

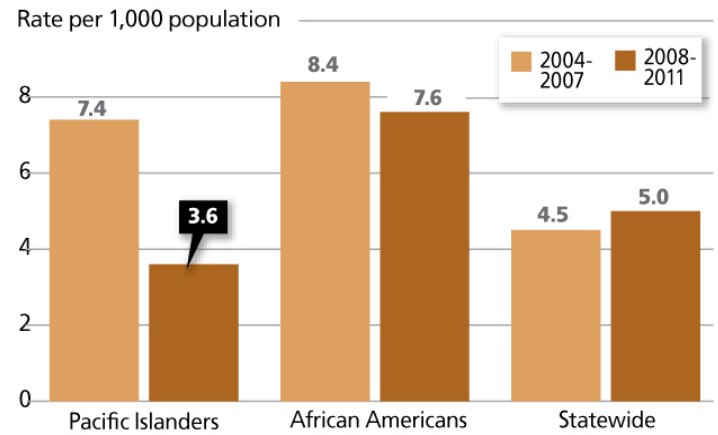
# 2013 Legislative Report

## Preventing Infant Death

OHD successfully addressed the infant mortality problem among the two Utah racial groups with the highest infant mortality rates, reducing the African American/Black infant mortality rate from 8.4/1,000 births in 2004-2007 to 7.6/1,000 in 2008-2011 and reducing the Pacific Islander infant mortality rate by nearly half, from 7.4/1,000 births in 2004-2007 to 3.6/1,000 in 2008-2011. Strategies included the first-ever statewide surveillance study of Pacific Islanders in the continental United States, new health promotion videos in English, Samoan, and Tongan featuring African American and Pacific Islander Utahns, and culturally appropriate health promotion and health care referral programs implemented in partnership with ethnic community-based organizations.

## Infant mortality

Infant mortality among Pacific Islanders in Utah dropped dramatically in the most recent four-year period.



	<p><b>For Me For Us Videos</b> 7 videos, 4 languages. Minority Utahns share health tips. &gt;18,000 views</p>		<p><b>Health in 3D Video</b> OHD's newest video for Utah health professionals. &gt;500 views</p>		<p><b>Website &amp; Blog</b> Multilingual library, disparities news, local/ethnic data. &gt;67,000 views/year</p>
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See [youtube.com/user/DisparitiesUtah](http://youtube.com/user/DisparitiesUtah) and [health.utah.gov/disparities](http://health.utah.gov/disparities)

## Bridging Communities and Clinics

Bridging Communities and Clinics links at-risk community members to healthcare providers, including the uninsured/underinsured, low-income populations, and racial/ethnic minorities. The model was designed by OHD to employ evidence-based best practices:

- A trained, diverse Outreach Team
- Screening for blood glucose, cholesterol, hypertension, body mass index, and health risk
- Referrals to free, reduced-cost, or income-based primary care services through local clinics
- Post-screening follow-up to assist participants with scheduling appointments, basic health questions, language barriers, etc.

During the pilot year, 24 outreach events were conducted through a network of 12 referral clinics and 22 community partners, providing 883 screenings, locating 178 people with health risk factors meriting medical referral. Of those reached through follow-up contact, 56% reported that they visited a medical provider to address their health risk factors.

## Nationally Recognized Success

OHD and its staff have been recognized for establishing best practices by the Journal of Public Health Management and Practice, the National Academy for State Health Policy, the Association of State and Territorial Health Officials, the University Health Consortium and the Robert Wood Johnson Foundation. Utah's OHD is one of only 22 state offices to win a federal State Partnership Grant for the next two years. Of states funded previously, 24 were not refunded and about half of the funded states received a funding reduction. In contrast, Utah OHD was funded at the same annual level of funding as previously: \$130,000/year.

### Mission

To reduce health disparities in Utah and to improve health outcomes for vulnerable populations as defined by socioeconomic status, race/ethnicity, geography, as well as other populations identified to be at-risk for health disparities.

### Mandate

Utah Code Title 26 Chapter 7 Section 2