

MCHCOM.COM Director's Webcast, November 2003

CHRIS DEGRAW: Good afternoon and welcome to the MCHCOM.COM webcast coming from HRSA's Maternal Child Health Bureau in Maryland. This our webcast for special health care needs directors. I'm Chris Degraw from the division of research and training. Sorry for the delay but we were having some problems here with the power went out in the building for a while. Fortunately it's back on for a moment and we hope it will last throughout the webcast. Today's webcast will present information from the Healthy People 2010 maternal child health review that took place on October 22nd. Before I introduce the place I'm like to review technical information about the webcast. Slides will appear in the central window and will advance automatically the slide changes are synchronized with the speakers' presentations. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the drop down menu and hit send. Please include your state or organization in your message so that we know where you are participating from.

The questions will be relayed onto the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your questions during the broadcast, we will e-mail you afterwards. Again, we encourage you to submit questions at any time during the broadcast. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loud speaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast the interface will close automatically and you will have the opportunity to fill out an on line evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support. Again, our webcast today will present data from the maternal infant child review that took place in October. Our speakers today are Stella Yu formula of the bureau's information management and currently the acting chief of the MCHB's research branch joining us from the National Center for Health Statistics and Centers for Disease Control Centers for Disease Control is Richard J Kline. I'll start off with Dr. Yu.

STELLA YU: I'm Stella Yu and as Dr. Degraw mentioned I've been involved with Healthy People 2010 for a very long time. I've been serving as the coordinator for the chapter for about 10 years now. Prior to Healthy People 2010, as you remember, we had Healthy People 2000 which there was a chapter on maternal infant health and HRSA was the sole lead for that chapter. As we move into Healthy People 2010, the agencies got together and developed a much larger and comprehensive chapter known as a focus area, and it is more encompassing. We included more objectives and children and older children and also adolescents. And the focus area is known as maternal infant child area. HRSA had the lead for disease control. And hers and CDC are totally on the chapter. The chapter is 23 objectives. Several of them are developmental. And as Dr. Degraw mentioned we're going to try to report to you on the progress review that was conducted on October 22nd.

For this particular progress review, we focus on three themes. Focus on maternal mortality and morbidity on healthy pregnancies and healthy infants and children with special healthcare needs. The last theme included discussions on the objectives related to development of disabilities. The three principal

discussions that had the dialog with the assistant secretary of health on the progress was Dr. Peter Van Dyck of MCHB Dr. Steve last wrath and Jose core Ray owe from the CDC. I guess I don't want to take up too much more time, because we have used up about 15, 20 minutes already. Let me just introduce our guest speaker who is going to give us a lot more detail about the progress review, mainly on the data aspects of what is happening with each of the objectives. Richard Klein, our speaker, he is the Acting Director of the division of health promotions statistics at MCHS and has been a long time leader in healthy people statistics. And it's a pleasure to welcome Richard.

RICHARD KLEIN: Thank you, Stella. I'm going to be going through a set of slides that you'll see on your screen. To give you a little background, these are from the progress review that's been mentioned. These are held, these progress reviews are held once a month for the assistant secretary for health for all of the 28 healthy people focus areas. So it takes several years to get through a round. We're about halfway through the Healthy People 2010 areas. The slides I'll present were discussed by the director of MCH Dr. Sondik at that meeting. You can find more information about the review including these slides, they're on line at the address that will be shown at the end of the presentation. The maternal and infant and child health chapter Stella mentioned is divided into three areas. The first area is the maternal mortality and morbidity objectives. These are listed in front of you. We talk about complications of labor and delivery, maternal deaths, Caesarean birth and entopic praens. You'll see that asterisks we see on the ectopic pregnancies you'll see that on a number of objectives.

This indicates what we call developmental objectives, which means that there was no data at the initiation of Healthy People 2010 back in January of 2000. Since then a number of these have been able to obtain baseline data. Looking at maternal complications during pregnancy, we see that the total rate is somewhat over 20%. I mean 30%, excuse me. It's a rate that hasn't changed very much at all in recent years and in fact hasn't changed much over at least the past decade. The rate for the black population, black women, is considerably higher than the rate for white women. We've put in the next slide to talk about what some of these conditions are, the next two. There's the 30% figure. It's surprising to a lot of people. That means 30% of all women are experiencing some type of complication. And the definition you see in front of you is a condition that adversely affects a woman's physical health during child birth, beyond what would be expected in a normal delivery. These are obtained from hospital records and they're a certain set of IPB codes depending on the hospital records. So again this is our figure for the 2001 figure of 30.7%.

To give you an idea of where the breakdown comes, these come from many different causes, but about 4% come from pre-existing medical conditions. And looking at the following table, where all these are broken out, you see that they come from a number of different places, including pre-(inaudible), trauma, hemorrhage, et cetera. Moving on to Caesarean births, in the right-hand corner of this chart is the Caesarean trend. This is something we've included in healthy people, since Healthy People 2010 and since the previous decade the Caesarean rates were going down. However, in recent years, since the late '90s, there's been an upward trend and somewhat steep, if you see overall on the right. It's gotten a lot of attention in the press. Looking at the rate by race, we see that they're fairly similar, the rate for black women somewhat higher. But the rates are fairly similar by race. Maternal deaths, another topic that's focused on healthy people, as a relative cause of death is rather small. We're only talking about two to 400 deaths a year. However, the idea that most of, if not all of these deaths should be preventable is of concern to public health.

Looking at the long-term trend over on the right, you see that the rate has gotten very low.

However, we're still higher than many countries in the world. What's of most concern is the threefold difference between the black and white population, and the black population is much higher in maternal deaths. The next area we focused on is the area of healthy pregnancy and infant death fetal death sz low birth weight, preterm birth and (inaudible) and other deaths. The infant mortality rates have been going down consistently for many many years. The rate for the healthy people tracking period, I should probably explain that. The tracking period goes back to 1998. Remember, we established these objectives three years ago. So we used the latest data available. In this case it was primarily 1998 data. You'll see some other years in the other slides. So we have a relatively short tracking period. Healthy People 2010 is a 10 year initiative to improve health in the U.S. over ten years, where about nearly half of the way through. So you're only going to see three, four years on these charts. In some cases like you've already seen, we will show a longer-term trend to put it in context.

But the purpose of the progress review was to look at how we're doing since the established baseline and going towards the healthy people target. For infant death, you can see the small decrease for the total population. You can see the rate for the Asian population is already exceeded the healthy people target. There's considerable disparities by race, particularly in the black population, which has consistently had a rate of about double the white population. A disparity that's not changed over the past many years and in fact tends to very gradually widen. To put this in some context, on the next slide, we brought in some international rates. The focus of healthy people is only on U.S. national data. But to put it into some context, you can see the rate for Japan is about four per thousand live births, which is very similar to the U.S. Asian rate. The Canadian rate, very similar to the U.S. white rate at about 6 per thousand. The rate per Kuwait, similar to our American Indian rate, and the rate for Bosnia, somewhat higher than the rate for U.S. blacks. So this puts this in an international context. By state, the rates for infant mortality are highest for the south, where we often see state rates in excess of 9 per thousand. Tend to be lowest out west and up in the New England.

To provide a little more context for infant mortality, we did a table of the leading causes of infant mortality, broken out by cross-tabulated by low birth weight and very low birth weight. It's a lot of numbers here, but on the next slide, you'll see the ones that we highlighted of interest. I missed one. The next one shows the social and economic impact, which of course, is substantial, in terms of social costs, economic costs, the cost of low birth weight to society is very important. So let's go to the next one. I think we didn't highlight on that table. We can go back to it if there's any questions. There's some interesting data on that table that we'll look at later that has to do with the rates for black and Hispanic. Looking again at another group for healthy pregnancies and healthy infants. We have prenatal care, substance abuse during pregnancy, public access, very low birth weight infants being born in level three hospitals. Breast-feeding and infants being put to sleep on their back. We'll look at a few of these now. The early prenatal care, the rates have been fairly consistent. The total population is about 83% of women getting care or beginning care in the first trimester of pregnancy. And even though the rates are over 80% for the total population, there's still significantly disparities by race.

Particularly American Indian, Hispanic and black populations have considerably lower rates than Asian or white populations. Looking at abstinence from smoking. This objective is in terms of women abstaining from smoking. That's why the rates are so high. We see that overall about nearly 90% of women reported not smoking during pregnancy. Those rates are much higher for Hispanic and Asian women up in the mid to upper '90s. Lowest for American women, only about 80% reported not smoking during pregnancy T for the total population, there's been a modest increase over the healthy people tracking period. Looking at abstaining from alcohol, the rates for all groups are fairly comparable, within the confidence intervals, the Hispanic, non-Hispanic black and white, all very similar. There's also a gradient by trimester of pregnancy. And as we'd expect, the abstinence from alcohol increases as the pregnancy progresses. The issue is that the abstinence of alcohol in the first trimester, women could still be drinking even be they're aware of the pregnancy.

Breast feeding in healthy people, we have three different targets. One is in-hospital. The next is a measurement at six months and the third is a measurement at 12 months. We have three different targets which you'll see on this chart for all three of the tracking periods. The rates are fairly similar by race group except notably for the black population where breast feeding rates at all three periods are considerably lower than Asian or white women. Asian being the highest. Looking at folate levels, we have data, measured data from the Hehns survey on the left where you can see there's been a considerable increase in the median red blood cell folate level in non-pregnant women 15 to 44, and approximately the past 10 to 18 years. Those are multi point measuring surveys. The thinking is that the supplementation improves and the various public health campaigns for increasing folate has made quite a difference. Correspondingly, on the right, we see an encouraging decrease in points of other MTBs associate with that increase folic acid use. The next is Sudden Infant Death Syndrome, which has gone down substantially since the mid- '90s to our last data point, 2001.

We're still far above the healthy people target, which is about 25 deaths per hundred thousand. When we look at the next slide, we can see that if we superimpose on top of these SIDS death rate another healthy people objective, which is the proportion of infants being put to sleep on their backs, we see a very strong association between the decrease in the SIDS rate and the increase in infants put to sleep on their back. Part of this is certainly attributable to the back to sleep campaign. The last area is children with special healthcare needs. And you notice from the list of objectives, that a number of these are developmental. This is an area that's not gotten a lot of data in the past. But there are a number of data collections planned and we hope to be able to get data for all of these objectives. We're going to go over a few measures. The first just kind of lays out the territory. This is not a healthy people objective, but this is the denominator for many of the healthy people objectives, and that is the proportion of children with special healthcare needs. Survey was done several years ago, a very big survey, to measure children with special healthcare needs and a lot of data continued to come out of that survey. And we find that about 12 or 13% of the population of children under 18 have special healthcare needs.

There's significant variations by race with the rates being very low for Asian. Some are low for Hispanic. The highest rates are for American Indians. We also see that this proportion increases with the age of children. Part of that increase is due to many of these conditions are diagnosed later, particularly when children enter school. Also the rates are higher among males than females, 15% compared to a little more than 10%. The final slide is on autism

in children three to ten years. There currently is no national data set to measure this. These data come from a surveillance system in metropolitan Atlanta that's been operating for a number of years. It shows that about a little more than three per thousand children in three to ten years old in the Atlanta metropolitan area reported to have autism. The rates are much higher for males than females, for both races, for black and for white.

As I mentioned, the materials for the process review, including these slides, are up on the MCH website. In fact, we have all the healthy people progress reviews to date which we've done about, I don't know, 14 or 15 of them at this point. And you can find the agendas and other materials and the slides can be obtained on that site. So at this point we'd be happy to open it up for questions or issues that you'd like to raise. Some of these I may turn over to Dr. Yu. I'm the data person. So if you have things that relate to the data, I'd be happy to address, substantive issues, we can refer to our HRSA colleagues.

CHRIS DEGRAW: So now is the time to ask questions. We don't have any questions in the queue at the moment. So we'll give you a couple of minutes to submit a question or two to our speakers. Hold on a minute so we can give anyone a chance for questions they might have for Dr. Yu or Richard Klein. Okay. We don't seem to have any questions. So I think we'll go ahead and if there aren't any questions, conclude our broadcast for today. We want to thank you all for participating in our monthly MCHCOM.COM and for persisting with us throughout the various technological difficulties and power problems today. I'd like to thank you our contractor the University of Illinois, Chicago School of Public Health for making this technology work in the face of adversity. Today's webcast as with all of our MCHCOM.COM webcasts will be archived and available within a couple of days on the website WWW.MCHCOM.COM. We encourage you to let your colleagues know about the website and hope they'll find it useful. We'd like to make these MCHCOM.COM as responsive to your information needs as possible. If you have suggestions for topics you'd like addressed on future webcasts or have comments in general, please e-mail them to us at info at MCHCOM.COM. Thank you all again and we thank you for your participation again next month.