department of Health Healthy Living through Environment, Policy, and Improved Clinical Care Program (EPICC) is working to help employers implement strategies to encourage healthy behaviors at work. Strategies include improving nutrition by providing healthier options in vending machines and cafeterias, increasing physical activity by providing exercise release time, and accommodating breastfeeding mothers. Employers throughout the state were invited to complete a wellness assessment. To date, 120 worksites of all sizes from both the public and private sector have participated. More than half (53.3%) of participating worksites have implemented at least one nutrition strategy, four out of five (80.0%) have at least one strategy to encourage physical activity, and almost 60% provide time and space to accommodate breastfeeding mothers.

Percentage of Worksites with ≥ 1 Strategy in Each Area



Source: EPICC Worksite Assessment 2017–2018

1. Workplace Health Promotion, CDC. <https://www.cdc.gov/chronicdisease/resources/publications/aag/workplace-health.htm>

Monthly Health Indicators Report

(Data Through February 2018)

Monthly Report of Notifiable Diseases, February 2018	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>)	13	27	51	57	0.9
Shiga toxin-producing <i>Escherichia coli</i> (<i>E. coli</i>)	4	2	5	4	1.2
Hepatitis A (infectious hepatitis)	30	0	61	1	101.7
Hepatitis B, acute infections (serum hepatitis)	1	1	4	1	2.9
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/influenza				
Meningococcal Disease	0	0	0	0	0.0
Pertussis (Whooping Cough)	15	53	31	114	0.3
Salmonellosis (<i>Salmonella</i>)	32	18	55	40	1.4
Shigellosis (<i>Shigella</i>)	2	3	5	7	0.7
Varicella (Chickenpox)	13	26	33	54	0.6
Quarterly Report of Notifiable Diseases, 4th Qtr 2017	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†	17	31	113	121	0.9
Chlamydia	2,441	2,077	10,088	8,279	1.2
Gonorrhea	638	372	2,548	1,307	2.0
Syphilis	30	16	118	66	1.8
Tuberculosis	8	7	29	32	0.9
Medicaid Expenditures (in Millions) for the Month of February 2018‡	Current Month	Expected/Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Mental Health Services§	\$ 13.9	\$ 13.9	\$ 112.5	\$ 113.6	\$ (1.2)
Inpatient Hospital Services	\$ 22.4	\$ 22.8	\$ 159.7	\$ 161.7	\$ (2.0)
Outpatient Hospital Services	\$ 4.9	\$ 4.9	\$ 29.4	\$ 31.5	\$ (2.1)
Nursing Home Services	\$ 31.3	\$ 31.5	\$ 152.1	\$ 155.7	\$ (3.6)
Pharmacy Services	\$ 9.6	\$ 9.7	\$ 79.0	\$ 80.6	\$ (1.5)
Physician/Osteo Services	\$ 5.1	\$ 5.2	\$ 40.7	\$ 42.2	\$ (1.6)
Medicaid Expansion Services	\$ 4.0	\$ 3.7	\$ 21.4	\$ 22.5	\$ (1.0)
TOTAL MEDICAID#	\$ 222.6	\$ 223.0	\$ 1,713.3	\$ 1,718.4	\$ (5.1)

Program Enrollment for the Month of February 2018	Current Month	Previous Month	% Change** From Previous Month	1 Year Ago	% Change** From 1 Year Ago
Medicaid	278,576	279,522	-0.3%	288,871	-3.6%
PCN (Primary Care Network)	15,475	12,730	+21.6%	14,233	+8.7%
CHIP (Children's Health Ins. Plan)	19,312	19,277	+0.2%	19,195	+0.6%
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 (2016)	297,106	8.7%	+3.0%	\$ 8,638.0	+8.4%
Non-maternity Hospitalizations (2016)	198,257	5.7%	+2.0%	\$ 7,466.1	+9.2%
Emergency Department Encounters** (2016)	756,376	22.8%	+7.6%	\$ 2,286.3	+21.7%
Outpatient Surgery (2016)	491,566	14.7%	+4.9%	\$ 3,000.6	-0.3%
Annual Community Health Measures	Current Data Year	Number Affected	Percent/Rate	% Change** From Previous Year	State Rank** (1 is best)
Obesity (Adults 18+)	2016	538,700	25.3%	+3.3%	10 (2016)
Cigarette Smoking (Adults 18+)	2016	187,400	8.8%	-3.3%	1 (2016)
Influenza Immunization (Adults 65+)	2016	176,300	54.9%	-6.9%	41 (2016)
Health Insurance Coverage (Uninsured)	2016	265,500	8.7%	-1.1%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2016	257	8.4 / 100,000	+2.0%	16 (2016)
Poisoning Deaths	2016	703	23.0 / 100,000	-1.1%	33 (2016)
Suicide Deaths	2016	612	20.1 / 100,000	-1.5%	47 (2016)
Diabetes Prevalence (Adults 18+)	2016	153,300	7.2%	+2.9%	8 (2016)
Poor Mental Health (Adults 18+)	2016	362,000	17.0%	+6.3%	21 (2016)
Coronary Heart Disease Deaths	2016	1,631	53.5 / 100,000	-1.3%	4 (2016)
All Cancer Deaths	2016	3,113	102.0 / 100,000	-1.3%	1 (2016)
Stroke Deaths	2016	927	30.4 / 100,000	+2.4%	32 (2016)
Births to Adolescents (Ages 15-17)	2016	447	6.2 / 1,000	-11.1%	11 (2016)
Early Prenatal Care	2016	38,003	75.3%	-1.5%	n/a
Infant Mortality	2015	257	5.1 / 1,000	+3.2%	12 (2015)
Childhood Immunization (4:3:1:3:3:1)	2016	37,100	73.6%	0.0%	26 (2016)

* Influenza activity was widespread through February 2018. As of February 28, 2018, 1,783 influenza-associated hospitalizations have been confirmed since the start of the influenza season on October 1, 2017. More information can be found at <http://health.utah.gov/epi/diseases/influenza/surveillance/index.html>.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ This state fiscal year (SFY) 2018 report includes supplemental payments to better match the SFY 2018 Medicaid Forecast Budget which costs have not been included in previous years.

§ The SFY 2018 Medicaid Forecast Budget includes Mental Health and Substance Abuse services together while this report only accounts for Mental Health services. This is to stay consistent with the previous years reports.

Medicaid Expansion Services was added to the Medicaid program in SFY 2018. Total Medicaid costs exclude the Prism Project.

** Relative percent change. Percent change could be due to random variation.

†† Treat and release only.

‡‡ State rank based on age-adjusted rates where applicable.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile Virus will start in June for the 2018 season.

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