



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Utah**

**Application for 2012
Annual Report for 2010**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Utah Department of Health has submitted the Assurances and Certifications to the authorized signatory and has on file the signed Assurances and Certifications dated July, 2011. The State Title V Office has on file a copy of the Assurances and Certifications non-construction program, debarment and suspension, drug free work place, lobbying program fraud, and tobacco smoke. They are available at any time for review upon request. The state Title V agency is compliant with all the federal regulations governing the Title V funding allocated to Utah.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public Input Process FY2012

Public input is a valued part of the annual MCH Block Grant application process. In April 2011, the Utah Maternal and Child Health Bureau announced to the public and stakeholders through various mechanisms that the Utah Department of Health (UDOH), Division of Family Health and Preparedness was soliciting public input for FY12 MCH Block Grant Application. The UDOH is the designated Title V agency for Utah.

Newspaper Ads/Public Notices

Public notices were published in major newspapers throughout the state. It was explained in the announcement that the Division of Family Health and Preparedness is responsible for administration of the MCH Block Grant received by the State of Utah under the provisions of Title V of the federal Social Security Act. Under this capacity, the Division is required annually to submit an application to the U.S. Department of Health and Human Services. These public notices made it known that the proposed program activities related to annual goals for the Fiscal Year 2012 MCH Block Grant Application were available for public review and comment.

Website Posting/Web Application

The proposed program activities were posted online at the following internet site: <http://www.health.utah.gov/mch/mchblock.php>. This link directed the user to the 2012 Annual Goals webpage. The webpage outlined the proposed activities targeted for three MCH populations (pregnant women & infants, children, and children & youth with special health care needs). Emails with this web URL was sent to an extensive list of stakeholders including: parents, consumers, health care providers, academia, community-based advocacy organizations, community health centers, local health departments, and various government agencies requesting input and feedback.

This year a number of modifications were made on the web application to enhance the system usability. Database functionality was added to collect input for new state performance measures identified during 2010 MCH Needs Assessment as well as to archive the comments from previous years. Three web tabs, each designed for a particular MCH population, were created for easier navigation. Under each tab, program activities and trend data related to each performance measure were listed for the user to review and make comments. The online comments were accepted between April 27 and May 16, 2011. We received valuable feedback on health needs and emerging issues as well as reaffirmation of the importance of current program activities. During the public comment period, the site had 591 pageviews.

Announcement Flyers/Newsletters

To increase public awareness about MCH program activities, we additionally requested Office of Health Disparities Reduction (formerly known as the Center for Multicultural Health) staff to add the public comment announcement in their on-line newsletter, Connections. We prepared a public comment announcement flyer to spread the news. This notification was posted on the Utah Department of Health (UDOH) employee intranet, Dohnet, which is available to approximately 1,300 employees. The UDOH news media director was contacted to put the announcement on UDOH twitter. Flyers requesting input were posted throughout the UDOH Building.

Other Outreach Methods

MCH staffs and other agency partners were informed and briefed about the Block Grant Application and public comment process during regular bureau, data, and taskforce meetings.

All input received from emails and web application was compiled in a document and shared with the core program staff responsible for specific National and State Performance Measures to consider for incorporation in the final 2012 Annual Plan. Comments were incorporated into the plan as appropriate.

The Application of last year and the needs assessment results and report have been posted on the bureau website to solicit continuous feedback on the block grant process and application.

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Title V Needs Assessment was guided by the State Department of Health's vision, "Utah is a place where all people can enjoy the best health possible, where all can live, grow and prosper in clean and safe communities". The Utah Title V vision is that all women, mothers, children, youth, including those with special needs, and families in Utah are healthy. These visions guided the framework of FY2011 MCH needs assessment process.

Prioritization Process

The original priority list consisted of 26 issues. Program managers held separate work group meetings with their staff to select their priorities and submitted them to the leadership team. Through discussion and review of impact, numbers affected, appropriate purview of the Department of Health, measurability and availability of data, issue is not covered in National Performance Measures, our ability to influence and success in addressing the issue, the Needs Assessment Leadership Team narrowed the list to 10.

The following is the list of Utah's ten priorities for FY11- 2015:

SPM 1: Increase the percent of women of reproductive age (18-44 years) who report that they take a multivitamin pill or supplement containing at least 400mcg of folic acid daily.

SPM 2: Reduce the percentage of primary Cesarean Section deliveries among low-risk women giving birth for the first time.

SPM 3: Reduce the percentage of live births born before 37 completed weeks' gestation.

SPM 4: Increase the percentage of Medicaid eligible children (1-5) receiving any dental service.

SPM 5: Increase the percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings in their practice.

SPM 6: Decrease the percentage of students who smoked cigarettes; smoked cigars, cigarillos, or little cigars; or used chewing tobacco, snuff, or dip on at least 1 day during the last 30 days.

SPM 7: Decrease the percent of adolescents who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the last 12 months.

SPM 8: Increase the percentage of students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on 5 or more of the past 7 days.

SPM 9: Increase the percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.

SPM 10: Increase the percent of children (birth -- 17) eligible for Medicaid DM who are also eligible for SSI.

/2012/ Needs Assessment Summary

a. Changes in the population strengths and needs in the State priorities since the last

Block Grant application

The 2010 Census results were released indicating that Utah's population is more diverse than originally thought at the time of the FY2011 Grant submission. Every population group grew during the ten year period of 2000- 2010. For example the Hispanic population grew almost 78%, Black populations grew almost 66%, the Native Hawaiian/Pacific Islander population grew 62%, Asian by 49%, and Native American/Alaskan Native population grew by almost 11%. The total population in Utah is 2,763,885 representing a 23.8% growth approximately a half million people in growth.

b. Any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application.

During the 2011 Legislative Session, the Department lost additional funding, though not at the drastic levels experienced in the previous three or so years. The economy seems to be picking up slowly and revenue projections indicate an expected increase.

The Title V programs did not sustain any additional state funding cuts, allowing us to stabilize our clinics for CSHCN. We are currently in the process of cutting back on some services, such as pediatric neurology in some of the outlying areas.

c. A brief description of ongoing needs assessment activities, such as data collection and analysis, evaluations, focus groups, surveys, that enable the State to continue to monitor and assess, on an ongoing basis, its priority needs and its capacity to meet those needs.

We have continued to review data and to discuss ways to address the State Performance Measures. We are currently engaged in a process with local health department leadership to review the Block Grant, its requirements, funding allocations, and services provided. The group is the result of legislation that went into effect in July 2010 that mandates review of all federal (and other sources) grants to determine if there is a role for local health departments and if so, to define that role and then to provide funding to support the local health departments' work. We are currently in the middle stages of the review process, having covered the grant requirements, the work to produce the grant, staff paid by the grant and responsibilities of the staff. We have also reviewed contracts and reporting requirements. Next steps include a further review of the role of LHDs and the budget, leading to recommendations to forward to the Governance Committee for consideration.

d. A brief description of any activities undertaken to operationalize the 5-year Needs Assessment, such as establishing an advisory group to monitor State progress in addressing the findings and recommendations resulting from the Needs Assessment.

Several actions that we have taken to operationalize the plans: we now have a position that is dedicated to training on the use of the Ages and Stages tool for child care providers. As we make inroads there, we want to expand the training and use of the tool to health care providers and others. To better address the health of school age children, we created a position for a school health consultant which will address health issues such as medication administration in schools, school nursing, health promotion, etc. We believe that this position is critical in enabling us to identify and address the health needs of the school age population, especially given how few school nurses we have.

In the federal review for FY2011 grant, comment was made about not explaining why certain measures were dropped and others picked up. One of the areas that came into question, youth suicide, is in fact covered in two ways: the National Performance Measure of youth suicide, and the State Performance Measure of youth feeling sad or hopeless. We were unsure why the question was asked as we believe that it is covered, though not identified as a state priority. We clearly stated that if an issue was covered with a national

performance measure, we would not declare it a priority area since we know we have to work on it anyway as a required national measure.

From the FY2011 Grant Application:

"The Leadership Team decided not to include in the list of priority issues any issue that was already addressed in a National Performance Measure so that we could specifically focus on other areas of need."

Additional comments on the changes in state Performance Measures:

Some of the State Performance Measures from the 2006 Needs Assessment were dropped because of health care reform, higher priorities to address, feeling as though we had gotten the message out about some health issues, such as healthy weight before and weight gain during pregnancy and/or difficulty in measuring a state Performance Measure. We decided to put emphasis on late preterm births, most of which are preventable, health concerns for children and adolescents, and coverage and services for children with special health care needs.

As we continue the work needed to address the ten priority areas, we are engaging our key partners, such as representatives of local health departments, advocacy organizations, existing advisory committees, and parents. //2012//

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Utah is largely a rural and frontier state, with the majority of the state's population residing along the Wasatch Front, a 75-mile strip running from Ogden (north) to Provo (south) with Salt Lake City, the state's Capitol, in between. The Wasatch Front comprises only 4% of the state's landmass, but 88% of the state's population. The rest of the population resides in the remaining 96% of the state's land mass comprised of rural areas of more than six, but less than 100 persons per square mile and frontier areas of less than six persons per square mile. Five percent of the state's population lives in the frontier area (70% of the land mass), and 19% lives in the rural portion (26% of the land mass). Utah has 27.2 persons per square mile compared to 79.6 nationally. This leaves vast expanses of the state nearly uninhabited, making the population the sixth most urbanized in the U.S.

For 2008, Utah is the fastest growing state in the nation with an increase of 2.53% since 2007. Utah's population estimate for 2008 was 2,736,424, a 22.5% increase compared to 8% nationally. Utah experienced a 29.6% population increase from the 1990 to the 2000 Census. Utah had five counties that ranked among the top 100 fastest growing counties from the 2000 Census to July, 2009. Washington County had a growth rate of 52.1% (26th in the country), Utah County ranked 34th with a 48% increase, Tooele County ranked 44th with a 43.2% growth, Wasatch County ranked 50th with a growth of 42%, and Iron County ranked 95th with a growth rate of 34%.

While Utah is predominately white, however racial and ethnic minorities now make up a larger portion of the state's population, comprising 17.6% of the state's total population in 2008 compared to 15.1% five years ago. In 2008, the population of every racial and ethnic group grew at a higher rate than the overall state population. Between 2003 and 2008, among the five race categories, the highest growth rate occurred among the Black population (47.1%), followed by Asian (38.1%), Native Hawaiian and Pacific Islander (30.6%), American Indian/Alaskan Native (21.5%), and White (20.5%). In 2008, Hispanics accounted for 12.1% of state's total population, a 23.9% increase since 2003 (10.2%). Foreign born individuals ranked Utah 21st with 8.3% of population compared to US foreign born of 12.5%. Refugee populations in Utah are growing, along with the Hispanic populations, with resultant increasing need for language translation services. These factors impact the health care system's ability to adequately address the needs of the diverse populations.

Utah ranked first for births among women between the ages of 15 - 50 years who gave birth in the previous 12 months at a birth rate 20.16 per 1000 population in 2008 compared to 14.3 per 1000 nationally (2007). Utah continues to have the highest fertility rate in the nation at 40.56 compared to 69.5 births per 1000 women aged 15-44 years for the nation.

Utah continues to have the youngest population in the nation with a median age of 28.7 in 2008 compared to 36.8 nationally. Two areas in Utah have median ages below the state median, Cache County at 24.9 years and Utah County at 24.4 years. These two communities have universities located in their county, so the median age difference may be attributed to a larger population of young students and their children. Utah's population rate of children under age 5 years is 9.8% compared to nationally 6.9%. For children under age 18, Utah's population is 31% compared to 24.3% nationally.

The American Community Survey Summary indicated that for many years Utahns have had larger households compared to the nation. Latest data (2008) indicate that Utah's household size was 3.15 people compared to the national average of 2.62. Utah's average family size was 3.67 people compared to the national average of 3.22. The percent of Utah family households with children is 21.5% higher than the rest of the nation, 39.1% versus 30.7%. Households comprised of single mothers with children are lower in Utah than the nation, 5.5% compared to 7.4%. Utah's median household income was somewhat higher than that of the U.S., \$56,484 compared to

\$52,029. However, Utahns have a significantly lower per capita income in Utah than in the U.S. overall, \$23,198 compared to \$27,589.

Utah's child population is relatively healthy when compared to national data as noted in the 2007 Survey of Children's Health. Over 90% of Utah children are reported to have excellent or very good overall health status compared to the national rate of 84.4%; 76.2% of children are reported to have excellent or very good oral health compared to the national rate of 70.7%. Utah has a lower percentage of children with overweight BMI (23.1%) compared to that national rate of 31.6%, and a higher percentage of children who exercised at least 4-6 days per week (44.3%) compared to the national rate of 34.4%. Utah scored lower than the national rate in the percentage of children having preventive medical visits (80.2% versus 88.5% nationally); however, Utah scored slightly higher than the nation in the percentage of children who received preventive dental visits (79.1% versus 78.4%).

/2012/ The recently released Commonwealth Fund's State Scorecard report for 2011 ranked Utah 23rd among states on overall child health status. The table below provides Utah's scores from the report.

2009 Child Health System Performance Across Dimensions

Dimensions:

Access & affordability 17

Prevention & treatment 25

Healthy Lives 5

Equity 42

In addition, the report indicates that of 21 indicators, Utah had 3 in the "top 5", 7 in the first quartile, 9 in the 2nd quartile, 2 each in the third and fourth quartiles, and one in the "bottom 5" among all states. The report showed that Utah's scores for certain indicators are excellent, such as Utah children having a medical home (14th), children ages 2-17 needing mental health treatment/counseling who received mental health care (18th), hospital admissions for asthma per 100,000 children ages 2-17 (8th), infant mortality (4th), young children (ages 4 months-5 years) at moderate/high risk for developmental or behavioral delays (8th), children ages 10-17 who are overweight or obese (1st), high school students who currently smoke cigarettes (1st), and high school students not meeting recommended physical activity level (7th).

On the negative side, the state's ranking for other indicators is not as good as it should be: children with insurance (36th), children receiving preventive medical visit (46th), children with preventive dental visit (25th), children with oral health problems (33rd), and parents reporting that they did not receive all needed family support services (51st).

Fortunately, even with the poor rankings, Utah is ranked 5th for potential to lead healthy lives. Not to dismiss the need to improve in some areas of health systems and indicators for children, we have a high hurdle to jump to ensure that Utah children continue to have a high potential to lead healthy lives. //2012//

Utah also ranks first for child dependency ratio at 51.8 versus 37.7. Based on the 2008 American Community Survey, Utah had a significantly higher percentage of its population with a high school diploma at 90.4 % versus 85% nationally among individuals 25 years and older. Utah's population is similar to the nation for percent of the population with a bachelor's degree or higher degree (29.1% in Utah compared to 27.7 % of the U.S. population). Even though the proportion of Bachelor's degree and higher education achievement was comparable, Utah has a higher percent of individuals with some college but no degree at 27.4% compared to 21.3% nationally. The high school dropout rate in Utah is lower than the U.S. at 3.1% of youth ages 16 to 19 years old versus 4.4% at the national level for grades 9 through 12. Data from the 2008 survey indicate

that Utah ranks 7th in the country for high school graduation at 90.4% compared to the national rate of 84.1%. In 2008 Utah ranked 17th among states for Baccalaureate degrees at 29.1% and 24th for advanced degrees at 9.4% compared to 10.2% nationally.

The National Center for Education Statistics identified Utah with the lowest funding per elementary and secondary student during 2005 to 2006 at \$5,964 per student compared to the national average \$9,963. Fortunately, the 2007 Utah Legislature approved an increase in teachers' salaries. However the student to teacher ratio is 23.7 students per teacher compared to the national ratio of 15.5 students per teacher. Utah classrooms in general have at least 10 more students per teacher than in classrooms across the nation.

Utah's predominant religion counsels against the use of tobacco and alcohol which consequently results in a lower incidence of diseases associated with abuse of these substances, such as liver disease, alcoholism, and lung cancer. Utahns pride themselves on family values and support many efforts to improve maternal and child health. The political environment is conservative with a fairly large group of individuals who hold anti-government philosophies that at times make it difficult to obtain state funding for state agency programs. Utah is one of the most religiously homogeneous states in the Union. Between 41% and 60% of Utahns are reported to be members of The Church of Jesus Christ of Latter-day Saints (also known as the LDS Church or Mormon Church) which greatly influences Utah culture and daily life.

Based on the Utah Health Access Survey (UHAS), 11.9% of Utah's population reported no health insurance in 2008, a steady increase from previous years. The proportion of uninsured has increased in the maternal and child populations as well. In 2008, 8.4% of children under age 18 were uninsured compared to 7.3% in 2003. Of females ages 18- 49, 14.3% reported no health insurance in 2008 compared to 11.3% in 2003. More than a third (36.5%) of the Hispanic population reported no insurance in the 2008 UHAS. The steadily climbing rates of uninsured individuals in the state especially children and women of childbearing ages, is very concerning.

//2012//The Department released information on the uninsured in Utah early June, 2011. The number of Utahns without health insurance showed little change from the previous year. UDOH reported 301,700 Utahns, or 10.6 percent of the total population, lacked health insurance coverage last year. The data represent a slight improvement from 2009 when 314,300, or 11.2 percent of the population, had no coverage. The change from 2009 to 2010 was not statistically significant. The uninsured rate of children who are eligible for the Children's Health Insurance Program (ages 0-18 with parents' income up to 200 percent of the federal poverty level) remained relatively steady at 12.3 percent compared to 16.3 percent in 2008 when the program was permanently opened to new enrollees. Of adults ages 19 -- 26, 28.6 percent were uninsured, the highest rate of any age group. Obviously women of childbearing age are represented in this group.//2012//

The Governor sponsored a state summit in 2005 to discuss issues related to a state plan to address the increasing rates. The Governor and the state legislature are leading an effort to develop a health care reform package to address the growing population of uninsured. Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger with a significantly lower per capita income in Utah than in the U.S. overall. Based on the 2008 American Community Survey Summary, Utah's median household income of \$65,226 was slightly higher than the U.S. average of \$63,366, ranking Utah 20th nationwide. Due to larger families in Utah, the per capita income ranked the state 45th lowest in the nation at \$18,905.

Utah's 2008 poverty rate (at or below 100% FPL) is well below the national average, 7.6% versus 13.2% nationally. For children under age 18, almost 9% (8.8%) of Utah children live in poverty compared to 19.0% nationally.

The geographic distribution of the state's population presents significant challenges for accessing

health care services for those living in the rural and frontier areas as well as for delivery of health care services. In the rural and frontier areas, many residents are not able to readily access health care services due to long travel distances and lack of nearby hospital facilities and health care providers, especially specialists. Specialists are not available to rural/frontier residents except by traveling hundreds of miles. In addition residents living in the rural/frontier areas may be reluctant, if not unwilling, to utilize certain services in their communities, such as family planning or mental health, because of concern for confidentiality and anonymity in seeking these services in a very small town.

Of particular concern is meeting health care needs of Hispanics due to the increasing number without documentation. These families are more difficult to reach due to language barriers; cultural beliefs about preventive health care; transportation constraints; and ineligibility for many government programs. Prenatal care for women without documentation is a problem since they are not eligible for public assistance, even though their newborns will be citizens and eligible for benefits. In 2009, the then Reproductive Health Program (now Maternal and Infant Health) participated in a qualitative data project of the Center for Multi-cultural Health to obtain data from Hispanic women to better understand their health issues. The Center is finishing a report on a number of health issues of various subpopulations in the state. ***//2012/State legislators have been committed to ensuring that illegal immigrants are banned from public services. Some public health services for children have been exempted from the ban.//2012//***

Utah Title V programs have worked to promote increasing awareness of the Department of Justice regulation announced in 1999 that assures families that enrolling in Medicaid or the Children's Health Insurance Program will not affect immigration status. While programs, such as the Covering Kids and Families Utah Project, have promoted this information, many families remain skeptical about applying for any government programs for fear they will be reported to the U.S. Citizenship and Immigration Services or that their immigration status will be affected. This fear and distrust of government agencies has been compounded by The U.S. Citizenship and Immigration Services (formerly INS) recent raids on Utah businesses with a large undocumented worker population resulting in deportation of the workers. In addition, the 2006 and 2007 Utah Legislatures debated bills restricting undocumented immigrants from obtaining a driver's license, in-state college tuition, and state funded programs and so on. The bills on drivers license, state funded programs and in-state college tuition all passed. The sentiment is not supportive of undocumented workers in the state. ICE has conducted a number of raids of businesses looking for undocumented workers with the result of families being torn apart, leaving some children without any parent to care for them. Raids on Utah businesses have escalated the past several years, with hundreds of undocumented workers being arrested and deported, leaving many children without a mother or father or both parents.

//2012/ Legislation passed in the 2011 Session requires that an adult applying for public benefits must provide proof of legal status before receiving services. The legislation went through numerous revisions until the final language passed through both houses. In addition, legislation was passed that created a guest worker program, which probably is in conflict with federal policy, but it was proposed as a state answer to a problem that the federal government needs to address effectively. Governor Herbert presented the state plan to national policy makers as a possible solution to the immigration issues. //2012//

Maternal and child health services, including services for children and youth with special health care needs, are provided in various settings: through medical homes/private providers; local health departments, community health centers, a clinic for the homeless, migrant health clinics, and several free clinics; itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty centers, such as the University of Utah Health Sciences Center, Primary Children's Medical Center, and Shriners Hospital for Children, and several tertiary centers for high risk perinatal and neonatal care. These centers of excellence provide centralized specialty and subspecialty services to pregnant women, infants and children with high-risk pregnancies, neonatal intensive care, and numerous disabling conditions, such as

asthma, hemophilia, cystic fibrosis, diabetes, Down syndrome, cancer and orthopedic disorders. Although this allows for better coordination of care because there are fewer providers, it also presents a problem of service delivery to high-risk mothers and infants, and special needs children in rural Utah. CSHCN provides direct services in their Salt Lake City office for three specific populations: follow-up of premature infants, developmentally delayed preschool aged children and developmentally/behaviorally disorder school aged children and youth.

Utah's public health system consists of 12 autonomous local health departments (LHDs). Six of the 12 local health departments are multi-county districts and cover large geographic areas. Many districts include both rural and frontier areas within the service region. Many local health departments are gradually moving away from direct services, recognizing that they do not have the capacity to provide primary care for those living in their communities. Each local health department determines which services they provide for mothers and children in their district. In the past few years, we have required the local agencies to conduct an assessment of health care needs for mothers and children. While some districts were reluctant to engage in the process, many found it to be helpful. When you do the same thing for years, sometimes it is difficult to step back and look at what you are doing versus what your needs are. This process helped some local health departments to reassess the services they offer and approaches they use. We since have simplified the reporting requirements due to concern over workload on local agencies.

Services available through LHDs vary district by district. For example, direct prenatal services are no longer available through LHDs, although two districts provide clinic space and support staff for pregnant women served by University of Utah Health Sciences Center providers and Family Practice Residents. Family planning services are available through mid-level practitioners in only a few health district clinics. The shift away from direct services provided by LHDs reflects the changing public health system to focus more on core public health functions, including health promotion and prevention services.

//2012/ In a 2010 survey of local health department nursing directors, about which services each provided out of 24 types of services, the range of services reported varied from 15 - 23 services. Services that are provided by all twelve of the local health departments include: immunizations, injury prevention, Presumptive Eligibility, tobacco cessation during pregnancy and breastfeeding. The services with the fewest local health departments include: mental health services for children and mothers (most local mental health agencies are in different agencies), and prenatal care reported by only three of the local agencies. //2012//

The community health centers throughout the state and the Wasatch Homeless Clinic in Salt Lake City provide primary care to underinsured and uninsured MCH populations. Seven of the ten community health centers are located in rural areas of the state. Two mobile Utah Farm Worker clinics operated under Salt Lake Community Health Centers, Inc. are co-located with Wasatch Front community health centers in Provo and Ogden with a third mobile clinic in Enterprise, Utah. Utah Farm Worker Program's permanent site is located in Brigham City, in Northern Utah. Unfortunately, many of Utah's Hispanic workers, especially along the Wasatch Front, are not engaged in farm work and therefore do not qualify for these services.

Since 1995 Medicaid participants living in Utah's urban counties have been required to enroll in a managed health plan. This requirement is the Choice of Health Care Delivery Program, which is allowed under a federally approved freedom-of-choice waiver. In FY05 the Utah Department of Health's Division of Health Care Financing (HCF), Utah's Medicaid agency, contracted with two managed health plans and one PPO to provide services to Medicaid participants, including children with special health care needs, in Utah's urban counties. In the past, HCF had contracts with four managed care organizations, but health plans struggled financially to continue delivering services to the Medicaid population. One health plan continues to expand into rural areas of the state providing an option for Medicaid participants in most areas of the state. At the present time

enrollment for rural Medicaid participants is voluntary, allowing them the option of choosing either fee-for-service, a primary care provider or a health plan if available in their area. Medicaid participants in all but three rural counties are enrolled in a Prepaid Mental Health Plan for behavioral health services.

The hospital health care system for MCH populations is well developed in Utah, with six large tertiary perinatal centers and three tertiary children's hospitals. We are reviewing data from all birthing hospitals to evaluate which hospitals really meet the criteria for a tertiary center. We would like to promote the importance of have tertiary level maternal fetal medicine physicians (MFM) as part of the definition of a tertiary perinatal center in addition to the neonatologist. In order to have good outcomes, the care of the mother needs to be at a tertiary level. All but one of the perinatal centers has a University of Utah Health Sciences MFM faculty member assigned and are well recognized throughout the state and the Intermountain West as a consultation and referral center for obstetrical and pediatric providers. The centers work with hospitals within their referral areas to encourage consultation and referral as needed, depending on the condition of the mother, infant or child. ***//2012/ We held the first meeting of representatives of the ten hospitals that self designate as Level III neonatal care nurseries The discussion was lively and the outcome of the meeting was that a smaller group of representative of the NICUs will meet to develop a set of guidelines for Level III NICUs. //2012//***

DFHP staff interfaces with faculty and staff from these centers through various efforts, including Perinatal Mortality Review, Child Fatality Review, Perinatal Taskforce, Perinatal HIV Taskforce, clinical services, joint projects, and other committee work. Through these efforts, the need and importance for consultation and referrals between levels of service are emphasized via reports of mortality review findings, or reports on specific topics, such as low birth weight.

Utah, not unlike other areas of the country, suffers from a shortage of certain types of health care providers in different geographic areas, including nurses, neonatologists, dentists, mental health professionals, etc. Provider shortages exist throughout the state. Utah's 2007 physician-to resident ratio was eighth lowest in the nation at 208 physicians per 100,000 resident population compared to a national rate of 271. The Health Professional Shortage Area (HPSA) maps detail areas of the state with provider shortages for medical, dental and mental health providers. Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. The University of Utah Health Sciences Center is currently working on a proposal for a dental school; however, local dentists by and large do not support the efforts. Mental health providers, especially those specializing in children's mental health, are limited, in part due to the mental health system in the state which is a Medicaid carve-out serving primarily the chronically mentally ill, but not necessarily those with acute conditions.

Urban areas also experience shortages of certain types of health care providers, such as nurses, pediatric neurology, genetics, developmental pediatrics and primary care providers who care for adults with special health care needs as they have transitioned from their pediatric providers. Access to maternal and child health care varies depending on the geographic area of the state. According to Health Professional Shortage Area surveys some areas in Utah have high ratios of women of childbearing ages to providers, resulting in limited access to a reproductive health provider in their area. Women in rural communities may have to travel many miles to a provider's office and/or hospital. More than half of Utah's counties are without any obstetrician or gynecologist for the management of high-risk pregnancies. One rural county has no prenatal care or family planning provider of any kind and several counties reported as few as 1 provider to 10,000 women of childbearing age, creating a need to assure better access to consultation services for rural providers.

Even where prenatal care providers are more numerous, under-and uninsured women may be confronted with caps on the number of women an agency is able to accommodate including Presumptive Eligibility determination. However, gaps exist in some areas of the state due to specific geographic situations, such as Wendover, uniquely located in two states with different

rules and regulations governing federal and state programs.

Since the income eligibility level for Utah's Prenatal Medicaid program has not been increased from the original 133% of the FPL since its beginning in 1990, many women and their families, best categorized as working poor, are ineligible for health care coverage, making it difficult for them to access health care, especially prenatal and family planning services. Medicaid's current eligibility level for children birth to 5 years is 133% FPL and 100% FPL for children 6 -18 years of age. Both the prenatal and the children's programs require an asset test for eligibility determination. The asset limit of \$3000 (reduced in 2010 from \$5000) prohibits many families that otherwise would qualify for the program from being eligible. Bills have been proposed in recent Legislative Sessions to remove the asset test without success.

Utah CHIP Program began in 1999 with an income eligibility of 200% of the FPL for children from birth to 18 years. The Program has suffered from budgetary limitations and has had to cap enrollment to stay within its budget. Since opening of the program until 2008, the state legislature had not appropriated enough funding for the program to maintain open enrollment. After inadequate increases in 2004, 2005, 2007, the 2008 State Legislature authorized additional funding for the CHIP Program and designated it as a state entitlement program. Obviously the legislators value the program as they are very reluctant to authorize "entitlement" programs. In March 2002, Secretary of Health and Human Services, Tommy Thompson, signed Utah's Primary Care Network (PCN), which had been approved by the 2002 Utah Legislature. Approximately 25,000 adults with incomes between 100% -150% of FPL without insurance will be able to qualify and enroll for preventive health services under this plan. PCN will enable women who are enrolled in prenatal Medicaid to continue preventive health care coverage for primary preventive care, including family planning services if desired.

Presumptive eligibility for prenatal Medicaid had been problematic in some areas of the state for a number of years, especially in the urban areas with limited Presumptive Eligibility (PE) sites. In 2001 Baby Your Baby by Phone was instituted enabling women annually to apply more easily than in person. For pregnant women ineligible for PE or Medicaid and unable to afford private care are referred to one of two University of Utah Health Sciences Center prenatal clinics located in local health departments or to a community health center located along the Wasatch Front offering sliding fee schedules. In 2008, the Department of Health eligibility workers were moved to the Department of Workforce Services to consolidate all eligibility workers. Though initially concerned that the move would impact customer service, it seems to be working ***//2012/ adequately for some populations. However, special populations, such as children with disabilities or children in Utah foster care or kinship placements are having a difficulties accessing the Medicaid for which they are eligible The difficulty is because Workforce Service intake workers have a general knowledge of Medicaid eligibility, but they often are not knowledgeable about special population Medicaid options. This problem is more common outside the Wasatch Front. The Utah Family to Family Health Information Network gets numerous calls from families who are unable to access Medicaid. //2012//***

Access to low-cost maternal and child health care services provided by community health centers is problematic in several areas of the state since they are not located in many rural areas. Fortunately in the five years new community health centers have opened in the more rural areas of the state. The Association for Utah Community Health, the state's primary care association, works to promote development of new or expansions of existing community health centers in Utah. Free clinics have formed to help address the needs of the uninsured population. Other areas of the state where access to low-cost health care services is problematic include: Tooele County, especially the Wendover area; Wasatch and Summit Counties; Bear River Health District; TriCounty Health District; and portions of Central and Southeastern Utah Health Districts Native American Indian women and their children in Southeastern Utah may have to travel to Tuba City, Arizona for services if they wish Indian Health Service to pay for their care. While the local health departments in all of these areas receive Title V funds, demand for services far outstrip the amount of funding available.

The Child Health Evaluation and Care (CHEC) Program, Utah's Early and Periodic Screening, Diagnosis and Treatment Program, provides coverage for services for Medicaid covered children that are recommended by the American Academy of Pediatrics. The guidelines for the CHEC Program are very similar to the AAP recommendations. The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) found that services and quality varied among small groups of pediatric practices that were engaged in quality improvement processes. These practices served children enrolled in Medicaid and children with private insurance. In 2006, Medicaid changed policy to allow reimbursement to pediatric providers for fluoride varnish applications for eligible children. The service has not been widespread to date, but some pediatric practices are considering providing the service.

Most specialty and sub-specialty pediatric providers are located along the Wasatch Front, including the state's tertiary pediatric care centers, Primary Children's Medical Center and Shriners Hospital for Children. The location of most pediatric specialists and sub-specialists in the most populous area of the state presents a problem for provider access for special needs children in rural Utah. In several counties of Utah, there are no pediatricians or sub-specialists, necessitating families to drive long distances to access care for their children. In most cases, there is only limited additional itinerant coverage from the private sector for this large geographic area. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers. ***//2012/ St. George, in the southwestern part of Utah, is the most promising of the remote areas of the state to begin to build pediatric subspecialty infrastructure. Intermountain Healthcare, a large Utah health system, has opened a St. George based Women and Children's Health Center, serving the five county area. This area is also home for approximately 45 physicians who are both family practice and pediatricians. There is now one metabolic geneticist. Additionally, the Intermountain hospital has a Neonatal Intensive Care Unit. //2012//***

Title V programs across the nation are working toward the six CSHCN core components of: 1) family and professional partnership at all levels of decision-making; 2) access to comprehensive health and related services through the medical home; 3) early and continuous screening, evaluation and diagnosis; 4) adequate public and/or private financing of needed services; 5) organization of community services so that families can use them easily; and 6) successful transition to all aspects of adult health care, work and independence. Over the past 5 years, numerous successful public and private projects have expanded and improved the service system for Utah CSHCN and families at both the state and community level. Despite significant changes and improvements in the system, gaps in services and needs remain as evidenced by data from surveys and reports from parents and providers.

Although components of Utah's system of care have greatly improved for families, the system itself has become increasingly complex, especially in the areas of funding, insurance coverage and the increasing number of Utah residents who are culturally or linguistically diverse. Utah has seen a series of funding cuts over the past 5 years, affecting health, educational and social services across the state. Though Utah has the highest birth rate in the nation and a rapidly growing population, there has been no appreciable increase in the availability of specialty pediatric services over the past several years. Families continue to face formidable barriers in accessing services and coordinating care for their CSHCN. ***//2012/ CSHCN traveling clinics, have been affected by several years of funding cuts, and now are facing a 10% increase in contract costs for physicians. As a result, the frequency of CSHCN clinics has been reduced in some areas. //2012//***

Families continue to face formidable barriers in accessing services and coordinating care for their CSHCN. ***//2012/ To mitigate these problems for families, CSHCN works closely with the Family to Family Health Information Network and has a small contract with the Utah Parent Center to help support information and referral for families of children with autism. //2012//***

The CSHCN Bureau is addressing these issues through the many initiatives, some of which include the Medical Home Initiative and MedHome Portal website, Telehealth, traveling multidisciplinary clinics, the Fostering Healthy Children Program, community based case management teams, Baby Watch/Early Intervention and collaboration with Family Voices and the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) grant. These initiatives are described in greater detail elsewhere in this document.

The current financial situation in Utah is fair to poor. Fortunately Utah has not been impacted as significantly as other states, but the unemployment rates reached an all time high during 2010. The rate is declining slowly as are the demands for services such as Medicaid, CHIP, food stamps and WIC. ***/2012/ Utah's economy has improved somewhat, but not to the level before the recession. However, the enrollment numbers for Medicaid has increased almost 13% from 12 months ago, and Utah's Primary Care Network enrollment has increased 22%. Interestingly, CHIP enrollment is down 10.2% from last year, perhaps reflecting a shift of eligible children from CHIP to Medicaid. //2012//*** The challenge for the Department is that there are few state dollars for services for mothers, children and adolescents, including those with special health care needs and their families. ***/2012/ The University of Utah, which contracts with CSHCN to provide physician coverage for the developmental clinics, is facing concerning budget constraints as well and this will likely result in a reduction of the number of itinerant clinics which CSHCN can provide.//2012//***

Local health departments also struggle to provide services with funding allocations that don't increase making it hard for them to meet the cost of living increases for their staff. The changing economy is resulting in less flexibility with dollars than in the past. State staff is sensitive to the impact that state budget cuts have on local agencies as well, and often will preserve the allocation of federal contract dollars to local agencies by eliminating state level Competition for funding is becoming a matter of carefully balancing what exists with current need, consideration of how the dollars will have the most impact. State level needs, as well as local level needs, may be sacrificed during a time of economic downturn.

As the Title V block grant is reduced by establishment of categorical funding streams, additional financial obstacles particularly when the required outcome has been legislatively mandated by the state, such as the State Dental Director, newborn hearing screening, and so on. While Utah is not suffering the degree of economic turn down that other states are experiencing, we are definitely feeling the impact of the projected decreases in revenues. The decrease in the Title V Block Grant over several years and the fact that the funding allocation has not kept up with inflation rates result in challenges for us to continue to provide the same level of services. Examples include loss of staff positions, loss of content areas, such as SIDS and school nurse consultation.

Documenting disparities at times is difficult given small numbers of populations in which to draw significance. The Department has endeavored to include data on subpopulations in the state in an attempt to better quantify the issues faced by various groups of individuals. The 2004 Legislature appropriated funding for the Center for Multicultural Health, which was supplemented in later years. The Center is housed in the Division of Family Health and Preparedness and assists the Department of Health in identifying priorities and needs of specific key populations in the state, updating an Ethnic Health Report, assessing the adequacy of ethnic data from common public health data sources and recommending improvements, informing ethnic communities about the Center's efforts and activities, and developing guidelines for cultural effectiveness for UDOH programs. The Center plays an important role in bridging the needs of ethnic communities in Utah and the work of the Department of Health and its partners in addressing these needs. The Center works closely with Title V programs to identify ways in which we can work more closely together on MCH needs. ***/2012/ In 2011 the Center was renamed as the Office of Health Disparities Reduction in order to put more emphasis on disparities which may occur among populations not necessarily defined by race or ethnicity. //2012//***

The Center has gathered information to publish "fact sheets" to outline key health issues for each

specific minority population. This approach will highlight the significant health problems for each population rather than by disease or health problem. The three Bureaus in the Division have designated at least one staff member who oversees MCH and CSHCN efforts in regard to multicultural activities and materials. The Center for Multi-Cultural Health has provided cultural competence training for both state and local public health staff. The Center is in the process now of identifying key health issues of each of the subpopulations living in the state. The Center has developed "fact sheets" for each subpopulation that addresses key health needs so that the specific needs of a population are highlighted rather than approaching health issues for minority groups by disease categories. These fact sheets have better enabled staff to focus efforts on the key health needs of each specific subpopulation.

In addition, the Department has a staff person designated as the Liaison to the Native American communities in the state, which is helpful to programs attempting to address the unique needs of the Native American populations.

The health care system in Utah is developing more cultural awareness, especially as the population of Utah changes. The results of a 2009 Department of Health qualitative study of ethnic populations indicated that individuals of ethnic populations feel as though they were inadequately or poorly treated because of their ethnicity; they wanted health care providers of their own ethnicity or providers who could relate to them and their beliefs; they want health care providers to ask them what they need and not assume what they need; they had to wait long times while others who arrived later were seen earlier; they need access to interpreters and materials in own languages; they want acceptance of their beliefs about health and prevention (one doesn't go to doctor if not sick); and, they want providers to be sensitive to gender issues. The Department plans on conducting another qualitative survey of ethnic populations in the state to determine current priorities.

The Division has built capacity for data analysis through the Data Resources Program. The Program has staff assigned to each of the three populations served by Title V programs. The Department has also built data capacity by forming the Center for Health Data which includes Vital Records and Statistics, survey data collection capacity (BRFSS, YRBSS, etc.), development of an Internet-based query system for health data (<http://ibis.health.utah.gov/>) that provides access to more than 100 different indicators and access to data sets, such as birth and death files, BRFSS, PRAMS, YRBSS, hospital and emergency department data, population estimates, and Cancer Registry. The Center for Health Data provides access to large data sets for analysis by Department staff (and others outside the Department as appropriate), and works with programs in the Department to assist in data analysis as needed. Medicaid has developed a data warehouse for Medicaid data that is used by Title V to link with vital records data to track outcomes for Medicaid participants. We still have not been able to access WIC data due in part to the system failure even though the system has undergone significant reprogramming and works well now. The Utah WIC program is part of a three state Consortium developing an entirely new system which is undergoing user acceptance testing during June, July and August. Once that system is installed and operational we should be able to access WIC data.

The Data Resources Program (DRP) includes staff assigned to MCH and CSHCN. The expanded capacity has greatly facilitated access to data, as well as data quality and use of data for program planning efforts. The DRP coordinates the MCH Epidemiology Network that includes staff from MCH, CSHCN and other Department programs to discuss data needs, projects and policy. In 2007, the Data Resources Program formed another working group, the MCH Bureau data group, to discuss data projects and ideas focused only on the MCH populations. Staff from the MCH programs participates in the meetings which provide a forum for setting priorities, developing concepts of a data study, and so on. They enable program staff to learn what the others are doing or would like to do and are able to contribute ideas to each other's projects. CSHCN joined this group which has led to increased awareness of available data and uses for data to encourage more active research efforts within CSHCN programs.

State statutes relevant to Title V program authority and their impact on the Title V program The Title V agency has authority under Statutory Regulatory Authority: Utah Code Ann. 26-1-18; 2610-1,2, 4, 7. This statute outlines the authority of the state agency in provision of Title V services for Utah's population, in developing a state plan for maternal and child health services, including those with chronic health problems. The Division of Community and Family Health Services **//2012/ Family Health and Preparedness//2012//** is the designated state Title V agency is responsible for meeting the federal Title V requirements.

The Utah Administrative Code provides access to medical records for public health surveillance activities, which allows the UDOH to utilize medical records for a variety of programs including the Perinatal Mortality Review Program to review maternal and infant deaths to identify public health issues amenable to prevention.

//2012/ Several state statutes regulate pre-abortion education of women seeking abortions in Utah. In addition, new legislation passed in the 2010 Utah legislative session mandated that women seeking abortions be offered a description of the fetus during an ultrasound if they so desired. The requirements of these statutes are funded with state general funds; however Title V staff has responsibility to assure that they are adhered to. In addition, a law passed in the 2011 Legislative Session required the Utah Department of Health to "license" all clinics, including private physician offices that perform abortions. The law also requires the Department to inspect the clinics twice a year, with one inspection being unannounced. //2012//

Hearing, Speech and Vision Services serves as the coordinator and central registry for State mandated newborn hearing screening under Utah's Newborn Hearing Screening Act, 26-10-6, 1998 General Session, Title 26, amended by Chapter 162. The database serves as the Utah registry for permanent hearing loss.

In 1965, statute (Section 26-10-6) was passed requiring that every newborn in Utah be tested for the presence of phenylketonuria (PKU) and other metabolic diseases, which may result in mental retardation or brain damage. In 2006, newborn screening was expanded to include 32 new tests; therefore the rule for this statute will be updated. The Newborn Screening Program provides tracking and follow up of abnormal screens and diagnostic testing, and provides education to institutions of birth, medical home (providers), and families. In January 2009, the Newborn Screening Program started screening for Cystic Fibrosis leading to 37 disorders being tested currently.

Related legislation or statutes, which impact Utah's Title V programs, include the ongoing challenge of addressing the needs of minors relative to sexuality and prevention of pregnancy, STDs, and HIV/AIDS. Current state law prohibits any government agency, including local health departments, from providing contraceptive information or services to minors without parental consent. The optimal situation is, obviously, parental involvement and the Utah Department of Health has worked, largely through the Title V-funded Abstinence-only Education Program, to promote increased parental knowledge, skills and abilities to discuss sexuality issues with their children in their homes. ***//2012/ In the 2011 Session, legislators passed a bill that will allow minor mothers to authorize their own immunizations. Previous to this bill, an adolescent mother could authorize immunizations and other health services for their child, but not for themselves. Local agencies are supportive of the legislation which will result in improved immunization rates for adolescent mothers. //2012//***

During the 2001 Legislative Session, Utah legislators passed a bill prohibiting the state from applying for CDC funding related to HIV/AIDS Education due to misunderstanding of CDC requirements for use of the funding. This legislation limits the state's ability to promote reduced risk for HIV/AIDS among its student populations. The impact of this mandate has resulted in the loss of YRBS funding as well. The political climate regarding CDC funding is unfortunately so controversial that the State Office of Education had not sought federal funding to continue YRBS

Surveillance. *//2012/ The State Office of Education has applied for and received funding for the YRBSS. //2012//* The Utah Department of Health coordinates this survey in collaboration with the State Office of Education and with support for data analysis by CDC.

Oversight of sex education curriculum approval in the state was moved from the State Office of Education to the local school district. This shift in oversight may in fact result in a less rigorous review than might occur at the State Office of Education level. Educational funding was changed to school district block grants for certain funding components allowing school districts to determine allocation of the funds. Included in the block granting was school nursing, raising a concern that school districts will prioritize other issues higher than school nursing. The 2007 Legislature appropriated \$1 million to the State Office of Education to enhance school nursing in the state. At this point, it is not known what the impact of the additional funding will have on the school nurse to student ratio.

Violence and Injury Prevention Program's statutory authority derives from the Utah Department of Health's (UDOH) responsibility for health promotion and risk reduction as defined in the Utah Code 26-7-1: "The department shall identify the major risk factors contributing to injury, sickness, death, and disability within the state and where it determines that a need exists, educate the public regarding these risk factors, and the department may establish programs to reduce or eliminate these factors."

The UDOH has also been empowered to "establish and operate programs necessary or desirable for the promotion or protection of the public health or which may be necessary to ameliorate the major cause of injury." The local health departments also have authority to "conduct studies to identify injury problems, establish injury control systems, develop standards for the correction and prevention of future occurrences, and provide public information and instruction to special high risk groups".

During the 2005 Legislative Session, a number of bills were passed that impact maternal and child health care in the state, such as increasing the CHIP budget by \$3.3 million, adding additional funding for the Center for Multicultural Health in the DOH, licensing of direct entry midwives the, including administration of some medications, with requirements for training. Bills that have not passed that impact health care included removing the asset test for pregnant women and children for Medicaid eligibility determination.

A state law went into effect January 2010 requiring all driver's license applicant to provide two official forms of identification, such as birth certificate, passport, etc. A driver's license was not considered adequate to demonstrate documentation. The legislature does not look kindly at undocumented individuals and is attempting to make access to services very difficult.

Each program that addresses the health of mothers and children has a specific program plan that identifies goals, objectives and activities. The process of strategic planning for each program varies from program to program. The Maternal and Infant Health Program, (formerly the Reproductive Health Program) has developed a plan based on the National and State Performance Measures and the one state Outcome Measure. *//2012/ now 2 state outcome measures //2012//* Each staff member is assigned responsibility for one or more measures. For other programs, each is assigned responsibility for the related National and State Performance Measures in their program plans. Additional goals and objectives are developed by each program as issues arise, such as the need for dental services for pregnant women is incorporated in the Oral Health Program plan. Generally each program holds an annual program staff retreat to review the previous year's accomplishments, strategies and needs. Based on these discussions, program managers amend program plans as needed. The annual report and application process provides an opportunity for each program to review its accomplishments and to amend their program plan as needed based on its achievement of the assigned measures.

An attachment is included

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

/2012/The Utah Department of Health has strong programs supporting the health needs of mothers, children and youth, including those with special health care needs and families. Services occur at all levels of the pyramid. MCH/CSHCN/CD program management oversees programs funded with other sources such as WIC and Part C. With the 2009 Department reorganization, most MCH and CSHCN programs were assigned to the Deputy Director of the Division of Family Health and Preparedness, Nan Streeter. Included are three Bureaus: CSHCN, Child Development (CD) and MCH. Other than Violence and Injury Prevention and School Health, MCH/CSHCN/CD programs are administered together by the Deputy Director. The reorganization has provided opportunities 1) one administrator to foster programs working together; 2) review of programs, budgets and issues with a fresh eye./2012//

/2012/Department executive leadership is assessing if the Department will seek accreditation within the next five years. The Title V Director is included in this effort./2012//

Title V staff continually reviews the needs of underserved mothers and children to prioritize resources. Staff identifies and weighs factors limiting access or availability of services across the state in partnership with community organizations and interested others. Staff develops plans and interventions to support health needs. Division staff review and analyze MCH data and produce reports, fact sheets, abstracts and articles for publication. Several published peer review journal articles included Division staff.

Budget shortfalls impacted MCH/CSHCN programs. The Governor has imposed a hiring freeze at least until July 1, 2010. As a result, we have 26 vacant positions. CSHCN programs have been impacted significantly with state cuts of \$1 million due to its large portion of state funds. In 2009 \$1 million was cut in the CSHCN budget, but restored for one year. In 2010, the funding was not restored, resulting in a shift of Title V funds, loss of staff, or discontinuation or reduction of clinic services. Some staff members have been reassigned to other work.

Title V programs

The Department has many programs that address needs of women, mothers, children and youth including those with special health care needs, and families. Some are fully funded with Title V dollars, while others are partially funded or funded by other sources, such as state or other federal funds. Programs outlined below provide preventive and primary care services to pregnant women, mothers, infants, and children and youth including those with special health care needs.

Bureau of Child Development

The Bureau of Child Development is a newly formed and brings together programs for young children: child care licensing, early childhood systems, Head Start State Collaboration Office, Early Intervention and the Office of Home Visiting. Plans are underway to hire a child development specialist to train providers on the ASQ and ASQ/SE tools to increase developmental screening in children. We will also recreate a lost position, the Child Health Nurse Consultant, to cover overall children's health not addressed by other programs. ***/2012/we have hired a School Health Consultant to address needs of school aged children and youth housed in the Bureau of Health Promotion (BHP) in another Division. Many BHP programs work with schools, so this facilitates coordination./2012//***

The Child Adolescent and School Health Program was dissolved in 2009 due to budget cuts. Two staff members were moved to the Child Development Bureau while the Adolescent Health

Coordinator, whose work has a strong reproductive health focus, was moved to the Maternal and Infant Health Program (MIHP), formerly the Reproductive Health Program. These moves are a better fit in that early childhood and reproductive health efforts are better aligned allowing improved collaboration.

CSHCN Bureau

The CSHCN Bureau oversees eight programs ~~/2012/now 7/2012/~~ focused on improving the statewide system of care for CSHCN and their families. The Bureau provides services through local and itinerant clinics, care coordination for children seen in clinics and for target groups of children such as those in foster care and those dependent on technology living at home. The Bureau works closely with hospitals and health providers to ensure that all newborns receive hearing and blood screening. CSHCN staff works closely with medical homes / primary care providers to ensure care is coordinated. Families are billed for clinic services on a sliding scale based on Federal Poverty guidelines. Clinics are primarily funded by the Title V grant, Medicaid, CHIP, state, and private insurance. Newborn blood screening kit fees now partially fund newborn hearing screening and fully fund the Newborn Blood Screening program.

The Bureau oversees efforts for the Autism Infrastructure Project in its third year of a HRSA ASD/DD system development grant which focuses on improved identification of cases and analysis of prevalence data. The Utah Newborn Screening Information Exchange project (UNSHIE) will expand the Child Health Advanced Records Management (CHARM) project which allows sharing of health data among different data systems. CSHCN continues other initiatives including the Medical Home, Transition for Youth; SSI outreach, information and referral.

Utah Birth Defect Network (UBDN) is a population-based statewide surveillance and research program. UBDN provides the basic infrastructure to monitor all pregnancies and infants with a birth defect in Utah. These data provide the necessary information to assess the prevalence of phenotypes, trends over time, and serve as the case group for research.

Developmental Consultative Services provides developmental evaluation, diagnosis, and referral to community resources throughout Utah for children under 8 who are at high risk of developmental delays or chronic disabling conditions. CSHCN clinicians coordinate services with the Medical Home or primary care provider for recommended follow-up and referral to appropriate services and early intervention programs.

Family Involvement and Leadership provides information and support to families of CYSHCN and the professionals who serve them. Families' needs and perspectives guide the information and support provided. Individual consultations, group trainings, publications and web-based educational materials are continually developed and enhanced through partnerships with other family and disability organizations. CSHCN programs collaborate with the Parent Training and Information Center, Utah Family Voices and the Family-to-Family Health Information Center to ensure family participation in all programs and services.

Utah Medical Home Program supports 22 medical home and 5 dental home teams statewide for children with special health care needs in primary care settings, building capacity for comprehensive, family-centered, coordinated, culturally competent health care. Medical Home teams include a parent partner, a care coordinator and office staff trained in the Medical Home model of care. For the past 3 years, staff has collaborated with the ASD MCH Grant to recruit and train 26 new practices and six additional dental practices with emphasis on rural Utah and family medicine physicians. The UofU Department of Pediatrics hosts a website developed through this collaboration that contains information on diagnosis, special education, transition, family, coding and resources for providers and families. The website is being adapted for six other states. www.medicalhomeportal.org.

Neonatal Follow-up Program tracks very low birth weight babies less than 1200grams through

their first

2 1/2 years. The program follows health and growth status, neurological function, learning and attention abilities, development, hearing and vision, behavior, language, school performance and social skills through periodic screenings. A summary report is shared with the Medical Home or primary care provider and respective newborn ICU. ***/2012/Admission criteria were changed to coincide with the national trend of following babies below 1250gms. The program has a new manager and a new developmental pediatrician./2012//***

Newborn Hearing Screening oversees mandated hearing screening. The program is responsible to assure all infants born in Utah are screened for hearing loss before 1 month of age; have a complete diagnosis before 3 months if they fail the screen, and as needed be referred for appropriate intervention before 6 months.

Pregnancy Risk Line (PRL) provides health care providers and consumers with accurate, current information on potential risks to a pregnant woman, fetus or breastfed infant due to exposure to drugs, alcohol, tobacco, chemicals, or infectious agents. PRL handled over 11,000 calls in FY10. PRL provides training and mentoring for pharmacy, nursing and genetic counseling graduate students. PRL collaborates with other agencies to educate about the dangers of alcohol, tobacco and other drugs and resources for treatment.

Specialty Services includes Hearing Screening and specialty services, such as physical and occupational therapy, transition and SSI outreach. The program oversees contracts with University and private providers for pediatric specialty care. Transition and SSI information and referral are available statewide through a CSHCN toll free line. CSHCN's transition services focus on a broader education approach for providers and families.

Maternal and Child Health Bureau

The Maternal and Child Health Bureau oversees four ***/2012/now 5 with Pregnancy RiskLine/2012//*** programs, three ***/2012/now 4/2012//*** of which are primarily funded with Title V funding: Data Resources, Maternal and Infant Health, and Oral Health. WIC is discussed later. The MCH Bureau oversees local health department contracts for services to mothers, children and youth. The Bureau also oversees the MCH Block grant application and needs assessment with input from CSHCN and other Department programs.

Data Resources provides analytic resources and statistical expertise for assessing the health status of the MCH/CSHCN population, planning and evaluating services and is headed by the MCH Epidemiologist with several staff. The staff is proficient in data linkages, such as Medicaid and vital records.

Maternal and Infant Health Program (MIHP) has six components. prenatal and family planning focus on access to care, Presumptive Eligibility, and enhanced Medicaid services in the underserved areas. The Perinatal Mortality Review reviews infant deaths and pregnancy related maternal deaths to identify trends and issues that, with change, might prevent future deaths. The adolescent health component works closely with stakeholders to analyze, prioritize and address critical adolescent issues. MIHP also includes PRAMS funded with CDC and state funds, and state-funded WeeCare, case management for high risk pregnant women enrolled in the Public Employees' Health Plan.

Oral Health Program, headed by the State Dental Director, promotes prevention to reduce dental decay and other oral diseases and increase access to services. The program provides technical assistance to LHD and others in the community.

The Violence and Injury Prevention Program, now in another Division, works to reduce injury with specific focus on youth... The program includes: prevention of school injury and youth suicide, pedestrian and bicycle safety, motor vehicle occupant protection, Utah Safe Kids Coalition, and child fatality and domestic violence fatality reviews. The program also works to prevent falls, rape

and sexual assault.

Other programs that serve mothers and children

Baby Watch/Early Intervention (EI) contracts with local entities to provide EI services for young children birth to 3. Local programs are available statewide through 15 organizations.

Fostering Healthy Children Program (FHCP), through contract with Division of Child and Family Services (DCFS), oversees and coordinates health, dental and mental health needs for children in DCFS custody. Nurses work with DCFS caseworkers to ensure children get required and follow-up health services. Nurses provide training to biological and foster parents so they can care for the child's health needs. Health care requirements for children in foster care were mandated by federal court settlement agreement.

Head Start State Collaboration Office (HSSCO) works with state agencies and others to promote better collaboration between agencies that provide services for young children. The HSSCO Director negotiates MOAs with state agencies for data sharing and other services. For example, the state WIC program shares health data such as hematocrits, saving unnecessary repeat testing. ***/2012/The 2011 Legislature cut state funding required as match, which will not allow us to apply for the funding./2012//***

Newborn Screening Program oversees the state newborn blood screening of 39 conditions and follow-up for positive screens. The program works closely with birthing hospitals to improve compliance for timely accurate bloodspot samples. CSHCN will issue "report cards" for hospitals and providers to improve the quality and timeliness of samples.

Office of Home Visiting (OHV) supports infrastructure for implementation of evidence-based home visiting programs to prevent child abuse. OHV supports programs through local collaboration, public awareness of the effects of abuse on children, families and communities and support of evidence-based practice. ***/2012/OHV oversees the ACA Home Visiting funding and works with other Department programs such as Medicaid, Injury Prevention, and Maternal and Infant Health. OHV will work with staff responsible for P--5 Home Visiting and the Medicaid Targeted Case Management./20112//***

Travis C. Waiver for Technology Dependent Children, Medicaid's Waiver for Technology Dependent Medically Fragile Children, offers home and community-based alternatives to nursing facility placement for those under age 21 requiring services of such complexity that they can only be safely and effectively performed by, or under the direction of, skilled nursing professionals. Waiver services augment and extend traditional State plan services including supportive services to relieve the parent/primary care giver from the stress of providing continuous care.

WIC provides services to more than 67,000 pregnant and postpartum women and young children annually. The program has earned a national reputation of leadership in several areas including an online system for vendors to enter food prices, early implementation of the new food rules, etc. WIC works with other programs on nutrition and obesity. /2012/WIC has rolled out its new system, VISION, to 10 of the 12 LHDs with great success. It will be statewide by fall./2012//

/2012/We now fund a portion of the Department's Patient Safety Coordination related to improved outcomes for mothers and children./2012//

State program collaboration

The Division collaborates with many programs and agencies in and outside the Department to improve services for mothers, children and children and youth with special health by other programs, other state agencies or community-based organizations. CSHCN and MCH programs work with the Department of Workforce Services, the Child Care Board, early childhood efforts,

home visitation, and Head Start. The Child and Family Services Division contracts with the Fostering Healthy Children Program described above. The Department works with the Division of Mental Health and Substance Abuse (DMHSA) on a variety of efforts, such as the Early Childhood Systems grant and UDOH's Adolescent Health Network.

UofU Department of Pediatrics and the Utah Chapter of the American Academy of Pediatrics oversee pediatric quality improvement efforts of UPIQ (Utah Pediatric Partnership to Improve Healthcare Quality). The state Title V Director and the Medicaid Assistant Director represent the agency on the UPIQ Steering Committee. UPIQ partners with Intermountain Healthcare, UofU, and HealthInsight (Utah's PRO). UPIQ sponsors Learning Collaboratives that bring practice teams together to learn QI principles and develop plans to apply the process. UPIQ is very involved in Utah's CHIPRA grant by helping make changes in quality health care for children and participating in the development of an integrated information system that starts at birth and follows children as they receive other health services, such as newborn hearing screening, newborn blood screening, immunizations, etc.

The University of Utah (UofU), Department of Psychiatry has served as a medical consultant for youth suicide prevention efforts. Utah State University (USU), especially the Early Intervention Research Institute (EIRI), has worked closely with the CSHCN Bureau on grant projects. This year CSHCN worked with Champions for Healthy Communities to begin a 5 year needs assessment of community based systems of care for CSHCN. USU, UofU and CSHCN work together on the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) project for advanced degree health care providers who work with CSHCN and families. In 2009, URLEND received two supplemental grants for mini projects focused on autism and hearing follow up.

Additional information is in Section E.

State statutes relevant to Title V program authority

In 1965, statute (Section 26-10-6) requires that every newborn in Utah be tested for PKU and other metabolic diseases. Newborn screening has since expanded to 39 disorders. The statute also includes mandatory hearing screening for all babies born in Utah. The Department is given statutory authority over certain records and data with provisions for privacy and confidentiality. For example, the Perinatal Mortality Review program is able to obtain prenatal and hospital medical records in review of infant or maternal deaths.

State law requires state agencies and political subdivisions, including LHDs, to obtain written parental consent before providing family planning information or services to unmarried minors, presenting a significant barrier to adolescents seeking family planning services. In 2001 a bill passed that prohibited the state from applying for CDC funding for HIV/AIDS education due to a misunderstanding of CDC requirements. The legislation limits the state's ability to prevent HIV/AIDS among its student populations. For a period of time the legislation resulted in loss of YRBS funding, but when CDC unbundled YRBS, the State Office of Education (USOE) successfully sought funding. Utah's YRBS does not include sexual health questions.

In 2009 SB 21 requires the Department to establish a committee of Department and LHD representatives (Governance Committee) to review federal grants to determine if the funding allocation to the LHDs is "fair". The law requires that federal grant funds may not be disbursed or encumbered by the Department before committee approval. Committee members review grant guidance to determine if the funding allocation is appropriate. The law went into effect July 2010. The Committee was formed early and has focused on 7 federal grants including Immunizations, STD, Cancer Control, PANO, Tobacco, Diabetes, and the Preventive Block grant. After these, the Committee will review other federal grants **/2012/such as the MCH Block Grant/2012//**.

Numerous statutes regulate abortion with one that particularly impacts Title V. Utah State Code 76-7- regulates informed consent for abortions, mandating that the Department publish print

material and a video that: provide medically accurate information on all abortion procedures; describes the gestational stages of an unborn child; and includes information on public/private services and agencies to assist a woman through pregnancy, childbirth, and while the child is dependent, including adoption. The law requires that materials be provided to any woman seeking an abortion. In 2010, slight changes were made, allowing the materials to be posted on the Department website, and that any woman considering an abortion who opts to have a free ultrasound prior to her decision may request information about the fetus during the ultrasound. Numerous other statutes govern public health, but they are too many to elaborate on.

State support and coordination for communities, LHD, CHCs

Title V dollars go to each local health department through contracts to support services for mothers and children in their districts. In our work with the LHD, we promote medical home, but also recognize that families do seek services at LHD for convenience. More information is below. Section C describes state support for LHD and community health centers, coordination of health services with other community services.

The Department provides Title V monies to local health departments (LHD) to address the needs of mothers and children in their districts. Each LHD has a contract to provide injury prevention activities. Another Title V contract provides funding for overall MCH services and Prenatal to Five home visiting. With these funds, LHDs provide services, such as family planning, presumptive eligibility for prenatal, oral health, preconception concepts, growth and development assessment, access to insurance, healthy weight for mothers and children, etc. Some LHDs have co-located services, such as immunizations in WIC clinics.

Preventive and primary care services for pregnant women, mothers, and infants

Reproductive health services, in some degree, are offered by the twelve LHDs with 11 providing Presumptive Eligibility (PE) screening and 10 performing prenatal risk assessment. LHDs assist the mother in finding a provider and other resources. Only 2 LHDs (Salt Lake and Weber/Morgan) support prenatal services but services are provided by UofU physicians and the Midtown CHC Family Practice Residency Program. A small amount of MCH funding for the Salt Lake Community Health Centers, Inc. supports prenatal services to uninsured women.

PE screening by phone, initiated in 2001, has been effective in getting eligible women to access early prenatal care. The on-line application system, UtahClicks, for PE, Head Start, Early Intervention, and CSHCN rolled out in 2006, has effectively helped families access public programs. When the state launched a new public assistance application system in 2009, use of UtahClicks dropped drastically, so the Division is strategizing ways to promote its ongoing use.

LHD family planning services have decreased considerably in the past 5 years. Only 7 LHDs provide complete family planning service, with 3 offering some service and 2 not offering any service. Low cost reproductive health services on a sliding fee scale are available in Wasatch Front and rural community health centers and in Planned Parenthood Association of Utah (PPAU) clinics, the state Title X grantee. MCH has a strong relationship with PPAU with a great deal of collaboration on many common issues.

Comprehensive health care for the homeless is available in one Salt Lake clinic including PE and family planning through a contract with PPAU. Centro de Buena Salud, a migrant health center, provides PE screening and prenatal care to eligible women. Prenatal care and family planning services are available to Native American women in Salt Lake City at the Indian Walk-In Center; in Southeastern Utah by the Utah Navajo Health Systems, Inc., and in northeast Utah at the Fort Duchesne Ute Reservation Indian Health Service facility.

Preventive and primary care services for children

Primary care services for children are provided in a variety of settings: private practice, LHDs, CHCs and free clinics. Medicaid eligible children along the Wasatch Front enroll in one of two Medicaid HMOs. LHDs do not provide primary care for children, but they do provide other

services such as immunizations.

All LHDs and CHCs are Vaccine for Children (VFC) providers, but shortages exist in the state, especially in rural and frontier areas. The Immunization Program has worked diligently to increase VFC providers by tying Medicaid provider enrollment with automatic VFC provider enrollment unless a provider opts out. The change has resulted in a significant increase in providers in the program.

In 2009, the Office of Home Visiting (OPHV) was created with federal grant funds to support evidence based home visiting programs. Salt Lake Valley Health Department started a Nurse Family Partnership Program with local funding. Community-based organizations have implemented Healthy Families America programs in four communities. The Department of Workforce Services has given the Office \$1 million over two years to support the local programs. Other LHDs are interested, but lack funding. We are very interested in expanding home visiting programs in the state. ***/2012/Currently there is no political will to support statewide home visiting leaving communities with no programs without resources. OHV supports existing programs in high risk areas; however, it plans to provide learning opportunities f so that communities understand the resources needed to start new programs./2012//***

A serious gap in services for children is the low school nurse to student ratio, along with lack of UDOH staff to support health for Utah children. Some school nurses are employed by LHDs, while others are school district employees. One of the serious challenges for school nurses is compliance with state laws on medication administration, such as epi-pens, glucagon and others and the Nurse Practice Act. In 2009, the UDOH's School Health Advisory Committee started to address the health needs of children and youth in schools. Representatives from various entities participate in its work and a subcommittee was formed to explore applying for CDC Coordinated School Health funding for the next funding cycle.

UDOH had been integrally involved in a state-level coalition for early childhood systems development, the Early Childhood Council (ECC). The Council included heads of state agencies that provide services to young children, service providers, and advocates. However, the ECC has not met since the change in governors. Until after the November election, we won't have a sense of the Governor's commitment to early childhood. The Governor's Deputy of Education is leading an effort to apply for ARRA funding for the Early Childhood Advisory Council as part of the Head Start reauthorization.

Staff works with Medicaid and CHIP staff to promote better access to health care for young children and youth. The state MCH/CSCHN Medical Director and the State Dental Director sit on the authorization committee for Medicaid and CHIP to authorize services for children.

The Oral Health Program supports fluoride rinse and sealant activities in schools. In fall 2010 the program will survey children ages 6-8 years for dental caries experience. We will compare 2010 results with 2005 data to identify trends and areas of need. Since two large counties have added fluoride to water supplies since 2005, the survey may provide important data to measure the impact of water fluoridation.

Primary care services for youth and young adults with special health care needs
Primary care services are not readily available throughout Utah for CYSHCN due to Utah's vast rural and frontier areas. Health care advances have allowed children with complex conditions to live longer and have more productive lives, however, adult primary care providers are often not familiar with the conditions and support needed for rare or complicated conditions.

Many children, youths, and adults with special health care needs are Medicaid recipients and low provider reimbursement rates are a barrier to finding providers. Routine preventive dental care for children, youth and adults with special health care needs is especially difficult to access because many dentists are reluctant and/or not trained to treat individuals with disabilities. The CSHCN

Transition and SSI work in the Specialty Services Program addresses some of these issues through information, referral and Transition to Adulthood training for Utah Medical Homes. CSHCN staff has been instrumental in developing transition modules on the utahmedicalhome.org website. CSHCN staff collaborates in the Utah State University's Center for People with Disabilities project "Becoming Leaders for Tomorrow". The CSHCN Bureau Director chairs the State Rehabilitation Council, which guides provision of rehabilitation services to youth and adults throughout Utah. The CSHCN Bureau collaborates closely with the Utah Developmental Disabilities Council and the CMS Medicaid Infrastructure Grant, "Workability".

CSHCN oversees direct clinical services, statewide consultation, education on several disorders, including communicative disorders, information about particular birth defects, exposures to medications, infections, chemicals, etc. for the public. The Bureau provides direct clinical services through multidisciplinary diagnostic evaluation and care coordination in CSHCN clinics in Salt Lake City and 9 other locations. CSHCN satellite clinics have been reduced: the Provo CSHCN, Ogden neurology and the Cedar City hearing clinics were eliminated and neurology clinics are being reduced.

Staff works with families in a consultative model, identifying community resources to support health needs. Transition services focus on community infrastructure building, training for families and providers, and informational materials. In Salt Lake, developmental clinics will be held jointly with the University of Utah (UofU) with the University billing for pediatric services provided.

Since Utah rates of autism exceed national estimates, the CSHCN Bureau provides state leadership to bring together agency representatives and advocates who influence services for children with autism spectrum disorder (ASD) and their families. CSHCN hosts the Utah Autism Initiative Committee, a multi-agency workgroup, and actively participates on the Autism Council of Utah. The Utah Registry for Autism and Developmental Disabilities (URADD) collects and manages prevalence data on Utah children with ASD and other developmental disabilities. UDOH and the UofU Department of Psychiatry jointly and successfully applied for additional CDC funds to expand surveillance activities. The Bureau received a 3 year award for the HRSA Autism Spectrum Disorder and Developmental Disability (ASD/DD) grant to focus on expanding state service infrastructure for children with ASD/DD and promoting early screening, diagnosis and treatment. New medical home practices will be recruited and trained on providing a Medical Home to children with ASD/DD and their families with emphasis on rural Utah and family medicine physicians. Dental practices will be trained to become "dental homes" for children with special needs. The program includes a "Learn the Signs Act Early" project in a pilot Early Intervention site to be adapted throughout Utah if successful. The medical home website contains information on diagnosis, special education, transition, family and other resources for providers and families.

The Utah Registry for Autism and Developmental Disabilities (URADD) recently reported that the measured administrative prevalence of ASD doubled from 2002 to 2008 in 8 year old children with the best estimate of ASD risk for Utah children as 1 in 77. The reason for the marked increase is not clearly understood at this time and is thought to be related to many factors, including increased public and provider awareness.

Culturally competent care that is appropriate to the State's MCH populations
The Department's Center for Multicultural Health (CMH) was created in 2004 through legislation (Utah State Code 26-7-2) that mandates the Center to:

- Reduce health disparities and improve health outcomes of multicultural populations.
- Improve access to healthcare for multicultural populations.
- Promote cultural competence.
- Improve translation and interpretation services at health agencies.
- Coordinate research, education, health promotion and screening activities related to multicultural and minority health issues.
- Share information about multicultural and minority health issues.

- Facilitate the Ethnic Health Advisory Committee.
- Help public/private organizations and advisory committees with minority health issues.
- Seek federal funding and other resources to accomplish its mission.

//2012/The Center was renamed the Office for Health Disparities Reduction to reflect a Department philosophy that disparities exist in a broad range of populations, such as low income, low education, etc.//2012//

The Center hosts monthly Ethnic Health Advisory Committee meetings that involve community leaders to discuss health issues for different populations and works closely with other Department programs and community organizations to promote cultural awareness. The Center spearheaded a committee to address issues of workforce diversity. The CMH works with Department programs and the minority and ethnic community on health issues of specific populations in the state. The Center compiled a study on health issues for different ethnic groups. Utah health indicators by race and ethnicity for many health conditions, such as overall health, access to care, health behaviors, infant health, reproductive health, infectious disease, chronic disease and injuries and violence are posted on the Department's website and are easily accessible to the public. The CMH published a report on "Public Health Messages from Utah's Racial and Ethnic Minority Populations" in 2008 presenting qualitative data from focus groups held with 17 ethnic community populations on their experiences with health care in the state.

The CMH website is full of information on many topics and in many languages. The CMH provides health education materials in many languages to assist health professionals in communicating with people who don't speak English or have a low English proficiency. In addition, on the website is Yahoo! Babel fish which allows anyone to enter words for a rough translation into twelve different languages.

The Center offers trainings to Department staff as well as local public health workers who are interested. Also, the Connection Newsletter is widely distributed which includes grants, jobs, training opportunities, upcoming events and articles about health, cultural competence and health disparities. Every month the Center sponsors a "Brown Bag" on an issue related to disparities or information about different ethnic and racial groups that make up Utah's population. An example is in February 2010, the Brown Bag focused on cardiovascular health disparities including obesity, tobacco use, diabetes, high blood pressure, etc. Website:

<http://www.health.utah.gov/cmh/>

//2012/Staff has worked with a Somali refugee leader in Salt Lake City, who was interested in education on "pregnancy spacing." He says "The women have a baby, go home, and next you know they are pregnant again." The leader was clear about acceptable types of family planning in their culture, Cycle beads and Depo Provera. He didn't want to talk about "birth control" or "family planning," but specifically pregnancy spacing. In meetings with the leader and members of the community to discuss their needs, they wanted us to train female members in Cycle Beads so they can train other members. Translation is a problem since the Somalian women do not speak English and are illiterate in their own language. These women are mostly home with their children and dependent on their husbands as they do not drive or "work". They have no formal way to learn English. Simple pictorial handouts of the female reproductive system and paper calendars were distributed to help track their menstrual cycles. Using this simple method facilitates education on fertility awareness. We have suggested that we return to discuss pregnancy spacing with men in the community and the leader is receptive.//2012//

An attachment is included in this section

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

/2012/ In January 2011, Gary Herbert became the 17th Governor of Utah, having succeeded in an election for completion of former Governor Huntsman's term of office. He will hold the office as Governor until 2012 when an election will be held for a full four year term. It is anticipated that Governor Herbert will run for Governor in 2012. //2012// Previously he had served as the Lt. Governor and was appointed Governor when former Governor Jon M. Huntsman, Jr. was appointed by President Obama as Ambassador to China. Governor Herbert had retained the Utah Department of Health's Executive Director, David N. Sundwall, who was originally appointed by Governor Huntsman, through his non-elected term as Governor, ***/2012/ Dr. David Sundwall resigned as Department Executive Director in mid January 2011. Deputy Director, David Patton, PhD, was appointed by the Governor to serve as the new Executive Director. Dr. Patton has years of experience in public administration and brings a wealth of experience and expertise in administration to the department. Utah law requires that if the Executive Director is not an MD that a Deputy has to be appointed that is an MD with a degree in public health. Dr. Patton has selected Robert Rolfs, MD, MPH as his deputy executive director. The Executive Director of the Department is a cabinet level position reporting directly to the Governor. //2012//***

Due to discussions among Utah legislators during the 2009 Legislative Session to dismantle the Department of Health, ***/2012/ now former Executive Director//2012//*** Dr. Sundwall initiated a Department-wide reorganization. The reorganization has resulted in four divisions being collapsed to three: Division of Family Health and Preparedness, Division of Disease Control and Prevention, and the Division of Medicaid and Health Care Financing. Former Title V Director Dr. George W Delavan retired in June 2009 which provided the Department an opportunity to examine its organizational structure. The reorganization allowed the Department to implement cost savings and align programs in a different way.

Utah's Title V programs, the MCH and CSHCN Bureaus, were moved into a new Division: Family Health and Preparedness. The Division is headed by Marc Babitz, MD, a primary care physician with many years of experience in primary care practice, national and regional positions. The Division also includes EMS, emergency preparedness, and primary care clinics. Unfortunately the Bureau of Health Promotion and the Immunizations Program were moved to the other Division. Dr. Babitz has appointed Nan Streeter as the state Title V Director and Deputy Director of the Division of Family Health and Preparedness over the MCH and CSHCN Bureaus and the newly formed Bureau of Child Development (CD). In addition, Harper Randall, MD was appointed the MCH/CSHCN/CD Medical Director.

The Division is organized into six Bureaus comprising approximately 30 programs. Each program reports to a Bureau Director. Since the Division also includes EMS, primary care, and health facility licensure, Title V programs have new opportunities to work more closely with these programs. Title V programs are housed in several bureaus in the Department both in the Division of Family Health and Preparedness and the Division of Chronic Disease Control and Prevention, a sister Division. The Division also includes other programs that address the health of Utah's mothers and children including the state Part C program, WIC program, and others.

The senior level management staff of MCH, CSHCN, and CD bureaus brings a wealth of experience and depth of training to their respective program areas. They have the opportunity to lead an expert staff of about 200 individuals to improve the health of Utah's residents. CVs for senior management are attached. The Bureau of Child Development is headed by Teresa Whiting. Teresa has background in child development, child care, Head Start state Office of Child Care and child care licensing. She has headed the Department's Bureau of Child Care Licensing, and now has expanded her responsibility to include other programs related to children. The CSHCN Bureau includes eight programs and the state Part C program, Baby Watch/Early Intervention. The Bureau Director is Holly Williams who is a Master's prepared nurse with more than 30 years of experience. The MCH Bureau includes 4 programs that specifically focus on mothers and children. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse, who brings more than thirty years of experience to this position.

Organizational charts are attached.

Describe concisely how the State health agency is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V" [Section 509(b)]. The Utah Department of Health is responsible for administration of programs that are carried out with Title V funding by housing the majority of Title V funded programs in the same Division, Family Health and Preparedness distributed among the three bureaus described above. The Department of Health's organizational structure provides for oversight of programs and budgets by program managers, bureau directors and the Division Director. The Department has a number of programs that address the needs of women, mothers, children and adolescents including those with special health care needs, and families. Some programs are fully funded with Title V dollars, some with partial Title V funding and some that are funded with other sources of monies. In addition, each Bureau oversees contracts that allocate Title V funds to LHDs, CBOs and academic institutions. Local health department funding supports services for mothers and children, P-5 home visiting and injury prevention. With the five year needs assessment, we will review the funding allocations to determine if we are adequately addressing identified priorities with the funding available.

Programs funded by Title V

The program descriptions outlined below provide the services of preventive and primary care to pregnant women, mothers, infants, and children as well as services for children and youth with special health care needs.

Each of the three Bureaus includes programs that specifically address the needs of mothers and children and are funded by Title V funds: the Bureaus of Child Development, Children with Special Health Care Needs and MCH. Bureau of Child Development includes 2 program positions funded with Title V funds, the currently vacant child development specialist and the child health consultant. The Bureau also includes the Head Start State Collaboration Office, the early childhood systems project, Early Intervention (Part C), Office of Home Visiting and child care licensing. Having all the childhood programs together will be advantageous in accomplishing improved collaboration and coordination of efforts.

Programs that focus on mothers and children

The programs are described in more detail in Section B.

Child Development

The Bureau includes the child development specialist and the child health consultant, both vacant positions. It also oversees the Early Childhood Systems grant. It also includes BabyWatch/Early Intervention, Child Care Licensing, the Office of Home Visiting, and the Head Start State Collaboration Office. ***//2012/ The 2010 Legislative Session cut the state funds that were used as match for the federal Head Start State Collaboration Office grant which will result in the Department having to forego future applications for funding beginning July 1, 2011. It is unfortunate that the funding was cut because the purpose of the Bureau of Child Development was to bring together all the early childhood programs to integrate work and activities. It is unknown at this time where the grant will go after June 30, 2011. The Governor is responsible for designating the grantee agency for the state. //2012//***

Children and Youth with Special Health Care Needs Programs

The eight CSHCN programs include: Fostering Healthy Children, Newborn Blood Screening, Specialty Services, (including Newborn Hearing Screening), Developmental Consultative Services, Neonatal Follow-up, Utah Birth Defects Network, and the Technology Dependent Waiver programs. ***//2012/ The Pregnancy RiskLine program has been moved to the MCH Bureau to coincide with the Bureau's mission of improving overall health of mothers and children. The program focuses on prevention and therefore really is not a CSHCN program. //2012//***

Maternal and Child Health Bureau Programs

The four MCH programs include: Data Resources, Maternal and Infant Health, Oral Health and WIC. The Maternal and Infant Health Program includes PRAMS and WeeCare, a case management program for pregnant women enrolled in our state public employees' health insurance program. ***//2012/ The Bureau now consists of five programs, with the shift of Pregnancy RiskLine to the MCH Bureau. //2012//***

Other programs that reach mothers and children:

Violence and Injury Prevention Program (VIIPP) works to reduce injury in the state of Utah, with a specific focus on youth injury prevention. The Baby Your Baby Program (BYB) and other health promotion programs including asthma, diabetes prevention, Tobacco Prevention and Control are housed in a sister Division, but work closely with MCH programs.

A new program was started last year, USDA's Commodity Supplemental Food Program (CSFP), started to take applications in March 2010. CSFP provides supplemental food for eligible women and children as they transition off WIC services and for eligible elderly individuals.

An attachment is included in this section.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Number and location of Title V program staff

Division staff members are primarily housed at the main building, the Martha Hughes Cannon Building, or at the clinical services building, the Center for Children with Special Health Care Needs.

CSHCN staff is based at the Center for Children with Special Health Care Needs located adjacent to Primary Children's Medical Center (PCMC) and the University of Utah Health Sciences Center (UUHSC) and within one mile of Utah's Shriners Hospital for Children. CSHCN offers clinical services at the SLC Center as well as in Provo, south of Salt Lake, and Ogden, north of Salt Lake. Some Salt Lake City based staff provide services in outlying areas of the state through itinerant clinics and other state staff is stationed in local communities. For example, twenty-eight nurses work throughout the state in the Fostering Healthy Children Program. The Specialty Services Program has SLC staff and outstationed staff in the southeast area (Moab) the east (Price) and in Ogden including an occupational therapist, audiologist, a speech pathologist and one support staff. The CSHCN pediatric clinics have 3 outstationed staff in Ogden, 2 in St. George, a growing community in southern Utah, and contract staff in 7 rural LHD satellite sites to support the CSHCN itinerant clinics.

In 2009 due to budget cuts the Provo multidisciplinary satellite clinic was discontinued and Utah County children are referred to SLC clinics. In July 2010 Newborn Followup Program clinics in Provo were halved to once a month. The satellite clinic staff is reduced to 3 RNs and 2 support staff. In 2009 CSHCN closed the Cedar City HSVS office and is closing its Price HSVS office this year. Services to these sites will be centralized and provided through itinerant clinics.

MCH Programs are located at the main Department building. Programs in the Child Development Bureau have moved from the main Department building to the clinical services building in the past month or so.

Senior Level Management

Senior level management is highly experienced in maternal and child health, including children and youth with special health care needs and families, administration, and program planning and evaluation. Marc Babitz, MD, is the Director over the Division of Family Health and Preparedness

(DFHP).

Three Bureau Directors oversee the Department's MCH/CSHCN programs. Teresa Whiting, with the Department for 4 plus years, oversees the Bureau of Child Development. Teresa has a degree in child and family development and extensive experience in child care, Head Start and program administration. Holly Williams, who oversees the Bureau of Children with Special Health Care Needs, has worked in the Department for 30 years. Harper Randall, MD, Medical Director of Maternal and Child Health/Children with Special Health Care Needs/Child Development, with extensive experience in community pediatrics, has been with the Department for 6 years. She works with a number of programs, such as autism, newborn blood screening, child death review, perinatal death review etc. The Deputy Director of DFHP, Nan Streeter, is also the state Title V Director and oversees the bureaus of CD and CSHCN. She is also responsible for administration of the Maternal and Child Health Bureau programs. Ms. Streeter has been with the Department for 20 years.

Division program managers are all well experienced skilled health professionals with significant experience in their field and in program administration, planning and evaluation.

Staff that provides planning, evaluation, and data analysis capabilities

Department data capacity is very strong and focused around the Center for Health Data (CHD) which serves as the central point for state health data. CHD includes the Office of Vital Records and Statistics, the Office of Public Health Assessment (OPHA), the Office of Health Care Statistics, and the Office of Public Health Informatics. The Division has strong working relationships with the four CHD offices and is intricately involved in projects, such as the cHIE grant, and other Department data projects. CHARM (Child Health Advanced Record Management), housed in CSHCN, links newborn hearing screening with newborn blood screening, vital records and immunizations. CHARM will enable providers to look up a child's records to determine immunization status, newborn screening results, etc. Eventually CHARM will be incorporated into the cHIE system to link multiple data sets. Division staff is part of the oversight committee for several grants awarded to the Office of Public Health Informatics.

CHD oversees the legislatively mandated Health Data Committee which is responsible for publication of hospital performance data on various measures, such as Cesarean deliveries. The Office of Health Care Statistics is responsible for health plan surveys and reporting plan performance annually and inpatient, ambulatory, and emergency room data. The Center's website includes "MyHealthCare in Utah" which is designed to help consumers make informed decisions about their health care.

The Office of Public Health Assessment (OPHA) includes Department health survey functions. BRFSS and PRAMS phone follow-up are done by the OPHA survey center. A major strength for the UDOH data infrastructure is the on-line Indicator-Based Information Query System (IBIS). IBIS acts as the primary point of data access and houses numerous data sets all easily accessible for use.

Division planning and evaluation occur primarily at the program level with support from Division and Department data resources. The MCH Epidemiologist ensures that data linking and data related to mothers and children are available to staff. The MCH Epidemiologist, also the Manager of the Data Resources Program, is very skilled and adept for the work and has extensive experience in survey development. The program is an invaluable resource to programs. MCH staff continues to partner with Medicaid to link birth and Medicaid eligibility data to assess birth outcomes among Medicaid women. With the Medicaid Data Warehouse, we have been able to access eligibility and claims data easily. Data Resources staff are skilled in data linkages which is very helpful in comparing the general population to CHIP and or Medicaid.

The MCH Epidemiologist hosts regular meetings of the MCH Epi Network to share data issues related to mothers and children. The MCH Epi Network is well attended by Title V staff and

Department staff including the CHD and its offices. The Network addresses critical issues related to MCH and CSHCN to share results or to problem solve an issue. Feedback from Network members has been invaluable for presentations, policy setting and review of data analyses. The Division has successfully submitted abstracts to national meetings for presentation and staff participated in the development of the national preconception health indicators.

A data group for MCH Bureau programs was formed several years ago to discuss common data needs and interests. Originally the focus was only on MCH, but last year, the group was expanded to include CSHCN staff. Initially CSHCN staff was reluctant to participate, but with time more staff has come to the meetings with great interest because they generate ideas and support for work.

Number and role of parents of special needs children and youth on staff

The CSHCN Bureau hired the Director for the Utah Chapter of Family Voices (UFV) as the Bureau family advocate. She is a parent of four special health care needs children with over 20 years of experience in parent self-advocacy training through the Utah Parent Information and Training Center (UPC). She has been very active on the Utah Medical Care Advisory Council for Medicaid, the Utah Legislative Coalition for People with Disabilities and the URLEND project. She has been integrally involved with the establishment of Utah Collaborative Medical Home Project and has provided support to the 23 trained parent advocates in the individual Medical Home practices across the state.

The Family to Family grant was awarded to Utah Family Voices (UFV) in 2008. Services for families continue through the Utah Parent Center, UFV and the Family to Family Health (F2F) Information grant. Although funding for the F2F Information Center has been uncertain, it is probable that HRSA will fund centers through the health reform legislation. CSHCN has provided funds to the Utah Parent Center to support their Autism Hotline. This year, CSHCN reallocated some ASD/DD carryover funding to support the F2F Center because CMS funding ends. CSHCN has dedicated MCH funding to enhance family-to-family activities and support development of a family database. Through this grant two Family Health Partners have been hired and trained to assist in family-to-family health information and education. The funding will reimburse families for their consultation and involvement in development of materials for various projects, such as the F2F project, the Utah Collaborative Medical Home project, the URLEND project and medical residency training. This funding also helped to establish a toll free information and referral line staffed by trained parents.

Through the F2F grant, a statewide Family Advisory Committee was established which includes families of CYSHCN, a young adult with special needs, key CSHCN staff, private providers and a Medicaid representative. The Utah Collaborative Medical Home Project collaborates with this committee. The committee stakeholders insure that the F2F Center project is effective in addressing the needs of Utah families of children and youth with special health care needs. UFV received a Health Insurance and Financing Technical Assistance Initiative through the federal Maternal Child Health Bureau. With this initiative, UFV has conducted parent focus groups to ascertain issues of health care insurance and financing parents of CYSHCN face. The results will be used to develop a parent focused tool kit for the MedHome Portal website and the findings will be published for key stakeholders to use in outreach efforts and policy development.

The Utah Family Voices Director is involved with the Family Advisory Committee at Primary Children's Medical Center (PCMC), Utah's tertiary pediatric facility. The committee will help develop best practice policies for family centered care through PCMC. Issues of discharge planning and linking hospital care to community services for children and youth with special health care needs are being addressed. The advisory committee has been established as a forum in which families of children and youth with special health care needs can resolve issues and problems of hospital care.

The toll-free Baby Your Baby Hotline provides information and referrals on providers and/or

financial assistance for prenatal care, family planning, well childcare, nutrition services, or other related services. The hotline staff collaborates well with community resources to ensure that information is current. The hotline is viewed as a valuable resource for both callers and community resources. Budget cuts in 2009 resulted in loss of staff, increasing the workload of the remaining staff.

The Department of Health employs about 174 ***/2012/ now 210 FTEs due to the reorganization //2012//*** FTEs at the state level to provide services to the public and infrastructure for addressing the needs of mothers and children, including those with special health care needs and their families. The state staff includes physicians, registered nurses, nutritionists, social workers, psychologists, audiologists, physical and occupational therapists, health educators, and other disciplines.

State staffing has been fairly stable which is helpful for continuity of operations. With the aging public health workforce, the agency has lost or will lose some highly experienced staff. Late 2009, the Department Executive Director offered an "early retirement incentive" if an employee retired before mid January. A number of employees took advantage of this offer, leaving the agency with vacant positions without the ability to fill them until the Governor lifts the hiring freeze he imposed in January 2010. Given the current economic environment, it is doubtful that staffing will increase in the MCH workforce at present.

We do not track staffing or FTEs at local health agencies since they are autonomous. However, it is important to note that one staff member in many districts wears several different hats in their daily work. Each health district has a Health Officer, Nursing Director, WIC Director and other health professionals. Because the state law doesn't require local health officers to be MDs, only two employ an MD as the Health Officer. All Nursing Directors are registered nurses. WIC Directors have various backgrounds with some being Registered Dietitians.

E. State Agency Coordination

Utah Title V programs coordinate efforts with numerous other Department programs, and outside agencies such as the Utah State Office of Education, Juvenile Justice, School for the Deaf and Blind, the Office of the Courts, and the Utah Highway Safety Office, LHDs, private not-for-profit organizations and community based agencies to improve the health of mothers, children and children and youth with special needs. ***/2012/The Division is represented on the state mandated Coordinating Council for People with Disabilities in which all state Divisions serving children and adults with disabilities are represented./2012//***

Mental Health and Social Services/Child Welfare

The Division works closely with the Department of Human Services, which serves the maternal and child population statewide in the areas of child welfare, mental health and substance abuse. For a number of years, the Department staff has sought to strengthen the relationship with the Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) with varying success. Administrative changes in the DSAMH have resulted in a high turnover of staff, including the children's mental health director and Division Director. These changes have made it difficult to engage their staff in our work. Their staff has been involved in our committee work and vice versa, such as DSAMH advisory committees and work with the Pregnancy RiskLine to promote messages about the impact of alcohol consumption during pregnancy.

The Division has developed a strong collaborative working relationship with the Division of Children and Family Services (DCFS) and Child Protective Services in a number of efforts, including providing services for children in foster care through a contract with the UDOH's Fostering Healthy Children Program (FHC). FHC is an exceptional program that ensures these children and youth receive needed services. CSHCN staff participates on the Health Care

Consortium Council for the Division of Child and Family Services (DCFS), which advises the DCFS Board on health issues for children in their system. UDOH Division representatives sit on the DCFS Child Abuse and Neglect Council, and an inter-agency group, Utah Prevention, to address substance use and other issues among youth. Division representatives are part of an inter-agency group to address youth transition issues.

The Baby Watch/Early Intervention (BWEI) Program works with DCFS to develop policy and procedures for CAPTA requirements for referral of children with substantiated abuse and neglect to BWEI. New DCFS procedures require child protective personnel to do developmental screening of children birth to three at the initial home visit. Children who show potential problems are referred to BWEI. Local BWEI agencies partner with local DCFS personnel to train on the developmental screening tool and design referral procedures for children suspected of a developmental delay.

The Interagency Coordinating Council (ICC), which provides advice to the BWEI, has 25 members representing the early childhood services community. The state brings together clinicians, political appointees, parents of special needs children, and administrative representatives of various agencies or providers such as mental health, human services, education, Department of Insurance, Head Start, Workforce Services, Division of Services for People with Disabilities, physicians and representatives from Early Intervention providers to provide a broad vision of the service system based upon the participation and contributions of providers and consumers.

Education

The Department works with the State Office of Education (USOE) on a variety of projects and issues, such as adolescent health, special education, school health. ***./2012/and state vocational rehabilitation services./2012//*** Previous difficulties in working with the State Office have resolved and we find the staff to be very supportive of collaboration with us. The Department engaged the State Office in discussions of submitting a grant to CDC on comprehensive school health and they have been very enthusiastic and supportive of this particular collaboration with the Department. UDOH has started a working committee to include the State Office staff to address issues related to school health. State Office staff is excited about this opportunity and have been supportive of what the Department wants to do to improve school health. USOE would apply for the next funding cycle for the CDC Coordinated School Health grant. USOE and UDOH staff is very interested in submitting a grant application probably in 2012 or 2013. We will continue momentum to work on school health regardless so that we can address the many needs of school age children and youth. The MIHP collaborated with the USOE and Planned Parenthood of Utah on an Adolescent Preconception Health Initiative supported by AMCHP. USOE was actively involved in this initiative. CSHCN Bureau and the Office of Students at Risk (SARS), the state special education program, enjoy a strong working relationship and have collaborated on a number of projects, such as Medical Home and the development of several learning modules on the MedHome Portal. A SARS staff member sits on the Medical Home Advisory Committee. CSHCN Bureau and SARS have worked together on the Utah Registry for Autism and Developmental Delays (URADD) grant. ***./2012/ UDOH now has a School Health Consultant to address health issues in schools and work with the Office of Education and school nurses./2012//***

Corrections

Traditionally the Division has not worked much with Corrections, however during the past year Maternal and Infant Health Program staff has initiated discussions with prison officials on providing education to female inmates on family planning. Data have shown us that many women of childbearing ages who have unintended pregnancies report using a contraceptive method, obviously incorrectly, or report non-use, requiring some education about contraception and its various methods. Women in prison and those transitioning to parole need this information to make informed decisions about their reproductive lives.

Medicaid

The Utah Department of Health houses the state Medicaid agency and very fortunately Title V enjoys a strong relationship with Medicaid. Since Utah's CHIP Program, a stand-alone program, is administered by Medicaid, we are able to collaborate with the CHIP Program as well. The Division works closely with Medicaid staff on pregnancy related services, EPSDT, oral health and other Medicaid administered programs that serve mothers and children. Medicaid provides match for a number of our programs that serve the Medicaid populations, such as Baby Your Baby outreach, PRAMS, etc. Medicaid developed a targeted case management (TCM) model for children up to age four in collaboration with Title V staff.

The Maternal and Infant Health Program has worked with Medicaid to certify smoking cessation interventions for pregnant Medicaid participants; provide case management to a subset of high-risk pregnant Medicaid women in Salt Lake County; and to ensure information for, outreach to, and access for Medicaid eligible children and youth with special health care needs and their families. Two Medicaid eligibility workers at the CSHCN clinics work with the Travis C. Waiver Program, CSHCN clinics and other Medicaid staff at two adjacent tertiary care facilities.

The MCH/CSHCN/CD Medical Director is a member of Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee, which meets twice a month to determine authorization for non-covered services for Medicaid recipients. The CSHCN Bureau Director and Medical Director serve on Medicaid committees and assist Medicaid with authorization of needed services for children with special needs. The Medical Director, State Dental Director and physical therapist sit on the CHEC authorization committee, but voting privileges are held only by the Medical Director and the Dental Director. The CSHCN Family Advocate Coordinator/Utah Family Voices director sits on the Medicaid Advisory Committee. ***/2012/With the state Dental Director on the committee we are able to continue to promote the importance of dental care. The Medical Director played a key role in the development of a proposal from Medicaid for an ASD waiver which was presented to the Utah legislature./2012//*** The Medical Director started quarterly meetings with Medicaid and the UUHSC Genetics Director to improve the coordination of EPSDT coverage of genetic testing for children.

The Oral Health Program has well-established relationships with Medicaid and CHIP to improve accessibility to Medicaid/CHIP dental services. Program staff collaborated in defining a basic scope of CHIP dental benefits; ensuring that eligible children can be seen by "any willing provider"; and, expanding CHEC (EPSDT) outreach programs for case management for children needing dental services. Program staff has been instrumental in working with Medicaid to cover fluoride varnish application by non-dental providers, i.e., pediatricians. Medicaid identified a medical billing code for this service for pediatric providers. SSI, DDS and Vocation Rehabilitation

The SSI Specialist position in CSHCN, established over ten years ago, continues to work with the Office of Disability Determination Services (DDS) that evaluates disability claims for SSI eligibility by reviewing DDS claims and providing outreach and referral for potentially Medicaid eligible children. The specialist provides information, referral and enabling services to families having difficulty accessing or utilizing services, such as Utah Legal Services, Disability Law Center or DDS. ***/2012/The CSHCN Bureau Director has participated for 5 years on the State Rehabilitation Council, advisory for all state vocational rehabilitation services provided through the Office of Education./2012//*** CSHCN staff is active in the Utah Center for Assistive Technology Center under Vocational Rehabilitation on advisory boards and coordinating direct care for individuals with disabilities.

Local public health agencies

The relationship between the local health departments (LHDs) and the MCH/CSHCN programs has had a strong history of working together, often in spite of tensions between the Department and the local health officers. Fortunately program staff generally does well in relating to their colleagues in the LHDs.

However, the relationship between the Department of Health and the LHDs reached such a level of conflict that it has been very difficult to proceed with any effort involving LHDs. In fact, LHD leadership supported a bill in 2009 that mandates UDOH to present any federal grant application to a Governance Committee consisting of UDOH representatives and local health officers. The local health officers are seeking additional funding from federal grants that could be allocated to the LHDs because they believe UDOH is keeping an unfair share of the funding. The Governance Committee was formed early in 2009 and went into effect July 2010. It remains to be seen how this process will work to improve services at the state and local level. To date, the Governance Committee has reviewed several grants and no funding has shifted to the LHDs because they are infrastructure grants. ***/2012/The Governance Committee assigned review of the Title V Block Grant to six UDOH staff and six LHD staff. The group started meeting in February 2011 and will continue to meet to discuss the grant and reach consensus on recommendations for the Governance Committee./2012//***

The Department provides Title V funds to LHDs via contracts. More about the LHD role in providing services for mothers and children is included in the Section B. State staff meets with local health officers and nursing directors during their meetings as needed or requested. Representatives of the local health officer association and the local nursing director association participate in various Division advisory committees or task forces to ensure their input and support.

Federally qualified health centers and state primary care association

While the relationship with community health centers (CHC) is positive and collegial, it always needs nurturing. Some LHDs see CHCs as "competitors" rather than a community resource which obviously doesn't support collaboration between the two entities. In fact, one local health department and community health center do not work together at all due to bad feelings that have developed between the two agencies.

However, UDOH has a positive relationship with the CHCs and the Primary Care Association, AUCH, Association for Utah Community Health. With Department reorganization, Title V programs are in the same Division as the Primary Care Office which will enable us to work more closely. Division staff has a strong collaborative relationship with the State Primary Care Association and the community health centers by invitations to sit on Division advisory committees, etc. We have a very small contract with the Salt Lake Community Health Center for prenatal care for uninsured women.

The Oral Health Program works with AUCH, Utah's PCA, to provide technical assistance to their dental clinics and encourage the addition of dental clinics in other community health centers. Now that the Title V programs are in the same division, we expect to work more closely with state and local staff. ***/2012/Unfortunately the state legislators cut primary care grant funds to CHCs because they believe the CHCs get adequate funding from the federal government. UDOH will have to cut any contracts with CHCs per Legislative intent./2012//***

Title V staff has for the past several years been invited to review grants submitted by community organizations and LHDs for the Department's primary care grant program. This program is important as it funds clinics and/or services that would otherwise not be available. Grants are awarded to agencies in urban and rural/frontier areas of the state. Unfortunately state funding cuts for this program have reduced the number of grants available. Projects funded include many to improve oral health, family planning, mental health and other services that are needed by MCH populations in communities.

Professional organizations:

The MCH/CSHCN Medical Director sits on the Executive Committee of the Utah Chapter of the American Academy of Pediatrics. Staff works with members of the Utah Chapters of the American College of Ob/Gyn, the American College of Family Practice and the American College of Certified Nurse Midwives on various projects.

Tertiary care facilities

The Division has effective relationships with many of the tertiary facilities in the state, seven perinatal centers and two children's centers. The Newborn Follow-up Program provides outcome data to the newborn intensive care units in the state. The University of Utah Health Sciences Center, a tertiary perinatal center, works closely with MCH Bureau staff on various grant projects. Our staff often provides linked datasets to the University for studies or grant applications.

/2012/The Maternal and Infant Health Program queried all delivering hospitals on neonatal care and capacity related to provider types, availability, and support services. Ten facilities self-designate as Level III, but only three met the AAP criteria. The Program met with hospital representatives to discuss survey results and to discuss criteria for Level III designation. The definition of "continuously available" is the sticking point in defining Level III./2012//

/2012/The Perinatal Mortality Review Committee engages medical staff from the UofU neonatology and maternal fetal medicine to review infant deaths due to perinatal conditions and women of childbearing ages who die within 12 months of a pregnancy. The Committee reviews each case to determine if the death could have been prevented./2012//

Primary Children's Medical Center (PCMC) and Shriners Hospital for Children, the two children's hospitals in the state, work closely with CSHCN to coordinate services. PCMC physicians ***/2012/as well as the MCH/CSHCN Medical Director./2012//*** participate in the Department's Child Fatality Review Committee to identify those deaths that possibly are preventable. The MCH/CSHCN/CD Medical Director is involved in University of Utah and PCMC based health services research committee. The CSHCN Family Advocate Coordinator serves on the PCMC Family Advisory Committee. The Utah Collaborative Medical Home Project, a collaborative effort with the UofU Department of Pediatrics, Utah State University (USU), Medicaid and Utah Family Voices, provided outreach and support to medical homes statewide for children with special health care needs. The project is guided by an advisory committee of pediatric and family practice physicians, families, allied health professionals and other partners, such as education, vocational rehabilitation and Medicaid.

/2012/The ASD grant recruited new medical home teams to participate; 26 practices and six dental homes have participated in Medical Home training, which has been provided jointly through the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) and CSHCN through HRSA ASD/DD grant funds. When the grant ends, CSHCN plans to continue to support medical homes through consultation and site visits as requested. CSHCN will collaborate with the UofU in providing support to CSHCN Medical Homes through the CHIPRA grant. CSHCN will also continue to collaborate with the UofU and Center for People with Disabilities in providing leadership training through the HRSA URLEND grant to professionals who serve children with disabilities and their families./2012//

Pediatricians from the UofU Department of Pediatrics are contracted to provide developmental pediatric assessments at CSHCN Salt Lake City and satellite clinics. Neurologists and geneticists from the UofU are contracted to provide sub-specialty evaluations at CSHCN satellite clinics.

Intermountain Healthcare, the state's largest health system, owns four perinatal centers and one pediatric tertiary care center. Department staff works with providers in these centers on a number of initiatives, including induction policies, appropriate delivery site for very low birth weight infants, electronic medical records, Perinatal Task Force, etc.

Public health and health professional educational programs and universities

Two universities and a private college offer a Master of Public Health degree (UofU, Brigham Young University and Westminster College). The UofU also offers a PhD in Public Health. None of the programs has a specific focus on maternal and children health, but rather a more traditional

public health focus.

The Utah Department of Health developed the Great Basin Public Health Leadership Institute, (GBPHLI) with the Nevada State Health Department. GBPHLI graduated its first class in 2005. The program continues to enhance Department leadership capacity.

Title V staff members have been involved with the Rocky Mountain Public Health Education Consortium which provides a number of educational offerings through on-site educational opportunities, such as the MCH Summer Institute, a MCH PH Certificate Program through the University of Arizona and distance learning opportunities, such as on-line modular courses. The Consortium is a collaboration of academic and state, local and tribal MCH leaders working to provide workforce development opportunities for public health professionals working in areas with a dearth of educational programs. The Division has sponsored several staff members to participate in the MCH PH Certificate Program and several have gone on to obtain their MPH degrees. However, with budget cuts, we are not able to sponsor staff participation. ***/2012/We no longer are able to support this./2012//***

MCH and CSHCN staff has been involved with several colleges and Universities in the state as well as out of state providing internships for students in these programs and others, such as nursing, pharmacy, pediatric medicine, social work, dental hygiene, and health education. CSHCN provides internship sites for University of Utah audiologists, social workers and clinical experiences for students and trainees through its multi-disciplinary clinics and through the Pregnancy RiskLine.

UofU faculty from different departments is involved in a number of Department efforts to improve the health of mothers and children, such as advisory committees, the Perinatal Mortality Review program, Child Fatality Review Committee PRAMS Advisory Committee, and others. The UofU Departments of Family and Preventive Medicine and Obstetrics and Gynecology invite Division staff to collaborate on a perinatal Epidemiology workgroup for projects related to mothers and children. The Department of Obstetrics and Gynecology often asks our MCH Epidemiologist to compile data sets for analysis, to support grant applications and grant requirements, such as a NIH-funded fetal death project. Faculty members are available for technical and clinical questions.

UofU Pediatric faculty serves on CSHCN advisory committees, including the Early Intervention Inter-agency Coordinating Council, the Medical Home Advisory Council, the Newborn Hearing Screening Advisory Committee and the Genetics Advisory Committee. The Medical Home Advisory Committee was dissolved at the end of the HRSA grant and the membership was revamped into the CSHCN Executive Group (CEG) to include key community advisors to CSHCN, including the UofU Department of Pediatrics, Utah State University (USU) Center for People with Disabilities, and Utah Family Voices. Other partners are invited to participate as specific issues arise. The CEG meets quarterly.

Utah CSHCN is in its third ***/2012/tenth/2012//*** year of the MCHB-funded Utah ***/2012/Regional/2012//*** Leadership Education in Neurodevelopmental Disabilities (ULEND) program. CSHCN collaborates with USU Center for Persons with Disabilities and University of Utah, Department of Pediatrics, in an MCHB Leadership Grant. UREND provides opportunities for students and professionals in health related disciplines (pediatrics, physical and occupational therapy, speech-language pathology, psychology, nutrition, social work, audiology, pediatric dentistry, genetics, nursing, business/marketing, special education and families) to increase their knowledge and skills in providing services and supports to children with neurodevelopmental disabilities. CSHCN collaborates with the UREND supplemental grants, in its fifth ***/2012/tenth/2012//*** year for audiology and ASD. ***/2012/A new UREND application has been submitted to continue for the next 5 years./2012//***

Other federal grant programs

The Division is the recipient of a number of federal grants from CDC, USDA, HRSA, etc, including

Early Intervention (Part C), WIC, PRAMS, Autism, Hearing, IT, oral health, and others as they become available.

WIC

The state WIC Program which is in the MCH Bureau greatly enhances opportunities for coordination of efforts. WIC has a strong collaboration with other programs focused on the health needs of mothers and children. Other programs have enthusiastically welcomed the collaboration opportunities with WIC. WIC staff members participate on various committees related to maternal and child health, including the Perinatal Task Force, MCH Epidemiology, nutrition, and data integration efforts.

The challenge remains, however, to get local agencies to view WIC as a program that has opportunities to promote healthy mothers and children through collaboration and integration of services. WIC committed to funding a half-time data analyst in the Data Resources Program to support review and analysis of WIC data. Program staff has much improved access to use of WIC data for program planning.

Family Planning Programs

The Title V agency has enjoyed a very strong relationship with the state Title X agency, Planned Parenthood Association of Utah (PPAU). The Chief Executive Officer of PPAU has participated for a number of years on various advisory committees and task forces to address the needs of women of reproductive age in the state. The Maternal and Infant Health Program provides technical assistance and consultation to LHDs on family planning services, methods and their use.

Family Leadership and Support Programs

CSHCN employs the Utah Family Voices Director to ***/2012/ lead the Family Leadership and Support programs which /2012//*** provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. ***/2012/ Family Voices was awarded the next three years of funding to continue the Family to Family Health Information project, under the Utah Parent and Information Center. Through the Family to Family Project information and referral is provided to families through a toll free information phone bank. Both the Utah Parent Center and Utah Family Voices provide resource information and support to families of children and youth with special health care needs, as well as leadership training and mentoring for parent leaders./2012//*** CSHCN includes families in the Part C interagency coordinating council.

F. Health Systems Capacity Indicators

Introduction

The Health System Capacity Indicators are measures to a certain degree of the capacity of Utah's system of health care for mothers and children.

a) The Program's ability to maintain or improve the HSCIs is facilitated by review of the data to determine if we are moving in the right direction or not. This information may tell us that we need to continue doing what we're doing, adapt what we are doing in a continuous quality improvement process, or discontinue the work as we are definitely not making progress or the indicator is declining because of what we are doing.

b) We are able to monitor trends in the indicators to tell us if we are making progress and if not, we have an opportunity to examine the indicator and its related factors to try to determine why progress is not being made. The information is helpful for us to plan to amend or cease what we are doing, and develop new strategies that are more effective.

c) Interpretation of the data includes a collaboration between program staff and data staff to ensure that each understands the context of the issue and the data meaning and quality. We

always operate from the perspective of team work and require collaboration between data and program staff. This approach has been very successful for us and results in higher quality work.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 14.6 | 15.4 | 17.0 | 17.2 | 17.2 |
| Numerator | 372 | 403 | 451 | 461 | 461 |
| Denominator | 255456 | 261329 | 265602 | 268059 | 268059 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.
 Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2009
 Denominator: IBIS Population estimates for 2009

Notes - 2009

Data reported are the most recent data available.
 Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2009
 Denominator: IBIS Population estimates for 2009

Notes - 2008

Data reported are the most recent data available.
 Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2008
 Denominator: IBIS Population estimates for 2008

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The Asthma Program through CDC funding has conducted several activities to help children under five manage asthma. During the past two years, trainings were given to child care providers to encourage asthma-friendly child care environments and to teach care givers to recognize and manage asthma symptoms. Several members of the Utah Asthma Task Force, comprised of various community and professional partners, conducted focus groups for mothers of children under five and have developed asthma educational materials based on the results. Materials will be distributed through various partners including the Baby Your Baby to help young mothers recognize and manage their children's asthma symptoms. The Asthma Program funds the Weber-Morgan Health Department to work with the Community Action Partnership to increase awareness of asthma resources and improve asthma management among Head Start families and staff by training staff members and educating parents at monthly meetings. Two more local health departments were funded to help spread asthma programs, education, and resources.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Asthma Program develops strategies according to its Utah Asthma Plan for 2007 -- 2011, to

be updated for 2012-2016. The plan was prepared with partners, such as the American Lung Association, the Asthma Task Force and others. The State plan is written to address several levels of Utah public including schools, community, health systems, environment and others.

The Asthma Program added numerous resources for health care providers and the public to its website, such as a health care provider manual and guidelines to manage pediatric and adult asthma and a guide to asthma and medications. Guidelines were developed about mold and its dangers and how to safely eradicate it. Online tutorials for the public on air quality and asthma were published on the website. The Utah Asthma Program website includes resources from a variety of sources and those the Program has developed. The website address is <http://health.utah.gov/asthma/>

New strategies recently developed include asthma trainings for child care providers and education for mothers of young children. A new strategy to expand the asthma-friendly child care program is to certify the training on the statewide Office of Child Care Career Ladder Program which will provide access to a large network of child care providers. Certification with the Career Ladder Program will provide continuing education credit hours for the training, an incentive for child care providers.

c. Interpretation of what the data indicate

The rate of hospitalization has increased annually since 2006 from 14.7 per 10,000 to 17.2 per 10,000 in 2009. The 2009 rate is less than the 2004 rate of 18.8 per 10,000, showing some improvement over the five years.

Several pockets in the state have been found with higher than average asthma hospitalization rates. The distribution of areas with increased rates was puzzling because one community with a high rate was adjacent to one with a lower rate. The Asthma Program will conduct future surveillance to determine reasons for the differences.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 83.9 | 86.4 | 87.4 | 83.0 | 83.9 |
| Numerator | 26977 | 18747 | 19088 | 18803 | 18803 |
| Denominator | 32137 | 21701 | 21831 | 22647 | 22404 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Data reported are the most recent data available.
 Numerator: CMS 416 for FFY 2010
 Denominator: CMS 416 for FFY 2010

Notes - 2009

Data reported are the most recent data available.
 Numerator: CMS 416 for FFY 2009
 Denominator: CMS 416 for FFY 2009

Notes - 2008

Numerator: CMS 416 for FFY 2008
 Denominator: CMS 416 for FFY 2008

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

This indicator has improved; however, it really doesn't measure the extent to which Medicaid children are getting regular periodic screenings, which would be a better indicator of the level of care a child receives.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The number of health care providers willing to accept low Medicaid reimbursement rates has decreased.
 Medicaid contracts with local health departments for CHEC (Utah's EPSDT) outreach to assist families in accessing health care services. The local health departments also provide targeted case management services for Medicaid families that include education about the importance of the well child visits, especially for children under age one year, and referrals to needed health care services when appropriate. Title V will continue to work closely with Medicaid to develop better strategies to improve access to health care for infants.

c. Interpretation of what the data indicate

The percent of Medicaid enrollees under age one receiving at least one initial periodic screen has been increasing since 2002 from 81.4% to 87.4% in 2008. The increases may be indicative of a positive impact of efforts to improve access to care for infants on Medicaid. However, the percentage dropped slightly in 2010 to 83.9% and we have more work to do to ensure that all Medicaid enrolled infants have access to health care given that 16 percent did not receive an initial screen.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 97.4 | 96.8 | 99.3 | 97.6 | 97.1 |
| Numerator | 185 | 182 | 286 | 283 | 299 |
| Denominator | 190 | 188 | 288 | 290 | 308 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Data reported are the most recent data available.
 Numerator: HEDIS measure "Well Child Visits in First 15 Months" 2010
 Denominator: HEDIS number of children under one in CHIP, 2010

Notes - 2009

Data reported are the most recent data available.
 Numerator: HEDIS measure "Well Child Visits in First 15 Months" 2009
 Denominator: HEDIS sample

The data were obtained through a combination of Hybrid and Administrative procedures from the providers.

Notes - 2008

Numerator: HEDIS measure "Well Child Visits in First 15 Months" 2008
 Denominator: HEDIS sample

The data were obtained through a combination of Hybrid and Administrative procedures from the providers.

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The HEDIS data as reported by the CHIP participating health plans assist us in determining the need for ongoing efforts to ensure children receive needed services. In 2005 the CHIP health plans started utilizing a combination hybrid and administrative data collection methodology designed to better capture the information.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Regardless of the reason for the increase, we are very pleased to see the ongoing improvement in screenings among this population of infants. Lessons learned from the CHIP population might be applicable to infants on Medicaid to improve their periodic screening rates, although the low Medicaid reimbursement rates continue to limit access to care for Medicaid children.

c. Interpretation of what the data indicate

This Health System Capacity Indicator has shown dramatic improvement. In 2002 only 53.5% of infants had received a periodic screen and in 2008, 99.3% received a service. The increases may be due to better reporting of information. The rate remained relatively stable for the last two years (97% - 98%).

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 82.2 | 83.2 | 82.5 | 82.8 | 82.8 |
| Numerator | 43970 | 44762 | 44643 | 41794 | 41794 |
| Denominator | 53475 | 53810 | 54085 | 50475 | 50475 |
| Check this box if you cannot report the numerator because | | | | | |

| | | | | | |
|--|--|--|--|-------|-------------|
| 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Eligibility for prenatal Medicaid in Utah is at the lowest allowable income. Utah women's income must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Because of this, many working poor women who may be eligible in most other states across the country are reduced to self pay for prenatal care affecting entry into and adequacy of prenatal care. We note a growing population of women who are not eligible for prenatal Medicaid due to citizenship status, which interferes with early and continuous prenatal care. With a limited number of safety net providers, access to care is very difficult for this needy population. The Maternal and Infant Health Program contracts with the Salt Lake City Community Health Centers Inc. to provide prenatal services for uninsured pregnant women who reside within the city limits, but funding is woefully inadequate to cover the need.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

We continue several initiatives to increase the rate of women who receive adequate prenatal care including: Baby Your Baby media and by promoting safety net providers that cover uninsured women. Baby Your Baby media campaign utilizes the "13/13" message, start prenatal care by your 13th week of pregnancy and get at least 13 visits. These messages are aired on television, radio and print in both Spanish and English. In addition, the Utah Clicks online enrollment application system provides easy access for pregnant women to begin their presumptive eligibility process to enroll in prenatal Medicaid. The MIHP recently printed and disseminated several thousand Utah Clicks promotional flyers to partners that are in touch with pregnant women throughout the state.

c. Interpretation of what the data indicate

In 2009, 82.8% of Utah women delivering a live birth received adequate prenatal care based on the Kotelchuck Index.

Among Hispanic women, only 70.3% received adequate prenatal care compared to 85.3% of non-Hispanics. This disparity is likely due to the large number of immigrants in Utah who do not

qualify for prenatal Medicaid due to their immigration status. While Hispanic mothers receive some prenatal care, because they are uninsured and paying out of pocket, they may be much more likely to skip visits. The low percent of women with adequate care may also reflect different cultural norms among Hispanic women who may see pregnancy as a time of health instead of a time to seek medical care.

Higher rates of inadequate prenatal care occur among women who reported an unintended pregnancy regardless of age. Among women who delivered a live birth and reported their pregnancy was unintended, 80.4% received adequate prenatal care compared to 88.2% of women who reported their pregnancies as intended.

Lower rates of adequate prenatal care also are noted among women who have had 3 or more previous live births. Among this group, 78.6% received adequate prenatal care compared to 83.5% of women with fewer than 3 previous live births. This disparity may be due to lack of time, day care for children and/or a feeling that they're experienced with pregnancy and do not need as many visits.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 93.5 | 93.5 | 86.6 | 86.6 | 84.6 |
| Numerator | 150379 | 150379 | 142476 | 142476 | 166381 |
| Denominator | 160915 | 160915 | 164602 | 164602 | 196665 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid from Medicaid Data Warehouse, 2010.

Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the BRFSS 2010.

Notes - 2009

Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid.

Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Healthcare Access Survey, 2008.

Notes - 2008

Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid.

Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Healthcare Access Survey, 2008.

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

This indicator has shown improvement since 2002. In 2008, 86.6% of potentially Medicaid-eligible children received a service compared to 78.5% in 2002. This increase in services received is very encouraging as it can be interpreted as evidence that Medicaid enrollment outreach efforts are paying off and the health care system has capacity for families to access care for their children.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Bureau of Maternal and Child Health staff participate in Medicaid enrollment outreach efforts through a community-based coalition that was formerly the Utah Covering Kids and Families Coalition. This Coalition makes recommendations to the Medicaid agency on how to streamline the eligibility process, how agencies can provide better coordination to lessen paperwork and verification requirements for families and how outreach efforts can be improved and made more effective.

c. Interpretation of what the data indicate

Medicaid Health staff work with the targeted case management staff in local health departments to help improve coordination between health care providers and families and to ensure that families have information about their Medicaid benefits and know how to access care.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 48.6 | 51.2 | 51.4 | 52.6 | 54.3 |
| Numerator | 13889 | 14920 | 15211 | 18550 | 21772 |
| Denominator | 28596 | 29135 | 29599 | 35280 | 40125 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Data reported are the most recent data available.
 Numerator: Medicaid CMS 416, FFY2010
 Denominator: Medicaid CMS 416, FFY2010

Notes - 2009

Data reported are the most recent data available.
Numerator: Medicaid CMS 416, FFY2009
Denominator: Medicaid CMS 416, FFY2009

Notes - 2008

Numerator: Medicaid CMS 416, FFY2008.
Denominator: Medicaid CMS 416, FFY2008

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

There has been an improvement in the percentage of children receiving dental services, in part, due to the emphasis that the Oral Health Program (OHP) has placed on early childhood dental caries prevention and education as well as the need for early and regular dental visits. The OHP has collaborated with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits for children.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The OHP collaborated with staff in the UDOH Medicaid to expand current CHEC (Utah's EPSDT) outreach programs. Through these expanded efforts, outreach workers have provided a higher level of case management for children needing dental services. The CHEC dental case management system has been implemented in all local health departments. CHEC outreach staff are responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating children and parents about CHEC benefits and the importance of keeping appointments; 3) working with parents to help reduce barriers to accessing care such as transportation, childcare, language, etc.; 4) serving as liaisons with dental offices to recruit and encourage dentists to become Medicaid providers. In addition, Division of Health Care Financing staff has worked with dental office staff on billing and other issues to reduce identified barriers to care. The State Dental Director has been working with the Utah Dental Association Access Committee to encourage dentists to see Medicaid eligible children to improve the percent receiving early and regular dental care. The Dental Director meets with members of local dental districts around the state to promote increased access for children to dental services.

The OHP has worked with the Utah Oral Health Coalition and Dental Select in the refinement and expansion of the "Sealant for Smiles" program. Second and sixth grade students from SaltLakeCounty, Davis and Tooele Title I schools are provided dental education, screened for dental disease and have dental sealants placed. Care is coordinated for those students who have dental needs. Plans are to take the sealant program statewide.

The OHP has collaborated with the Utah Oral Health Coalition and the Salt Lake Valley Health Department in researching oral health education materials/curriculum and have endorsed the American Dental Association program which is being used in elementary schools to increase awareness of good oral hygiene habits and the value of early and regular visits to the dentist.

c. Interpretation of what the data indicate

Data indicate that efforts to increase access to dental care for this population have been successful but that ongoing work is necessary to assure that Medicaid children have access to routine dental care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 19.9 | 22.5 | 23.1 | 18.7 | 15.8 |
| Numerator | 742 | 919 | 981 | 846 | 743 |
| Denominator | 3728 | 4089 | 4239 | 4522 | 4709 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN DDS Log and MegaWest data, 2010

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2010

Notes - 2009

Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN systems data for age matched for, SSN, name and date of birth.

Denominator: SSI for calendar year 2009

Notes - 2008

Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN systems data for age matched for, SSN, name and date of birth.

Denominator: SSI for calendar year 2008

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Insufficient information about possible SSI eligibility may be lacking thus limiting application for eligibility and receipt of services.

Data from DDS (Disability Determination Services) to CSHCN (Children with Special Health Care Needs) is processed by two people now for completeness and will process the information faster. We have stability of the same two people working on this system database for the last several years.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

This last year we have received some returned notification envelopes due to address changes. Some of the returns have an address change listed but many do not. From the time we receive the information from DDS we will now send out our informational page within a week or less.

Children who have SSI are generally eligible for Medicaid, although the application processes are

separate. CSHCN encourages families to apply for Medicaid because SSI/Medicaid allows children a broader array of services beyond those provided by CHIP or CSHCN clinics.

The CSHCN Bureau employs an SSI Specialist who works with the Office of Disability Determination Services (DDS). As a member of the DDS Advisory Council, the Specialist offers consultation on DDS policy and service administration and fosters the relations among SSI/DDS, Medicaid and CSHCN. DDS sends referrals for all potential recipients up to age 18 years, for the Specialist for outreach and information about potential Medicaid eligibility, as well as community resources.

The Specialist provides information, referral and enabling services to families whose children have been denied disability and need support with reconsiderations or hearings for SSI, Medicaid or CHIP eligibility. The Specialist is English/Spanish speaking and works with Spanish speaking families. These English/Spanish Speaking families are referred to resources like Utah Legal Services, Disability Law Center or other consulting staff or agencies.

CSHCN also employs a transition specialist who provides information, consultation, and support to CSHCN Bureau staff and itinerant staff on adolescent and young adult transition services. Staff training is provided on identification of potential candidates for SSI participation and increasing successful referrals.

CSHCN focuses on reporting of SSI coverage by parents and our clinicians. Intake staff ask each time a CSHCN client comes to clinic about their SSI eligibility. Our SSI specialist keeps the DDS log updated from the information DDS sends. When information is missing, CSHCN requests information to update the record. Then an informational letter is sent in a timely manner to inform families they may be eligible for Medicaid "D" and they need to apply. Many families call due to the letter and seek counsel in SSI/ Medicaid matters. The SSI specialist returns the call and answers questions.

c. Interpretation of what the data indicate

These data indicate that for 2010, the percent of identified SSI beneficiaries who received rehabilitative evaluation services decreased. Possible factors such as fewer clients seen, change of address, and DDS not having current address information to give us.

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of low birth weight (< 2,500 grams) | 2009 | matching data files | 8.6 | 6.3 | 7 |

Notes - 2012

Based on linked Medicaid Eligibility and Birth 2009 data.

Medicaid eligibility file (n=139,206)

Birth file (n=53,894)

Linked medicaid matched cases=16,871 (31.3%)

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

It is clear that the outcomes for women covered by Medicaid are poorer when compared to women in the general population in Utah. Through analysis of Utah PRAMS and birth certificate data, women enrolled in Medicaid during pregnancy have an array of risk factors that are also commonly identified at higher rates among women who have low birth weight births. These risk factors include lower levels of education, low socio-economic status, being unmarried, using tobacco before and during pregnancy, and being of racial or ethnic minorities. Programs work to improve pregnancy outcomes in general, identifying risk factors for low birth weight, issuing briefs on the impact of pre-pregnancy body weight on low birth weight and so on.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Many risk factors are not amenable to Title V interventions, such as income and education, however those that are, e.g., tobacco use, are being addressed through ongoing collaborations with Medicaid and Tobacco Prevention and Control Program and others to promote tobacco cessation strategies for pregnant women. We also work with partners to address other issues associated with low birth weight such as substance use, elective inductions, and so forth. Staff from Medicaid and the Maternal and the Infant Health Program are working together to educate women who enroll in Medicaid about the potential of preventing recurrent singleton preterm births with the early and continuous use of 17 alpha hydroxyprogesterone (17P).

c. Interpretation of what the data indicate

Data indicate that women enrolled in Medicaid fare far worse than their non-Medicaid counterparts. The percentage of low birthweight births among Medicaid women was 8.6% in 2009 compared to the state rate of 7.0%. Utah's Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that women enrolled in prenatal Medicaid are more likely to have numerous risk factors which make them more likely to have a LBW infant, for example they are more likely to be younger, have less than a high school education, be of a racial or ethnic minority group, be unmarried and use tobacco during pregnancy. These factors may be contributing to higher rates of LBW among our prenatal Medicaid population.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------|------------|--------------|-----|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Infant deaths per 1,000 live births | 2009 | matching data files | 5.3 | 4.9 | 5 |

Notes - 2012

Based on linked Medicaid Eligibility and Birth 2009 data.

Medicaid eligibility file (n=139,206)

Birth file (n=53,894)

Linked medicaid matched cases=16,871 (31.3%)

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The Utah Department of Health's Maternal and Infant Health Program (MIHP) has administered the Perinatal Mortality Review (PMR) Program since 1995. The program provides a forum in which infant deaths due to perinatal conditions are identified through vital records events. These cases are then thoroughly reviewed by our PMR Coordinator, a Certified Nurse Midwife with many years of clinical experience, and presented to a committee of perinatal health care providers on a monthly basis. Case reviews result in recommendations from committee deliberations that are implemented, as possible, to prevent future infant deaths.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Department developed and implemented the Power Your Life social marketing campaign in 2010 with First Time Motherhood/New Parent funding from HRSA's MCHB. The campaign encourages women of reproductive age to reach optimal health by using novel and established social marketing approaches to: increase awareness of the importance of being at optimal health prior to pregnancy, increase awareness of existing preconception/interconception, prenatal and parenting services and programs, and to address the relationship between such services and health/birth outcomes and a healthy first year of life. The target populations of the media campaign are low income women and women of racial and ethnic minorities who have higher rates of infant mortality.

The MIHP staff carried out a survey of delivery hospital staff during 2010 to obtain objective data from which to assess NICU levels in hospitals. Survey results indicated that there are several hospitals who are marketing themselves as Level III NICUs but do not meet the AAP criteria to do so. The program will convene a group of stakeholders from NICUs around the state to discuss survey findings. It is hoped that these discussions will clarify this important issue.

c. Interpretation of what the data indicate

The rate of infant mortality for the nation as a whole was 6.75 infant deaths per 1,000 live births (2007). Utah compares favorably with a rate of 5.0 infant deaths per 1,000 live births (2009), one of the lowest infant mortality rates in the country. However, women enrolled in prenatal Medicaid have a higher rate of infant mortality than the state as a whole (5.3/1000 live births, 2009). Again, we know that women enrolled in prenatal Medicaid have numerous risk factors which make them more likely to experience an infant death, for example they are more likely to be younger, have less than a high school education, be of a racial or ethnic minority group, or be unmarried. These factors may be contributing to higher rates of infant mortality among our prenatal Medicaid population.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2009 | matching data files | 62 | 75.9 | 71.6 |

Notes - 2012

Based on linked Medicaid Eligibility and Birth 2009 data.

Medicaid eligibility file (n=139,206)

Birth file (n=53,894)

Linked medicaid matched cases=16,871 (31.3%)

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Utah has seen a decline in the percentage of Medicaid enrolled women who entered prenatal care during the first trimester in 2009 (62%). The overall entry into prenatal care for Utah pregnant women was 71.6% compared to the non-Medicaid rate of 75.9%. The revised birth certificate went into the field in Utah during 2009 and thus the method for calculating prenatal care entry changed, which could account for this decline in percentage.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

We have seen a steady increase in the number of applications for presumptive eligibility for prenatal Medicaid come in through our online web-based application system, UtahClicks. We continue to add Qualified Providers for prenatal presumptive eligibility applications around the state to expedite a pregnant woman's ability to enroll in the program and begin prenatal care before the end of the first trimester.

c. Interpretation of what the data indicate

Utah remains significantly below the Health People 2010 goal for 90% of women entering prenatal care during the first trimester; we do however continue to have comparatively good pregnancy outcomes. While we continue to promote early and regular prenatal care in Utah through our Baby your Baby 13 Campaign (get in by the 13th week of pregnancy and get at least 13 visits), we are now also placing emphasis on promoting preconception health among reproductive age women through our Power Your Life campaign.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE | POPULATION | | |
|--|------|---------------------|------------|--------------|------|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2009 | matching data files | 75.2 | 86.2 | 82.8 |

Notes - 2012

Based on linked Medicaid Eligibility and Birth 2009 data.

Medicaid eligibility file (n=139,206)
 Birth file (n=53,894)
 Linked medicaid matched cases=16,871 (31.3%)

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

See HSCI #04. Eligibility for Utah Medicaid prenatal services is the lowest allowable income level of income for enrollment. Utah women must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Because of this stipulation, many working poor women who may be eligible in most other states across the country are reduced to self pay for prenatal care affecting their entry into and adequacy of prenatal care. The growing population of individuals with citizenship issues due to federal restrictions on eligibility prevents a large number of women from early entry. Since there are a limited number of safety net providers to provide prenatal services to this needy population, it is difficult for these women to get any prenatal care. The Maternal and Infant Health Program contracts with the Salt Lake City Community Health Centers Inc. to provide prenatal services for unfunded pregnant women who reside within the city limits, but the funding is inadequate to cover the need.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

We continue to focus on several initiatives to continue to reduce the rate of women who receive inadequate prenatal care in Utah including: strategies to reduce the teen pregnancy rate and to promote safety net providers who will cover uninsured and undocumented women and encourage them to receive early and adequate prenatal care services. In addition we continue to implement the Baby Your Baby media campaign which utilizes the "13/13" message, start prenatal care by your 13th week of pregnancy and get at least 13 visits. These messages are aired via television, radio and print in both Spanish and English.

c. Interpretation of what the data indicate

Women enrolled in prenatal Medicaid (75.2%) are significantly less likely than non-Medicaid (86.2%) women in Utah to have received adequate prenatal care based on the Kotelchuck index. We know that Medicaid enrolled Utah women are also much more likely to have reported their pregnancies as unintended and as a result, less likely to have entered prenatal care in the first trimester. Late first trimester entry into prenatal care is likely the reason for a lower percentage of adequate prenatal care being received by our Medicaid enrolled pregnant women.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|---|-------------|--|
| Infants (0 to 1) | 2010 | 133 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Infants (0 to 1) | 2010 | 200 |

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Efforts to drop the required asset test for infant Medicaid has not been successful to date. In fact, the asset allowable level was dropped from \$5000 to only \$3000.

During the past five years, due to inadequate state funding, CHIP was not able to maintain open enrollment. However the state legislators have since appropriate additional state funds to allow CHIP to remain open for enrollment.

The 2007 Legislature allocated additional funding to Medicaid to cover the anticipated increase in eligible children due to the CHIP application process which starts with a determination of Medicaid eligibility. With the economic downturn, more children have been enrolled in both programs. Enrollment numbers have steadily increased.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

It is very difficult to impact these numbers due to the factors that influence enrollment. The Department works with its partners, community-based organizations and advocates to reach out to individuals who may possibly be eligible for either program.

c. Interpretation of what the data indicate

This HSCI has been constant since the two programs were started in the state. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The required asset test prevents an individual with some resources (above \$3000) from being determined to be eligible. The state legislature controls the state funding that is required for both of these programs limiting the eligibility to their current levels.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|---|-------------|--|
| Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to) | 2010 | 133 100 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Medicaid Children (Age range 1 to 18) (Age range to) (Age range to) | 2010 | 200 |

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

See 6A

b. What efforts are being made by the program in developing new strategies for meeting the

HSCIs?

See 6A

c. Interpretation of what the data indicate

See 6A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL Medicaid |
|---|-------------|--|
| Pregnant Women | 2010 | 133 |
| INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
| Pregnant Women | | |

Notes - 2012

Pregnant women are not covered under Utah CHIP.

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Advocates have garnered some support to get legislators willing to sponsor a bill to drop the required asset test. However, to date this effort has been unsuccessful.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Department works with its partners, community-based organizations and advocates to reach out to individuals who may be eligible for Medicaid prenatal. The Division of Family Health and Preparedness administers the Baby Your Baby Presumptive Eligibility (PE) Program to ensure access for potentially eligible women to apply for PE while waiting for determination of their Medicaid eligibility. With the implementation of UtahClicks, access to PE is easier and more convenient.

c. Interpretation of what the data indicate

This HSCI has been constant since the Medicaid prenatal program was first implemented. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The asset test prevents an individual with some resources (more than \$3000) from being determined to be eligible. The state legislature controls the state funding that is required for this program limiting the eligibility to their current levels. It is not likely that this HSCI will change unless the income eligibility changes at a later date.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
|--|---|---|
| <u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates | 3 | Yes |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 3 | Yes |
| Annual linkage of birth certificates and WIC eligibility files | 1 | No |
| Annual linkage of birth certificates and newborn screening files | 3 | Yes |
| <u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges | 3 | Yes |
| Annual birth defects surveillance system | 3 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 3 | Yes |

Notes - 2012

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

We are very fortunate to have strong data linkages with vital records, PRAMS, and Medicaid. We have not yet been able to link data with WIC due to information system challenges. The Utah WIC Program will be rolling out an entirely new information system in fall of 2011, so once that is out and the bugs are worked through, we will be able to begin work on the linkages with other data sets.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Linkages in general have improved in the past few years, as well as surveillance efforts. The Department conducts an annual Health Status Survey which provides additional data on the general population in the state. This dataset is often used for our work in MCH/CSHCN. The Data Resources Program has been able to link Hospital Discharge data with Vital Records data. In the future, we hope to link to the All Payor Database.

c. Interpretation of what the data indicate

The Utah Department of Health has a well-developed Center for Health Data in which vital records, survey, hospital discharge, all payer databases and other data systems are available. The Department has the benefit of excellent data staff that are able to link datasets, analyze the data, etc. Program staff reviews the data for trends or factors associated with trends to determine what interventions might possibly impact the rates for a large number of indicators.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|-----------------------------------|---|---|
| Youth Risk Behavior Survey (YRBS) | 3 | Yes |
| Youth Tobacco Survey | 3 | Yes |

Notes - 2012

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Utah uses the Youth Risk Behavior Survey (YRBS) to monitor trends in youth tobacco use. During the years 2003 -- 2007, the Utah YRBS was funded by the Utah Department of Health through various sources. The 2003 State Legislature prohibited the State Office of Education from applying for CDC funds related to HIV prevention which was linked to the YRBS funding. Starting in 2003, the YRBS was integrated into Utah's SHARP project, a larger biennial school survey that also includes Utah's substance abuse survey overseen by the Division of Substance Abuse and Mental Health. The Utah Department of Health received a CDC grant to conduct the 2009 YRBS because CDC changed their funding practices to allow health departments to apply. Weighted results for the 2009 YRBS are available on the web-based Utah Department of Health Indicator-Based Information System for Public Health (IBIS).

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Department of Health, in collaboration with the State Office of Education and the Division of Substance Abuse and Mental Health, conducts the Youth Risk Behavioral Survey (YRBS) in schools in the spring of odd years. Utah's YRBS methodology follows CDC's requirements. Since the combined school and student participation rate has been above 60% for all survey years, Utah has consistently received weighted YRBS data from the CDC. Utah will continue to administer the YRBS in collaboration with other state-sponsored school surveys to reduce survey cost, achieve adequate participation rates despite Utah's active parental consent requirement, and minimize the survey burden on schools.

c. Interpretation of what the data indicate

Utah continues to have low rates of tobacco use among high school students. Youth tobacco use has not changed significantly since 2007.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The initial planning process for the FY2011 - 2016 needs assessment process included a review of the previous needs assessment processes of 2000 and 2005 as well as methodologies used by other states for their needs assessments. After review of a number of different processes, the leadership team decided to use some of our previous processes and to enhance the scope of information gathering from external stakeholders through different methods. We reviewed the past five -- ten years of data on Performance Measures, Outcome Measures, health status indicators, health systems capacity indicators, and gaps to identify strengths and challenges in meeting the needs of the MCH populations in Utah. We reviewed what has worked to enhance health and wellness and what hasn't. We will develop new strategies and programs to address the gaps and shortfalls after we submit the grant and have an opportunity to strategize how best to address the priorities.

The leadership team developed the five-year needs assessment plan that included enhancing the stakeholder survey for each of the MCH populations and health service or system issues that had been used in the previous needs assessment processes. The stakeholder survey was revised from the previous one to include more issues related to the health needs of mothers and children, including those who special health care needs. We also developed a parent survey to gather information from those with children or youth with special health care needs.

We sent the stakeholder survey to partners, individuals on advisory committees for their input. Parent contacts came from Family Voices, parents of children served through CSHCN clinics. Both surveys were designed for online response. The response numbers were impressive to us and have provided us with enough responses to feel we can use the input we received.

State Performance Measures were determined based on the priorities identified. For example, preterm births and folic acid were identified as a priority, so they became the State Performance Measures for the next five years.

For the FY10 reporting year, we achieved 12 out of 18 measures and did not achieve 6 measures. The measures that we fell short on included: immunizations, sealants, breastfeeding, suicide, prenatal care and very low birth weight births at Level III facilities. We will continue to work on these areas to promote improvement.

We have been putting a great deal of effort into the issue of VLBW infant births at tertiary centers. As noted elsewhere, we have been concerned about the increase in the number of hospitals in the state that are self-designating as Level III NICUs. In reviewing capacity in these hospitals, it is clear that they are not Level III, but market themselves as such. We are meeting with stakeholders to discuss how to address the issues related to this self-designation.

Another issue tied into this is the birth hospital for the mother. The focus generally is on the infant outcome, but if we do not provide the same level of care that a high-risk mother needs, we will continue to see babies with poor outcomes. We have to recognize that the hospital of birth relates not just to newborn care, but also maternal care. If the mother is delivered in a hospital with a NICU, but not staffed by a maternal fetal medicine specialist, we are doing both mother and infant a great disservice. We have to acknowledge that tertiary care relates to the mother and the infant.

The state priorities have been "assigned" to specific programs and staff. One of our programs includes the assigned performance measures to the staff member's performance plan. Every quarter, the staff reviews progress on the performance measure.

B. State Priorities

The Needs Assessment Leadership Team met to review the information we received from the surveys we conducted to determine which ten priorities we were going to focus on for the upcoming 5 years. We decided on the following priorities based on impact to population, numbers impacted and ability to address. For an in-depth discussion of State Priorities, please refer to the Five Year Needs Assessment documents.

For Mothers and Infants

- Prevention of preterm births
- Reduction in C/Sections for low risk pregnant women
- Neural tube defects prevention

Children and Youth

- Early childhood developmental screening
- Access to oral health for young children -- birth to 5
- Reduction in obesity among children/ physical activity
- Reduction in tobacco use among youth- we selected this measure as a proxy for substance abuse
- Improved access to mental health services

CYSHCN

- Reduction in out of pocket expenses for health care for families with children or youth with special health care needs
- Services for children and youth with special health care needs in rural areas

The needs assessment process included a review of status on National and State Performance and Outcome Measures, as well as Health Status, Health Systems Capacity Indicators and health care systems in the state. This review assisted in identifying priority areas along with the top issues obtained from the key informant survey.

The Leadership Team decided not to include in the list of priority issues any issue that was already addressed in a National Performance Measure so that we could specifically focus on other areas of need. Some of the State Performance Measures from the 2006 Needs Assessment have been dropped because of coverage provided through health care reform, higher priorities to address, difficulty in measuring a state Performance Measure. We decided to put emphasis on late preterm births, most of which are preventable, health concerns for children and adolescents, and coverage and services for children with special health care needs.

The Division will continue to explore information related to the state priorities to assist us in planning methods to address the specific issues. The state Title V agency will develop specific plans to address the ten priorities through input from partners and others.

Recognizing that the needs assessment is an ongoing process, Title V leadership will continue to monitor Utah's progress in the priority areas identified in the needs assessment process, including those that were not included in the final list. Each year as additional data become available, such as adequacy of prenatal care statistics, programs review the data and seek strategies to address the findings. We will continue to review data as it is available to assess needs of mother, infants, young children, school-aged children and youth, including those with special health care needs as we implement the plans for the coming five years.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 403 | 479 | 463 | 423 | 423 |
| Denominator | 403 | 479 | 463 | 423 | 423 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes - 2010

Data reported are the most recent data available.
Utah Newborn Screening Program Database, 2009

Notes - 2009

Data reported are the most recent data available.
Utah Newborn Screening Program Database, 2009

Notes - 2008

Data reported are the most recent data available.
Utah Newborn Screening Program Database, 2008

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 100% and the Annual Indicator was 100%.

The Newborn Screening Program (NSP) continued its surveillance and identification of children with congenital hypothyroidism, galactosemia, biotinidase, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders, and fatty acid disorders.

Cystic Fibrosis screening began January 1, 2009. During the year, education to hospitals, medial homes and other health care providers was offered in the form of newsletters, Grand Rounds at Primary Children's Medical Center and Dixie Regional Medical Center and an article in the Utah Chapter of the American Academy of Pediatrics newsletter.

Changes in reporting out 'not normal' hemoglobin results were accepted well. All letters and notifications were sent out in a timely manner.

The new protocol for the sick/preterm infant was begun in March, 2010. Education was provided to newborn intensive care units (NICU) by web-cast. Information was also available on the NSP web-site. Along with the new protocol, a change was made to the levels for reporting of TSH results for hypothyroidism. If the TSH was ≥ 40 and the T4 was normal, the report was marked as "elevated" and a note was added that results were consistent with early draw time and a recommendation that a second specimen be collected for normalization of values. All TSH

results of >230 are called out as critical whether the child is full term or a sick/preterm.

All newborns that required testing beyond the newborn screening panel were referred to medical homes and subspecialists as needed. If a family had moved out of state or the baby had been adopted by a family out of state, every attempt was taken to locate the family and medical home as well as notifying the newborn screening personnel in that state. Final diagnosis was requested and confirmed by either the medical home or the subspecialist. Forms for collection of this information were sent and receipt tracked. A case was closed only upon receipt of the form.

In September, 2009, the Bureau of CSHCN made a change to the financial assistance for a family with a child/ren with PKU. With the current economic environment, more families are requesting assistance as jobs and insurance coverage have been lost. The Bureau's ability to fund assistance has decreased due to significant funding cuts. After discussions with all parties and the Newborn Screening Advisory Committee, a decision was made to direct the resources available to lower income families. Previously, children from birth-18 years of age and pregnant women qualified for assistance regardless of income. The criteria have been changed: children birth - 5 qualify regardless of income; children 6 -18 years qualify if their family's income is less than 225% of the Federal Poverty Level and is required to pay the insurance co-pay; women planning to become pregnant or pregnant women qualify if the family's income is less than 225% of the Federal Poverty Level with a requirement for payment of the co-pay required by their insurance. Families were sent individualized letters discussing this change and a presentation was given at the Intermountain PKU and Allied Disorders meeting.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Abnormal screening results, if appropriate, were called to the newborn's medical home. | X | | | |
| 2. All newborns referred for confirmatory testing were tracked to final outcome – normal or disorder identified – and referred to sub-specialist, as needed. | X | | | |
| 3. Education was offered to hospitals, medical homes, other medical providers, families and the general public. | | | | X |
| 4. The sick/preterm protocol was implemented. | X | | | |
| 5. Levels for reporting of TSH results on sick/preterm infant changed. | X | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Newborn Screening Program (NSP) is continuing its surveillance and identification of children with congenital hypothyroidism (CHYP), galactosemia (GALT), hemoglobinopathy (Hb), biotinidase (BIOT), congenital adrenal hyperplasia (CAH), cystic fibrosis (CF) & amino acid and acylcarnitine disorders.

The Genetic Advisory Newborn Screening Subcommittee continues to meet on a quarterly basis. Presentations on Spinal Muscular Atrophy and Severe Combined Immunodeficiency have been made.

The hospital QA report card process is continuing. There are issues in the area of 'batching' (3 or

more days of collection specimens received at the same time). A potential problem has been identified internally and is under review.

A review was conducted of the screening for thyroid disorders (primary TSH) for the past 18 months. Under consideration was decreasing the level of TSH for determination of "abnormal" results without missing a true disorder. After extensive review of the data with endocrinology consultant, it was agreed that a change to the reporting level be made. As of March 1, 2011, if the TSH =40 and = 100 and the T4 is normal, the results are reported as 'elevated' and a note is added with explanation and a request for collection of the second screen to confirm normalization of values. If TSH is > 230, it is called out as a critical value. These changes will greatly reduce false positive rates, decrease program and provider workload, additional testing and anxiety for families.

c. Plan for the Coming Year

The Newborn Screening Program (NSP) will continue its surveillance and identification of children with congenital hypothyroidism (CHYP), galactosemia (GALT), hemoglobinopathy (Hb), biotinidase (BIOT), congenital adrenal hyperplasia (CAH), cystic fibrosis (CF) and amino acid and acylcarnitine disorders. Care coordination and data tracking will be ongoing. Collaboration will continue with the Pediatric Department at the University of Utah, the Associated Regional and University Pathologists, Inc, and the UDOH State Laboratory to provide testing for disorders and follow up.

The NSP will participate in discussions with the Genetic Advisory Newborn Screening subcommittee to look at expanding the number of disorders tested by the State. We will begin reviewing the addition of Severe Combined Immunodeficiency Syndrome (SCIDS) to our panel of screens.

The QA Report Card to hospitals of birth will continue with the emphasis on decreasing unsatisfactory specimens, incomplete data on cards and improving timeliness of specimens receipt at the laboratory. Review of internal processes that may affect these processes will be undertaken. NSP will continue to work with hospital staff to determine problem areas and develop solutions.

Newborn screening kits will be sold to all institutions of birth and to direct entry midwives. Consultations with all providers will be available by phone or site visit. Consultations and education of families and the general public will continue.

The NSP will continue to collaborate on data integration and streamlining of data collection. Linking newborn databases through the birth record number will continue and NSP will become a link in CHARM. NSP will continue its involvement in the cHIE project. It will support and facilitate the 'Medical Home' model of health care. NSP will work in conjunction with Birth Defects Registry on its National Birth Defects Prevention Study project.

The NSP will work with its lab partners to review the screening processes and test results to reduce the false positive rates and improve the overall quality of our services.

Collaborative and financial support to the University of Utah's Metabolic Follow-up Clinic, which follows children with PKU and galactosemia, will continue. NSP will work with families, the Utah Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| | | | | | | |
|---|--|------|--|------------------------------------|--|-------|
| Total Births by Occurrence: | 55143 | | | | | |
| Reporting Year: | 2009 | | | | | |
| Type of Screening Tests: | (A) Receiving at least one Screen (1) | | (B) No. of Presumptive Positive Screens | (C) No. Confirmed Cases (2) | (D) Needing Treatment that Received Treatment (3) | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | 54697 | 99.2 | 8 | 2 | 2 | 100.0 |
| Congenital Hypothyroidism (Classical) | 54697 | 99.2 | 575 | 14 | 14 | 100.0 |
| Galactosemia (Classical) | 54697 | 99.2 | 66 | 1 | 1 | 100.0 |
| Sickle Cell Disease | 54697 | 99.2 | 252 | 3 | 3 | 100.0 |
| Biotinidase Deficiency | 54697 | 99.2 | 18 | 3 | 3 | 100.0 |
| Congenital Adrenal Hyperplasia | 54697 | 99.2 | 34 | 4 | 4 | 100.0 |
| Cystic Fibrosis | 54697 | 99.2 | 1065 | 24 | 24 | 100.0 |
| Homocystinuria | 54697 | 99.2 | 55 | 0 | 0 | |
| Maple Syrup Urine Disease | 54697 | 99.2 | 0 | 0 | 0 | |
| beta-ketothiolase deficiency | 54697 | 99.2 | 0 | 0 | 0 | |
| Tyrosinemia Type I | 54697 | 99.2 | 2 | 0 | 0 | |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 54697 | 99.2 | 8 | 2 | 2 | 100.0 |
| Argininemia | 54697 | 99.2 | 1 | 0 | 0 | |
| Argininosuccinic Acidemia | 54697 | 99.2 | 0 | 0 | 0 | |
| Citrullinemia | 54697 | 99.2 | 2 | 0 | 0 | |
| Isovaleric Acidemia | 54697 | 99.2 | 4 | 0 | 0 | |
| Propionic Acidemia | 54697 | 99.2 | 7 | 0 | 0 | |
| Carnitine Uptake Defect | 54697 | 99.2 | 90 | 1 | 1 | 100.0 |
| 3-Methylcrotonyl-CoA Carboxylase Deficiency | 54697 | 99.2 | 12 | 3 | 3 | 100.0 |
| Methylmalonic acidemia (Cbl A,B) | 54697 | 99.2 | 7 | 1 | 1 | 100.0 |
| Multiple Carboxylase | 54697 | 99.2 | 0 | 0 | 0 | |

| | | | | | | |
|--|-------|------|-----|-----|-----|-------|
| Deficiency | | | | | | |
| Trifunctional Protein Deficiency | 54697 | 99.2 | 0 | 0 | 0 | |
| Glutaric Acidemia Type I | 54697 | 99.2 | 2 | 1 | 1 | 100.0 |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 54697 | 99.2 | 9 | 9 | 9 | 100.0 |
| Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency | 54697 | 99.2 | 0 | 0 | 0 | |
| 3-Hydroxy 3-Methyl Glutaric Aciduria | 54697 | 99.2 | 0 | 0 | 0 | |
| Methylmalonic Acidemia (Mutase Deficiency) | 54697 | 99.2 | 0 | 0 | 0 | |
| Hearing Screening | 54225 | 98.3 | 639 | 71 | 57 | 80.3 |
| Biopterin Deficiency | 54697 | 99.2 | 8 | 1 | 1 | 100.0 |
| Galactosemia (not classical) | 54697 | 99.2 | 66 | 57 | 57 | 100.0 |
| Hemoglobinopathies (not sickle cell disease) | 54697 | 99.2 | 252 | 227 | 227 | 100.0 |
| Hydroxprolinemia | 54697 | 99.2 | 0 | 2 | 2 | 100.0 |
| Melonic academia | 54697 | 99.2 | 1 | 1 | 1 | 100.0 |
| Multiple Acyl-CoA Dehydrogenase Deficiency | 54697 | 99.2 | 2 | 1 | 1 | 100.0 |
| Phenylketonuria (non classical) | 54697 | 99.2 | 8 | 5 | 5 | 100.0 |
| Short Chain Acyl-CoA Dehydrogenase Deficiency | 54697 | 99.2 | 18 | 8 | 8 | 100.0 |
| Tyrosinemia (Tyrosine) | 54697 | 99.2 | 44 | 0 | 0 | |
| Diet Monitoring Pregnant Women | 77 | | 6 | 6 | 6 | 100.0 |
| Diet Monitoring, 0-18y | 721 | | 78 | 78 | 78 | 100.0 |

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------------------------------|------|------|------|------|------|
| Annual Performance Objective | 65 | 65 | 52 | 55.1 | 55.1 |
| Annual Indicator | 63.7 | 55.1 | 55.1 | 55.1 | 55.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See | See | See |

| | | | footnote for source | footnote for source | footnote for source |
|---|-------------|-------------|---------------------|---------------------|---------------------|
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 55.1 | 55.1 | 56 | 56 | 56 |

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Data are pre-populated from the National Survey of CSHCN. The same questions were used to generate the NPM02 indicator in 2001 and 2005-2006 survey.

Notes - 2008

Data are pre-populated from the National Survey of CSHCN. The same questions were used to generate the NPM02 indicator in 2001 and 2005-2006 survey.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 55.1% and the indicator was 55.1%.

The CSHCN Bureau provides funding for the part-time Utah Family Voices director to manage the Family Involvement and Leadership program in collaboration with Utah's Family to Family Health Information Center. This collaboration has expanded limited resources to continue the valued family and consumer participation within many MCH programs and activities.

Families are continually asked for their participation in a variety of funded projects. The parents that do participate are highly respected for their experience and expertise and are compensated for their involvement. Numerous families were compensated to be ASD consumer experts in their local communities throughout the state. These families have made and continue to make great strides to educate the community about Autism Spectrum Disorders. They also provide information to families, agencies and organizations through local events, information dissemination, presentations, fundraiser and media activities to name a few.

Families working in partnership with professionals were able to get Autism, Disabilities and Faith proclamation as well as an official license plate for autism with proceeds going to the Autism Council of Utah, which is an independent council working to foster collaboration, communication, and learning among families and agencies.

Many other parents were identified to be Parent Partners within Medical Homes throughout the state. They provided their perspective to practice policies and procedures, developed local community resources lists and provided family to family support to other parents. A caregiver educational series was developed for families of children who are newly diagnosed with an ASD. The 12 hour curriculum consists of six two hours modules. The modules were developed by both professionals and families who are the experts in the field of autism in Utah. The six week series was successfully implemented with two separate pilot trainings.

Families were compensated for serving on state level committees including the Primary Children's Hospital and Medicaid. Some families provided presentations to OT, PT, and Early Interventionist students at the University of Utah as well as medical and nursing residency students. Presentations were provided to dental and medical homes about family centered care, the day in the life of families of CSYHCN and essential parent/professional partnerships.

The state's Parent Training and Information Center (Utah Parent Center) received a small contract to help provide an autism information toll-free line and up to date resources and fact sheets for families of children with an Autism Spectrum Disorder. The Utah Parent Center is the umbrella organization for Utah Family Voices' Family to Family Health Information Center. The Utah Parent Center, the Bureau of CSYHCN and Utah Family Voices work collaboratively in efforts to sustain Utah's Family to Family Health Information Center and the vital purpose it serves for families throughout the state of Utah.

Family involvement in the Utah Regional LEND program and Medical Home initiative remains a priority. Families were compensated to discuss the parent perspective for weekly didactic seminars. The families also mentored trainees from various disciplines outside of a medical setting about their success and challenges as a family. These visits usually took place in the families' homes but some were held in a school or recreational setting.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. A parent as paid CSYHCN staff. | | | | X |
| 2. Compensation for family involvement - Families of children with ASD - Parent Partners in Medical Homes - Family involvement in the LEND program | | | | X |
| 3. Educational series developed for families of children with Autism. | | X | | |
| 4. Training developed and implemented to professionals by families. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Family Involvement and Leadership program is expanding through collaborative efforts with Utah Family Voices and Medical Home initiatives. The Utah Department of Health and the University of Utah received a CHIPRA grant to demonstrate the effectiveness of Medical Home. Through this initiative more families have been invited to participate as a partner and team member to the selected clinics and practices. The recommendation to compensate participants for their time and expertise will continually be reinforced and modeled.

Families are expanding their training experiences for LEND trainees, medical students and residents. Families are speaking with nurses and medical residents at the Primary Children's Medical Center in addition to the continuing activity of providing information about family centered care to the second year pediatric medical residents at the University of Utah during their CSYHCN rotation.

The ABCs of Autism, a twelve-hour program which consists of six, two-hour modules, was developed and presented in rural areas of the state as well as on the Wasatch Front to both families of newly diagnosed children with ASD and to professional partners.

An interagency Autism State Plan committee was developed and continues to meet to address the issues and needs of children, youth and young adults with ASD and their families. The committee helps to facilitate and coordinate possible solutions and supports from many different agencies, experts and resources.

c. Plan for the Coming Year

The CSHCN Bureau will continue to employ a part-time parent staff member to enhance the family involvement and leadership activities and Medical Home initiatives in the state. These efforts will provide a mechanism for family partners and consultants to work directly with parents and family organizations in providing them with resource and advocacy information. Having a parent staff member will also provide ongoing family perspective and input to all of the new grants or projects developed including the MCH Block grant.

The Family Involvement program manager will collaborate and partner with other family, disability and advocacy organizations to recruit and train new family leaders in the state to expand the capacity. Through partnerships with many agencies and organizations compensation to families will continue to develop and be enhanced across service systems.

CSHCN and Utah Family Voices will continue to collaborate in efforts to support and sustain the MCH funded Family-to-Family Health Information Center. The Center will continue to partner with the Family Involvement / Medical Home program to provide vital information and support to systems of care for families of CSHCN. The collaboration will enable additional family staff members to provide credible and time-sensitive information, training, and guidance regarding the needs of CSHCN to health care and other professionals.

Outreach, training, and information dissemination on the Affordable Care Act, health care funding and resources, family-centered care, family/professional partnerships and the ABCs of Autism will be provided in new creative mechanisms such as webinars and other web based trainings in efforts to reach more families.

CSHCN will continue to partner in supporting the annual Family Links conference. A staff member will participate on the planning committee to help address the needs and provide health care and related information for families of CSHCN and the professional partners attending the conference. Presentations will be provided on health care funding resources, emergency preparedness, medical home and community resources and the provisions of the ACA.

Site visits to rural clinics and Medical Homes across the state will be provided to at least six communities. Family Voices will plan and provide information and technical assistance about the needs identified by the clinics, practices and families in the community which will include education and materials about effective family involvement, family support resource, health care funding and autism resources.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance | 2006 | 2007 | 2008 | 2009 | 2010 |
|----------------------------------|------|------|------|------|------|
|----------------------------------|------|------|------|------|------|

| | | | | | |
|---|-------------|-------------|-------------------------|-------------------------|-------------------------|
| Data | | | | | |
| Annual Performance Objective | 60 | 60 | 49 | 52.2 | 52.2 |
| Annual Indicator | 55.9 | 52.2 | 52.2 | 52.2 | 52.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See footnote for source | See footnote for source | See footnote for source |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 52.2 | 52.2 | 55 | 55 | 55 |

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

The Performance Measure was achieved. The performance objective was 52.2% and the Annual Indicator was 52.2%.

Activities for the Medical Home program (MH) included year two activities of the State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorders. The advisory group met in January 2010 and brainstormed ideas on more effective roles for parent partners in the medical home, recruitment of family medicine practices, and participation in a Medical Home website user study. The CSHCN consultant group, external organization representatives, was informed of activities and given an opportunity to provide feedback at the quarterly CSHCN administration meetings.

Eight medical practices identified a core medical home team that participated in the 6-month project. The teams attended a day-long learning session in June 2009 and were provided with tools and information about the signs of autism, performing autism screenings during all 18- and 24-month well visits, making referrals when indicated, developing a registry of children with autism or developmental delay, implementing a family-centered medical home approach, and

increasing their knowledge of community resources. Clinician completed a pre- and post-collaborative survey in addition to a project summary. Prior to the learning session, each practice received medical home training to help each office implement medical home processes. After the learning session, two site visits were made to each office to help with implementation issues and four conference calls were held.

Five dental practices participated in a 6-month Learning Collaborative, "Creating a Dental Home for Patients with Autism". Each practice sent a team to attend a half-day learning session in February 2010, followed by in-office dental home training, site visits in March and June, and three conference calls. Each medical/dental home received a packet with diagnosis information, screening tools and resources, including a 47-minute DVD on the D-Termined™ program. Staff recruited eleven more medical practices to participate in a 6-month Learning Collaborative that began in June 2010 and included a peer-mentoring component.

Support continued with email resource outreach, site visits with a structured interview at each site, and documentation of progress. The MH coordinator published three articles in the Utah Chapter of the American Academy of Pediatrics newsletter and published two MH newsletters that were sent to every pediatrician and family practitioner in the state. The articles and newsletters focused on the resources available on the Medical Home Portal, recruitment of dental practices, and screening for autism. Support for Parent Partners (PP) continued with encouragement for communication between families and the practice PP. The five family resource navigators, lay individuals trained to help families navigate the system of services, provided training and support to families and participated in community events that support autism initiatives and education. Support and technical assistance were provided by the CSHCN Family Involvement and Leadership program and Utah Family Voices.

Collaboration with Family Voices, Utah State University, University of Utah, and Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) regarding CSHCN projects, medical and nursing school curricula and the Medical Home Portal continued. Medical students met with Utah Family Voice Staff to gain a perspective from families with CSHCN. URLEND trainees provided consultation to the practices involved in the CSHCN medical home trainings along with families of CSHCN.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) trained medical homes on screening for autism and developmental delays. | | | | X |
| 2. Eight medical homes participated in a 6-month learning collaborative training. | | | | X |
| 3. Eleven medical homes in 14 locations began a second UPIQ project and participated in a half-day Learning Session in June of 2010. | | | | X |
| 4. Five dental homes trained in serving children and youth with autism. | | | | X |
| 5. Children with Special Health Care Needs Bureau (CSHCN) and Medical Home Portal published a newsletter on screening for autism. | | | X | |
| 6. Families and professionals helped improve content on the Medical Home Portal website, www.medicalhomeportal.org . | | X | | |
| 7. Utah Regional Leadership Education in Neurodevelopmental | | | | X |

| | | | | |
|---|--|--|--|--|
| Disabilities (URLEND) trained medical, nursing, and allied health students. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Year three of the State Implementation Grant involves medical homes using a peer mentoring model by physicians from the initial project, to improve screening and referral for autism and developmental delays. Eleven new medical homes in 14 locations participated in the second 6-month UPIQ project and attended a half-day learning session. They also participated in an in-office Medical Home and Family Perspectives trainings, site visits, and conference calls in late 2010. Five peer mentors from the first project were partnered with practices to facilitate learning and implementation of screening and referral. Each practice identified a parent partner to help identify 3-6 other parents to meet in focus-group fashion with the goal of obtaining parent perspectives of the practices and improving family-centered practice.

The video series for parents of newly diagnosed children with autism is being presented throughout the state. Trained family navigators are accompanying the presentations to answer questions and assist in locating community resources.

Outreach plans include dissemination of medical home topic-oriented newsletters to pediatricians and family practitioners and posting on the Medical Home Portal, www.medicalhomeportal.org. The Portal team continues to develop new content and add new resources to the website. The Portal team is in negotiations to include other states' list of community services, beyond the current genetic providers for eight states.

c. Plan for the Coming Year

The final year of the State Implementation Grant includes supplemental funding for public awareness based on the "Learn the Signs. Act Early" (LTSAE) campaign from the Centers for Disease Control and Prevention. In FY12, the campaign will provide outreach to families of young children, ages birth to four, in Salt Lake County. CSHCN staff in partnership with Utah State University's Center for Persons with Disabilities will distribute materials to help families learn about developmental milestones, recognize the early signs of developmental delays, and understand what actions to take to obtain a diagnosis and find early treatment if needed.

CSHCN will provide in-office training as requested on medical home basics for medical practices. Support will be provided for previously-trained medical and dental homes through problem-solving upon request; sharing of resources and new opportunities; and development of news articles.

To address the large rural and frontier portions of the state, the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) will complete training, started in the previous year, of 8 primary care practices to participating in a long-distance 3-month Autism Spectrum Disorders Learning Collaborative using distance learning approaches (telehealth).

CSHCN will partner with the Medical Home Portal to develop quarterly articles for the Utah Chapter of the American Academy of Pediatrics newsletter. The Medical Home Portal will develop content related to genetic and other chronic conditions to help medical homes provide care for children and youth with special health care needs. Outreach to families will continue through participation at community events.

CSHCN will be represented on committees and boards to improve the coordination of services

and the provision of family-centered care. Staff will serve on the Coordinating Council for People with Disabilities, the Utah Parent Center Board, the Interagency Outreach Training Initiative Committee, and other interagency committees.

CSHCN will continue to support the URLEND in an effort to improve providers' understanding of the service system and chronic conditions of children with special health care needs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|-------------------------|
| Annual Performance Objective | 59 | 59 | 59 | 59.5 | 59.5 |
| Annual Indicator | 57.2 | 59.5 | 59.5 | 59.5 | 59.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See footnote for source | See footnote for source | See footnote for source |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 59.5 | 59.5 | 59.5 | 60 | 60 |

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Data are pre-populated from the National Survey of CSHCN. The same questions were used to generate the NPM04 indicator in 2001 and 2005-2006 survey.

Notes - 2008

Data are pre-populated from the National Survey of CSHCN. The same questions were used to generate the NPM04 indicator in 2001 and 2005-2006 survey.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 59.5% and the Annual Indicator was 59.5% (data from 2005/6 National CSHCN survey).

Bureau programs assisted families in obtaining health care coverage by providing outreach to potentially eligible Medicaid, CHIP and SSI families. Numerous outreach methods were used including face-to-face encounters at statewide CSHCN clinics, on-line applications through Utah

Clicks, posting eligibility information on the Medical Home web-portal and providing office space for an on-site Medicaid and CHIP eligibility worker. Open enrollment for CHIP was continuous throughout the year. Families were encouraged to apply for UPP (Utah's Premium Partnership for Health Insurance) to help pay their portion of the monthly health insurance premium through their employer's health insurance plan or COBRA coverage.

Potentially SSI eligible children in Utah were identified and letters were sent in English and Spanish informing these families of their possible Medicaid and CSHCN program eligibility. CSHCN collaborated with hospitals and other community organizations to help cover the cost of medical services for eligible children who do not have access to public or private health insurance.

Through Medicaid's waiver for Technology Dependent/Medically Fragile Children, 132 families had access to Medicaid and waiver services which provided the services and supports needed to keep their child safe at home and in the community. CSHCN provided the day-to-day administration, case management and service authorization for this waiver program.

Through an MCHB funded Family-to-Family Health Information and Education Center grant, Parent Partners responded to the needs of families through direct family-to-family support. The parent partners informed families how to access health-related information including eligibility and application information in order to obtain public and private health insurance. Utah Family Voices collaborated with the Utah Parent Center and the Bureau of CSHCN to implement additional activities to reach and further expand parent partners in health care and involvement on all levels of state decision making. CSHCN continued to provide representation on the Family-to-Family Health Information and Education Center Advisory Committee.

CSHCN provided membership and consultation to Medicaid on their EPSDT Expanded Services and Prior Authorization Committee. The consultations and recommendations on service coverage for children with special health care needs are important for families to help them obtain the health services and support their children need.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provided Medicaid, CHIP and SSI outreach to families of potentially eligible CYSHCN. | | | X | |
| 2. Provided access to Medicaid for families with technology dependent children through a Medicaid home and community-based waiver program. | | | X | |
| 3. Provided resource information through the Medical Home web-portal and simplified program application processes through Utah Clicks. | | X | | |
| 4. Supported Utah Family Voices and the Family-to-Family Health Information and Education Center. | | X | | |
| 5. Provided consultation and input to Medicaid in determining medical necessity for children/youth/young adults up to 21 years of age through the EPSDT Expanded Services and Prior Authorization Committee. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |

| | | | | |
|-----|--|--|--|--|
| 10. | | | | |
|-----|--|--|--|--|

b. Current Activities

Outreach activities are being conducted to identify children who may qualify for public funding of health care. Outreach efforts are conducted statewide through CSHCN clinics, case management programs and on-line information and application systems. SSI eligible children who are not yet enrolled in Medicaid are being identified and letters are sent informing families of their child's potential eligibility for Medicaid and CSHCN clinical programs.

The Bureau collaborates with hospitals and community organizations to help cover the cost of medical services for children who do not have access to public or private health insurance. CSHCN works collaboratively with Utah's Family-to-Family Health Information Center to respond to the needs of families with information on public and private health insurance including the changes that have occurred as a result of the Affordable Care Act.

CSHCN is providing the day-to-day administration for Medicaid's Technology Dependent Waiver. The waiver program assists families in coordinating health care benefits between private insurance plans and Medicaid and referring families to the Medicaid Buy-out Unit for evaluation of cost savings to Medicaid by paying the child's private insurance premium.

CSHCN is monitoring implementation of provisions of the Affordable Care Act and other forthcoming initiatives that affect health care coverage and will be proactive in supporting creative approaches that aim to reduce the financial strain on families.

c. Plan for the Coming Year

Financing health services for CYSHCN will continue to be an essential element in meeting the needs of children and families. Outreach efforts to identify children, especially minority populations, who may be eligible for public funding of health care will be a priority. Educating families by providing culturally relevant and linguistically appropriate information on available programs, eligibility requirements and application processes will occur through CSHCN statewide clinics, the Med Home web-portal, Bureau web-site and Utah's Family-to-Family Health Information and Education Center. A database will be used to identify SSI eligible children not yet enrolled in Medicaid. Letters will be sent out in English and Spanish informing families of their potential eligibility.

The Bureau will collaborate with hospitals and community organizations to assist in covering the cost of health care services for eligible children who do not have access to public or private health insurance. CSHCN case managers and clinical staff will help families work with their private insurance plans to access needed health related services.

CSHCN will continue to provide the day-to-day administration for Medicaid's Technology Dependent Waiver program. Medical eligibility, service authorization and care coordination will be performed statewide. The waiver program will assist families in coordinating medical benefits between their private health insurance and Medicaid and refer families to the Medicaid Buy-out Unit for evaluation of cost savings to Medicaid by paying the child's private insurance premium.

CSHCN staff will provide Medicaid administrative case management activities including outreach, information and referral, service coordination, evaluation and monitoring activities to ensure EPSDT eligible children receive timely and appropriate access to needed Medicaid-covered services. CSHCN will continue membership on the EPSDT Expanded Services and Prior Authorization Committee for Medicaid reviewing documentation and providing recommendations on service coverage.

CSHCN will work collaboratively with Utah's Family-to-Family Health Information Center to respond to the needs of families through direct family-to-family support and information on public

and private health insurance including implementation of the Affordable Care Act. CSHCN will monitor other forthcoming initiatives that affect health care coverage and provide input and education to families as applicable.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|-------------------------|
| Annual Performance Objective | 82 | 82 | 82 | 86.2 | 86.2 |
| Annual Indicator | 79.1 | 86.2 | 86.2 | 86.2 | 86.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See footnote for source | See footnote for source | See footnote for source |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 86.2 | 86.2 | 86.2 | 86.2 | 86.2 |

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 86.2% and the Annual Indicator was 86.2 % (from the 2005/2006 CSHCN Survey).

Children with Special Health Care Needs (CSHCN) faced major funding cuts due to State budget

shortfalls and flat Federal funding. Over the past several years, CSHCN has sustained \$2.5 million in cuts of state general funding. The impact of these cuts has been cuts to or elimination of programs, loss of staff positions, and a decrease in the numbers and locations of clinics. CSHCN staff worked closely with Utah Medical Home Program, University of Utah health care providers and Utah Family Voices on efforts to enhance access, collaboration, and efficient and effective clinical services and care coordination among community agencies, health care providers and families. CSHCN and University of Utah Pediatrics entered into a more comprehensive collaboration during this reporting period, to increase the availability of their specialty consultations. Continued use of our online/hard-copy referral form and process, to gain input and information from primary and community providers on service access and communications efficiencies, was maintained on a statewide basis.

Despite significant funding cuts and cuts in staff positions, CSHCN provided access to community-based specialty care through statewide satellite case management and traveling clinics. Specialists travel to a select number of rural areas in Utah to provide evaluations, diagnostic services, transition support and follow-up. Specialty areas included the following: developmental pediatrics, psychology, speech pathology, genetics, neurology, occupational/physical therapy, audiology, orthopedics, cranio-facial and transition services.

CSHCN provided case management to high-risk populations of children, including those dependent on technology in Medicaid's Travis C. Waiver Program and in foster care through the Fostering Healthy Children Program (FHC). FHC assisted foster families in coordinating community care and collected and documented medical information for approximately 4,500 children in the foster care system. FHC worked with Utah Medicaid to improve health status outcomes for children.

Other CSHCN Bureau programs augmented community clinical services, case management and capacity building efforts to enhance a coordinated system of care. The Newborn Follow-up Program (NFP) continued to provide assessment and developmental follow-up at selected sites around the state, for approximately 1,700 eligible infants and children meeting certain criteria once they are discharged from Utah newborn intensive care units.

Prior to being moved under the administration of a new Bureau, the Baby Watch Early Intervention Program (BWEIP) provided services for over 6,500 infants and toddlers with disabilities and their families through 15 local programs statewide. BWEIP provided training and technical assistance to providers. BWEIP continued its effective use of the statewide database, BTOTS, which allows the program to monitor family and child outcomes in relation to BWEIP interventions.

CSHCN worked with the Department's Multicultural Health Center and Indian Health Service to improve access and collaboration with community providers of health, education, vocational rehabilitation, and health care coverage for populations served by those agencies.

Increased CSHCN collaboration with UHIN, CHARM, cHIE and other like entities, focused on developing and implementing greater data sharing capabilities for agencies and health care providers of children with special needs. Initial exploration of electronic medical records (EMR) systems was begun in order to eventually meet future mandates.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. CSHCN collaborated with Utah Medical Home Program and University of Utah health care systems to enhance access and coordination of services. | | X | | |

| | | | | |
|---|---|---|--|---|
| 2. Continued use of referral form and process initiated statewide to enhance access to and coordination of services, along with complete update and maintenance of the Bureau website for ease of use. | | X | | |
| 3. Utah's Family Voices and the Family-to-Family Health Information and Education Center provided parent-to-parent support and information on community resources and services. | | X | | |
| 4. CSHCN provided access to community-based specialty care through statewide satellite case management and traveling clinics. | X | | | |
| 5. CSHCN provided case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). | | X | | |
| 6. Bureau programs augmented community clinical services, case management and capacity building efforts to enhance a coordinated system of care, including coordination with the Multicultural Health Center and Indian Health Service. | | X | | |
| 7. The Baby Watch Early Intervention Program (BWEIP) provided multidisciplinary services to infants and toddlers with disabilities and their families through a statewide program, which includes 15 local programs. | X | | | |
| 8. Neonatal Follow-up Program continued provision of clinical diagnostic, assessment and follow-up for NICU graduates meeting program eligibility criteria. | X | | | |
| 9. Collaborated with CHARM, CHIE, UHIN, and other like entities, and explored EMR systems for future records management. | | | | X |
| 10. | | | | |

b. Current Activities

In the face of decreasing Federal funding and State budget reductions, Children with Special Health Care Needs has had to respond by reorganizing, eliminating staff positions and reassigning staff to meet the needs of the special needs community in the state. CSHCN, in collaboration with University of Utah pediatric specialists, continues to provide access to community-based specialty care, transition services and coordination through statewide satellite case management and traveling clinics. CSHCN continues to provide case management for high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program. Bureau programs continue to evaluate the service delivery system to increase efficiency, and assess for needed changes in case management and clinical services.

The NFP continues to provide multidisciplinary clinics for NICU graduates and collaborates with the University of Utah in research projects for this population. They have completed and are using the first version of a new clinical database. The program was reorganized with changes in program management and health care provider coverage that will better meet the needs of the infants and children seen in the program.

Bureau efforts to implement data sharing capabilities and move toward electronic medical records continue via collaboration with entities such as CHARM, UHIN and CHIE.

c. Plan for the Coming Year

On-going State budget cuts and decreasing federal funding for CSHCN clinics will serve as the impetus for the Bureau to closely evaluate the clinic service delivery system to increase efficiency, possibly combining or eliminating clinics as needed. Continued collaboration with University of Utah providers will be maintained in order to facilitate ongoing provision of multidisciplinary specialty clinics in Salt Lake City.

CSHCN will provide access to community-based specialty care and transition services through statewide satellite case management and traveling clinics. Specialists will travel to the rural areas in Utah to provide diagnostic, transition, care coordination services and follow-up. CSHCN will provide case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). The nurse case managers for FHC will continue to assist foster families access health-related and community care and to collect and document health information for children and youth in the foster care system.

CSHCN will continue to strengthen the community-based infrastructure for CSHCN. Bureau programs such as the Utah Medical Home Program, Family Voices and the clinics will augment community clinical services, case management and capacity building efforts to enhance a coordinated, community system of care. This will be done via specialty care coordination and education of local providers and agencies. Utah's Family-to-Family Health Information and Education Center will provide parent-to-parent support and information on community resources and services. During this next year, the center will continue its focus on collaboration and sustainability by developing new family advocacy and interagency relationships with community-based organizations at the local, state and national level.

CSHCN programs will collaborate with the Center for Health Disparities Reduction (previously known as the Center for Multicultural Health, Indian Health Service and other community cultural organizations and agencies to improve access and partner with community providers of health, education, vocational rehabilitation, and health care coverage.

The Newborn Follow-up Program (NFP) will continue to partner with the University of Utah and other agencies to provide multidisciplinary clinics to NICU graduates. The program will develop a strategic plan to prioritize program goals, such as timely reporting of outcome data to NICUs that refer to the program.

Continued collaboration among CSHCN clinical entities and CHARM, UHIN and cHIE will focus on implementing and expanding data sharing and the future implementation of mandated use of electronic medical records to meet "Meaningful Use" certification for records management and billing services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------------------------------|------|------|------------------|------------------|------------------|
| Annual Performance Objective | | | 36 | 42.5 | 42.5 |
| Annual Indicator | 5.8 | 42.5 | 42.5 | 42.5 | 42.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See footnote for | See footnote for | See footnote for |

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| | | | source | source | source |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 42.5 | 42.5 | 44 | 44 | 44 |

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Data are pre-populated from the National Survey of CSHCN. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008

Data are pre-populated from the National Survey of CSHCN. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 42.5% and the Annual Indicator was 42.5%.

In FY2010, the Bureau of Children with Special Health Care Needs (CSHCN) promoted and supported transition services for young adults, their families and health care providers. CSHCN employed a transition specialist who provided transition planning to young adults with disabilities and their families in Blanding, Moab, Montezuma Creek, Price, and Vernal clinics. Two of the clinics were visited on more than one occasion. These services are especially important, as rural Utah presents significant challenges for families in successful transition into adult health care services for their children. The transition specialist also provided services to young adults with disabilities and their families at CSHCN programs and clinics based in Salt Lake City. In rural sites and Salt Lake City the transition specialist coordinated with local health department staff, health and mental health providers, and other state and local agencies.

In addition to the onsite consultations, phone consultations and email correspondence were available to young adults, their families and their health care providers. The transition specialist was also available to community agencies for needs assessment and transition planning.

The transition specialist maintained current resource information critical for young adults and their families for transition from pediatric health services and programs to adult services and programs. This information was available through onsite, phone consultation, via email and written correspondence as well as the Medical Home Portal.

A Memorandum of Agreement with Work Ability Utah (WAU) has facilitated transition training opportunities at the rural clinic sites for health care providers. Trainings were held in Blanding, Moab, Richfield and Vernal. Three of these training sites included multiple local practices and at one location a family support group. Pre and post surveys were done to understand and address the specific needs of each community. Additional trainings were scheduled for rural clinic sites throughout the state for the remainder of the year.

The transition team included a SSI specialist, a Spanish-speaking social worker. He supported Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services. He provided transition information and support to Latino young adults and their families. He collaborated with the Center for Multicultural Health.

CSHCN promoted other collaborative efforts in the area of transition to continue to improve the health of the state's special needs population by working with various state and federal agencies, including: Medicaid, Social Security Administration, Utah State University Center for Persons with Disabilities (CPD), Division of Services for People with Disabilities, Utah State Office of Education, Vocational Rehabilitation, WAU, Utah Developmental Disability Council, The Employment Partnership and other community programs.

The transition specialist along with the project coordinator for the Becoming Leaders for Tomorrow (BLT) Project spoke about transition issues in the CSHCN Bureau for the Access Utah Network available as a webcast. Additionally the transition specialist was a presenter/panel participant for the Critical Issues statewide mental health conference. In collaboration with WAU and Utah State Office of Rehabilitation, a representative payee training was presented for families, CSHCN staff and staff from other local agencies and organizations.

The BLT Project funded by the Administration on Developmental Disabilities through September 2010 maintained an advisory committee of young adults. The young adults provided input to the CSHCN Bureau staff regarding transition services and materials. The young adults on the advisory committee also spoke at local transition training events for young adults and families. The BLT distributed the Youth Leadership Toolkit with a training guidebook and videos for professionals, parents, and young adults to help these groups improve transition for young adults with disabilities.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Transition training sessions presented in Blanding, Moab, Richfield and Vernal, Utah for medical providers. Additional trainings were planned for the remainder of the year. | | | | X |
| 2. Provided onsite transition services for young adults and their families at rural clinics and CSHCN Bureau programs based in Salt Lake City. Telephone consultation, email correspondence, written communication and other supports were available. | X | | | |
| 3. Telephone consultation, written and email correspondence were available to providers and community agencies for needs assessment and transition planning throughout the state. | | X | | |
| 4. Participated as a panel presenter at a statewide conference. Spoke about transition issues for CSHCN for Access Utah Network. | | | | X |
| 5. Maintained current resource information for adult services and programs. | | X | | |

| | | | | |
|--|--|---|--|--|
| 6. Wrote a technology review for the Medical Home Portal. | | X | | |
| 7. The BLT project advisory committee provided training and materials for providers, young adults and families. These materials were developed in partnership with the young adults. | | X | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Children with Special Health Care Needs (CSHCN) employs a transition specialist who provides services to young adults with disabilities and their families both in rural Utah locations and locally based CSHCN programs. The transition specialist and Becoming Leaders for Tomorrow (BLT) Project coordinator offer transition training to CSHCN Bureau employees at their annual service program in addition to medical providers in two practices in St. George in collaboration with Work Ability Utah. Pre and post surveys conducted will provide an understanding of specific transition issues identified by employees in various programs throughout the CSHCN Bureau and in each medical practice. More training will be scheduled for rural sites throughout the state.

The transition specialist and BLT coordinator have attended a number of transition fairs to disseminate resources and information in the community setting. As members of The Employment Partnership they are writing a Work Sheet which provides a synopsis of monthly meetings.

The transition specialist maintains resources for adult services and programs for use by young adults, families and medical providers. This information is available through consultation, email, telephone contact, the Medical Home Portal, partner websites, medical providers, and community agencies.

The Spanish speaking SSI/Medicaid specialist has completed translation of the transition brochures and all are posted on the transition page of the CSHCN website.

c. Plan for the Coming Year

In FY2012, the Children with Special Health Care Needs (CSHCN) transition specialist will continue to provide educational training opportunities for health care providers in rural locations. Pre and post surveys will be conducted in order to better understand and address transition issues and specific concerns identified by each community. By bringing this information to health care providers, through them, we have the ability to reach more young adults and their families in these communities. This is a collaborative effort with the Medical Home Program and funded through a Memorandum of Agreement with Work Ability Utah.

Even with an emphasis on providing transition information and resources directly to rurally- based health care providers, the transition specialist will continue to travel to rural sites to provide transition planning for young adults and their families. Rural sites include Price, Blanding, Moab, Montezuma Creek, Ogden, Richfield and Vernal. The young adults and families in the Salt Lake City based CSHCN programs are served by the transition specialist. In serving all of these young adults and their families, the specialist will collaborate with local health departments, other state agencies, health and mental health providers, and community programs. Onsite consultations, telephone consultations, written and email correspondence, and other supports will continue.

Additional educational opportunities for young adults and their families will be offered by the transition specialist and the Medical Home Program, both locally and rurally (in conjunction with itinerant pediatric clinics) and when possible through taping or telehealth for rural clinic sites.

The transition team will update information and resources for the transition section of the CSHCN

website and partner websites encompassing the spectrum of transition to adult services and programs. The team will work with community partners to develop a comprehensive plan for the Bureau for provision of services for transition to adulthood.

The transition team will continue to develop new relationships and work collaboratively with federal, state and local agencies and organizations to provide transition services and information to young adults, families, providers and other agencies.

The Spanish speaking SSI/Medicaid specialist will support Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services. He will also facilitate the translation of transition materials to Spanish. He will collaborate with the Center for Health Disparities Reduction in providing transition information and support to Latino young adults.

The CSHCN Bureau Director will work with the newly formed DOH Multicultural Workforce Development task force to develop a comprehensive plan for recruitment and retention of DOH employees from varied cultural, ethnic and linguistic backgrounds, including adults with disabilities.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 80 | 80 | 85 | 82.5 | 80 |
| Annual Indicator | 80.4 | 78.5 | 78.1 | 75.8 | 75.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 75.8 | 75.8 | 76.5 | 76.5 | 76.5 |

Notes - 2010

Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2009 National Immunization Survey (NIS) which is only available at the state level as a percentage.

Notes - 2009

Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2009 National Immunization Survey (NIS) which is only available at the state level as a percentage.

Notes - 2008

Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2008 National Immunization Survey (NIS) which is only available at the state level as a percentage.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 82.5% and the Annual Indicator was 75.8%.

The Utah Immunization Program (UIP) developed and implemented a comprehensive quality improvement program to assist providers in increasing immunization coverage levels using all aspects of the AFIX strategy. The Utah Pediatric Partnership to Improve health care Quality (UPIQ) project conducted assessments for Phase 1 and 2. AFIX policies and procedures manual was submitted to the CDC and provider relations staff were trained on its contents.

The Utah AFIX Program implemented face-to-face feedback sessions with VFC provider offices. The provider relations staff met with clinic staff including the physician, medical assistants, front desk staff and billing staff to discuss the clinic's immunization rates and ways to improve. Forty-two offices received a face-to-face feedback session. UPIQ can now offer both ABP credit for pediatricians as well as ABFM MC-FP credit for family physicians.

Six programs (local health departments and the Teen Mother and Child program) participated in Tdap cocooning projects, urging the mother and close contacts of newborns to receive the Tdap vaccine to protect the infants from pertussis. Currently, the uninsured close contacts of these newborns can receive the vaccine at no cost.

The UIP and Utah Statewide Immunization Information System (USIIS) have implemented an annual USIIS data query that allows us to assess immunization data for the childhood series on a statewide and regional level. These queries include the total population, as well as population organized by race/ethnicity and population based on Medicaid enrollment status. It is critical that we continue to improve the accuracy/quality of these data and to utilize the results in planning future actions with stakeholders.

Outreach, enrollment and training activities for USIIS were supported by the UIP to all USIIS users. The number of provider offices participating in USIIS increased 19% from July 2008 to June 2009. UIP continues to actively recruit provider participation in the immunization registry through a variety of activities. UIP supports USIIS users by providing training to individuals through one-on-one or group training, and Helpdesk requests. UIP worked with USIIS and vital records staff to establish/accept new race and ethnicity codes from vital records birth certificate data. USIIS accepts codes as established by vital records which has moved from using only 5 codes to 15 codes.

The statewide "Immunize by Two" public awareness campaign was suspended due to a loss of funding and a reduction in program funds. Available funding was distributed to local health departments during January -- December 2010 to continue a limited campaign at the local level. The UIP continued participation in the Hallmark Greeting Card Program. During April 2010, UIP collaborated with the Northern Utah Immunization Coalition (NUIC) to conduct their annual immunization conference in conjunction with National Infant Immunization Week (NIIW). Additional support was provided for the Greater Salt Lake Immunization Coalition (GSLIC) for their annual NIIW provider workshop. The NUIC conference and GSLIC workshop were marketed to providers in the Intermountain Pediatric Society and the Utah Medical Association.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. UPIQ project assessed 10 clinics for Phase 2 of the program and 10 clinics for Phase 1. | | | | X |
| 2. Provider reps conducted 42 AFIX site visits to VFC providers. | X | | | |
| 3. Six programs participated in Tdap cocooning projects. | X | | | |
| 4. Increase of 19% in USIIS providers. | | | X | |
| 5. Increased from 5 to 15 race codes in USIIS. | | | X | |
| 6. Continued participation in the Hallmark Greeting Card Program. | | | X | |
| 7. Flu Summit 2010 and presented on employee influenza data. | | | | X |
| 8. Yellow fever vaccination course requirement implemented for all certified yellow fever vaccination sites in Utah. | | | | X |
| 9. ARRA funding zoster pilot project which supplied 2,500 doses of zoster vaccine to one urban and one rural health district. | X | | | |
| 10. UIP continues to encourage parents to stay on schedule with childhood immunizations by providing an electronic immunization reminder service. | | | X | |

b. Current Activities

The AFIX Program feedback sessions have continued by the provider relations staff; a display and brochures were created to promote the program. The Utah AFIX program continues to recruit providers to participate in face-to-face feedback in a hope to increase the up-to-date rates of children by age 2. In our contract with AUCH (Association of Utah Community Health) this year, all the community health centers are participating in face-to-face feedback as well as implementing the AFIX quality improvement plans in their health centers every year.

The Adolescent 101 project with Select Health collected adolescent data this year that will be reportable to CDC by the Utah Immunization Program.

The UIP and USIIS are continuing to develop a method to use USIIS to assess immunization coverage (general population, race/ethnicity and Medicaid) levels statewide, and regionally. USIIS has increased the number of children birth to five years with at least two vaccinations recorded in the registry. USIIS now automatically accepts race/ethnicity data from vital records when USIIS is updated weekly with birth certificate data.

To date VFC provider reps continue to meet with physician offices to discuss AFIX which includes the importance to increase immunization rates within each office. The electronic Immunization Reminder Service continues as an ongoing service to remind parents of timely immunizations.

c. Plan for the Coming Year

Provider relations staff will continue to assist VFC providers with understanding of immunization best practices; conduct 200 CASA/AFIX assessments and coverage will be established at 120 clinics. The Utah Immunization Program (UIP) Provider Relations Staff will continue to implement the quality improvement program, AFIX. They will work towards the goal of 20% of providers receiving face to face feedback on their 4:3:1:3:3:1 immunization rates every year. AFIX will be promoted to providers through VFC site visits, brochures, and participating in local conferences with the new AFIX display. The UPIQ project will continue recruiting providers to participate in quality improvement activities. UIP will collaborate on the Adolescent 101 project with Select Health to gather data on 4:3:1:3:3:1 as well as adolescent data that is comparable and reportable

by UIP to the CDC.

We will continue to query data from the USIIS data base to determine coverage levels based on race/ethnicity and Medicaid status. The annual coverage report will be disseminated to UIP partners/ stakeholders and posted online. As funding allows, the "Immunize by Two" public awareness campaign will continue with local health departments. The UIP will continue to participate in the Hallmark Greeting Card Program, and continue the electronic Immunization Reminder Service.

Our program goal is to provide age/culturally appropriate educational/informational immunization materials to consumers. All program materials will be available in English and Spanish. The UIP will promote the VFC Program with articles in minority magazines and newspapers. We will provide education and information through media sources that target ethnic populations. Collaborations with federal, state and local Indian Health Services (where appropriate) to provide immunization information among ethnic populations (especially American Indians) will be initiated. Our goal is to continue our work with Utah Indian Health Advisory Board to create culturally and linguistically appropriate posters, radio ads, and place articles in Native American tribal newsletters/newspapers to promote immunization.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 14.8 | 15.7 | 16.5 | 18.5 | 18.5 |
| Annual Indicator | 16.3 | 18.6 | 18.5 | 16.5 | 16.5 |
| Numerator | 981 | 1133 | 1122 | 995 | 995 |
| Denominator | 60026 | 61060 | 60796 | 60127 | 60127 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 16.5 | 16.4 | 16.4 | 16.3 | 16.3 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009
 Denominator: IBIS Population estimates for 2009

Notes - 2009

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2008

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008
Denominator: IBIS Population estimates for 2008

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 18.5 and the Annual Indicator was 16.5.

As of June 30, 2009, the Department of Health and Human Services, Administration for Children and Families (ACF), Title V federal funding for Abstinence-only Education Program, expired. Legislation was not passed by Congress to extend the authority and funding for this program. The Maternal and Child Health Bureau continued to track legislation for possible future funding opportunities for teen pregnancy prevention. In spring 2010, the U.S. Department of Health and Human Services Office of Adolescent Health announced that new funding had been allocated for abstinence education and comprehensive reproductive health evidence based education programs. The funding announcements and directions for applying for these funds will become available to states in FY 2011.

The Adolescent Health Coordinator continued to oversee the Utah Adolescent Health Network, which continued to focus on adolescent reproductive health issues. The network was comprised of two subcommittees. Those subcommittees were Teen Pregnancy Prevention (TPP) and Sexually Transmitted Disease (STD) Prevention. The network continued to work on reaching the Utah State Teen Pregnancy Prevention Goal: By the year 2015, Utah will achieve a 20% decline in the pregnancy rate among girls between the ages of 15-19 (Baseline year 2003, 36.7 per 1,000 females of this age group). If Utah were to meet this goal, by the year 2015 the pregnancy rate among Utah girls between the ages of 15 --19 would be no more than 31.7 per 1,000 females. The rate for 2008 (most current data) was 39.1 pregnancies per 1,000 Utah females. The network also revised goals and objectives to assist in reaching this goal.

The Utah Adolescent Health Network completed a state report entitled: 2010 Utah Adolescent Reproductive Health Report. This report provided a snapshot of reproductive health issues pertaining to Utah adolescents. The focus of the report was adolescent pregnancy and how certain behaviors can increase the risk of youth engaging in unsafe practices. For the purposes of the report, adolescence was defined as ages 11-24. The authors and contributors represented an interdisciplinary group of researchers, health educators, clinicians, and other advocates for the health and well-being of Utah adolescents. This report is available electronically on the following website:http://health.utah.gov/mihp/pdf/2010_Adolescent_Health_Update.pdf

The Teen Pregnancy Prevention subcommittee of the Utah Adolescent Health Network continued to seek funding opportunities to utilize the Centers for Disease Control and Prevention (CDC) Parents Matter program to plan and implement parenting programs within communities. This program is an evidence-based parent intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction for parents of 9-12 year olds. No funding sources were identified.

The Maternal and Infant Health Program developed the final draft of a teen life planning booklet. It was entitled: Plan Your Health: Live Your Life. This resource promotes the concept of lifetime health among adolescents. It also focuses on the importance of making a life plan and deciding whether that plan includes becoming a parent someday or not. Whether or not a pregnancy occurs in the future, adolescents need to be aware that how they treat their body now can directly affect their own health later in life, and if they get pregnant at some point, birth outcomes. The

Maternal and Infant Health Program presented this booklet to the Utah State Office of Education Curriculum Review Panel with the hopes of adding this resource to the approved core resource package for Utah teachers. The teen life plan was not approved by the Utah State Office of Education Curriculum Review Board. Even though the plan did not go against Utah's sex education policy, those on the board were still hesitant to add the plan to the approved resource list for Utah schools due to the reproductive health subject matter. The booklet can be viewed electronically at the following site: http://health.utah.gov/mihp/pdf/Teen_RLP_082709.pdf.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Tracked federal funding sources for teen pregnancy prevention programs. | | | | X |
| 2. Monitored, analyzed, and released Utah teen pregnancy, birth and STD data. | | | | X |
| 3. Provided oversight of the Utah Adolescent Health Network (focus on adolescent reproductive health). | | | | X |
| 4. Completed and released the 2010 Utah Adolescent Reproductive Health Report. | | | | X |
| 5. Worked to reach the 2015 State Teen Pregnancy Prevention Goal. | | | | X |
| 6. Sought funding for the Parents Matter Program. | | | | X |
| 7. Developed final copy of the Plan Your Health: Live Your Life teen life planning tool. | | | X | |
| 8. Sought approval of the Plan Your Health: Live Your Life teen life plan from the Utah State Office of Education. | | | X | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The U.S. Department of Health and Human Services released the following two funding announcements addressing the prevention of teenage pregnancy: 1) Abstinence Education Programs, and 2) Personal Responsibility Education Programs. The Maternal and Infant Health Program was awarded funding for both of these funding opportunities which will bring \$844,301 of teen pregnancy prevention funds into Utah for the next 5 years.

The Adolescent Health Coordinator continues to oversee the Utah Adolescent Health Network. The Network is taking a different direction this year. Instead of focusing on Teen Pregnancy and Sexually Transmitted Infection Prevention, the Network is now serving as a venue for overall adolescent health professional development.

The Adolescent Health Coordinator continues to work on reaching the Utah Teen Pregnancy Goal: By the year 2015, the Utah pregnancy rate among girls between the ages of 15-19 will be 31.7 per 1,000 females. The Adolescent Health Coordinator continues to monitor and share state birth data and distribute the 2010 Utah Adolescent Reproductive Health Report.

The Maternal and Infant Health Program is partnering with the Utah State Office of Education and the Utah Parent Teacher Association to develop methods for educating students, teachers, and policy makers on the importance of sex education. The teen life plan entitled: "Plan Your Health: Live Your Life" is being distributed among Utah adolescents and community groups.

c. Plan for the Coming Year

The Maternal and Child Health Bureau will continue to oversee the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), federal funding for the Title V State Abstinence Education Program and Personal Responsibility Education Program (PREP). The Adolescent Health Coordinator will carry out oversight and technical assistance to funded community-based projects. The abstinence education projects target Utah youth ages 10-16 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, and youth residing in areas with birth rates higher than Utah's state rate. All funded abstinence programs must ensure that abstinence from sexual activity is the expected outcome as outlined in the federal requirements. PREP projects will focus on programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. PREP will target Utah youth ages 14-19 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, current teen moms, and youth residing in areas with birth rates higher than Utah's state rate.

The Adolescent Health Coordinator will continue to oversee the Utah Adolescent Health Network, which will serve as a venue for overall Adolescent Health professional development and training. Network meetings will be held each quarter that will include a presentation or training by an expert in a general adolescent health topic, time for discussing the topic, and time allotted for member networking and project sharing.

The Maternal and Infant Health Program will continue to work on reaching the Utah Teen Pregnancy Goal: By the year 2015, the Utah pregnancy rate among girls between the ages of 15-19 will be 31.7 per 1,000 females. The Adolescent Health Coordinator will continue to monitor and share state birth and pregnancy data pertaining to this goal. The Utah Adolescent Reproductive Health Report will continue to be distributed and used as a tool to educate the Utah public on adolescent pregnancy and how certain behaviors can increase the risk of youth engaging in unsafe practices.

The Maternal and Infant Health Program will continue to partner with the Utah State Office of Education and the Utah Parent Teacher Association to develop methods for educating students, teachers, and policy makers on the importance of sex education. The teen life plan entitled: "Plan Your Health: Live Your Life" will continue to be distributed among Utah adolescents and community groups. A companion tool will also be developed for the teen life plan. This tool will assist health educators with facilitating discussions and learning activities pertaining to the plan. The plan will also be presented to individual Utah school district boards for possible approval to distribute the materials in their schools.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 50 | 45.1 | 45.1 | 45.1 | 45.1 |
| Annual Indicator | 45.1 | 45.1 | 45.1 | 45.1 | 41.9 |
| Numerator | 155 | 155 | 155 | 155 | 392 |
| Denominator | 344 | 344 | 344 | 344 | 935 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because | | | | | |

| | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|
| 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 41.9 | 41.9 | 41.9 | 41.9 | 42 |

Notes - 2010

Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
Unweighted=40.2%, weighted=41.9%

Because our original objectives were set higher than what we had achieved in 2010, we adjusted down the performance objectives for subsequent years as we will not have new data available until 2015.

Notes - 2009

Data reported are the most recent data available.
Oral Health Survey 2005, Oral Health Program, UDOH

Notes - 2008

Data reported are the most recent data available.
Oral Health Survey 2005, Oral Health Program, UDOH

a. Last Year's Accomplishments

The performance measure was not achieved. The performance Objective was 45.1% and the Annual Indicator was 41.9%.

A statewide survey of first through third grade children was performed during this year and the data are currently being analyzed. During FY10, the Oral Health Program (OHP) promoted sealants through screening and referral activities. The program supported direct delivery of sealants at the local health department level, and promoted education/awareness programs among dental professionals, pediatricians and the public. The OHP concentrated on training Sealant for Smiles staff providing screening and referring procedures for children attending high risk elementary schools in Salt Lake Valley, Davis, Summit and Tooele Health Departments.

The OHP supported and provided technical assistance in collaboration with Dental Select's sponsored "Sealants for Smiles" school-based preventive dental program. In spite of decreased funding the "Sealant for Smiles" program provided education and direct services to schools in Davis, Tooele, Summit and Salt Lake counties. Nearly 6,000 children were screened and nearly 16,000 sealants placed on low-income uninsured and Medicaid/CHIP insured children.

The OHP also supported and provided technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene Programs at Weber State University, Utah Valley State College, Utah College of Dental Hygiene and Dixie College. Sealant projects in the Weber-Morgan, Utah County, and Southwest Utah health departments included health department, school personnel, volunteer dental hygienists, dentists and dental assistants.

The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center dental clinics, promoted oral health prevention including sealant application to the public. Other activities included making presentations and providing educational material regarding the benefits of

sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provided technical assistance for local health department to form local Oral Health Task Forces and emphasize placement of dental sealants. | | | | X |
| 2. Used data from statewide survey of 6-8 year old children to develop strategies for direction efforts to reduce the percentage of children with untreated dental decay and increase the number of children with dental sealants. | | | X | |
| 3. Supported and provided technical assistance to Sealants for Smiles for free sealants to low-income and underinsured first and second grade children in Salt Lake, Davis, Summit and Tooele counties. | X | | | |
| 4. Supported the prevention and education activities of the Utah Oral Health Coalition in the promotion of dental sealants. | | | X | |
| 5. Worked with Sealant for Smiles in modifying the program developed by the American Association of Community Dental Programs called "Seal America" and used it as a guide to promote dental sealant programs at the community level. | | | X | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

During FY11, DFHP Oral Health Program (OHP) is promoting dental screening, sealant and referral activities. A statewide survey of 6-9 year old children was performed during FY10 and a report will be published FY11. The OHP is supporting direct delivery of sealants at the local health department level and promoting education/awareness programs among dental professionals, pediatricians and the public.

The OHP is collaborating, supporting and providing technical assistance to Dental Select's "Sealant for Smiles" school-based preventive dental program. Reduced funding has necessitated canceling schools in Summit County and scaling back projected goals in Tooele, Davis and Salt Lake counties. Nonetheless, it is anticipated that more than 7,000 low-income uninsured and Medicaid/CHIP insured children will be screened and have sealants placed.

The OHP is supporting and providing technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by dental hygiene programs statewide. Other activities include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

c. Plan for the Coming Year

During FY12, the Oral Health Program (OHP) will promote sealants through screening and referral activities. A statewide survey of 6-9 year old children was performed in FY2011 and

results will help direct OHP activities in the future. The OHP will support direct delivery of sealants at the local health department level and promote education/awareness programs among dental professionals, pediatricians and the public. The OHP will concentrate on training local health departments on screening and referring procedures for children attending high risk elementary schools in their communities.

The OHP will support and provide technical assistance in collaboration with Dental Select's "Sealant for Smiles" school-based preventive dental program. It is hoped that additional funding will be made available to allow the "Sealant for Smiles" program to expand to include more schools in Tooele, Summit, Davis and Salt Lake counties. It is anticipated that more than 7,000 children will be screened and over 18,000 sealants placed on low-income uninsured and Medicaid/CHIP insured children. Plans are being made to expand the program statewide.

The OHP will also support and provide technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene Programs at Weber State University, Utah Valley State College, Utah College of Dental Hygiene and Dixie College. Sealant Projects in the Salt Lake Valley, Weber-Morgan, Utah County and Southwest Utah health departments will include, in addition to health department and school personnel, volunteer dental hygienists, dentists and dental assistants.

The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center dental clinics, will promote oral health by including sealant utilization and other dental disease preventive measures to the public. Other activities will include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 4.6 | 5.1 | 4.5 | 3.4 | 4.3 |
| Annual Indicator | 2.9 | 3.2 | 4.6 | 2.2 | 2.2 |
| Numerator | 20 | 23 | 33 | 16 | 16 |
| Denominator | 686219 | 708557 | 723026 | 736615 | 736615 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 2.2 | 2.2 | 2 | 2 | 2 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2009

Denominator: IBIS Population estimates for 2009

Because our original objectives were set higher than what we had achieved in 2010, we adjusted down the performance objectives for subsequent years anticipating that the realistic objectives follow a trend.

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2009

Denominator: IBIS Population estimates for 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2008

Denominator: IBIS Population estimates for 2008

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 4.3 and the Annual Indicator was 2.2. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children was 2.2, thus exceeding the annual performance measure by a large margin.

The Violence and Injury Prevention Program (VIPP) collaborated with many partners to implement interventions for reducing motor vehicle crash (MVC) deaths among children in Utah. Funding and assistance to each local health department (LHD) was provided to conduct local injury prevention programs on bicycle, pedestrian, and motor vehicle safety. Over 263,899 people were reached through 1,942 events promoting motor vehicle safety. In addition, there were 33 media events promoting motor vehicle safety.

VIPP worked with LHDs to promote use of child safety seats through: Boost Till'8 Campaign which promoted car seat use to over 15,538 individuals with 1,149 activities at day care centers, schools, doctor offices, and businesses; distribution of more than 2,100 child safety seats; inspection of almost 3,700 child safety seats; conducting 55 car seat checkpoints; and educating the public through 11 media activities.

The pedestrian safety interventions included: promoting pedestrian safety to 121,057 individuals through 220 events; coordinating with local law enforcement on pedestrian safety enforcement; educating the public through media activities; and, providing pedestrian safety information on the UDOH website. The "Heads Up" pedestrian safety campaign that VIPP had developed was passed to Utah Department of Transportation (UDOT) in order for it to become more self-sustainable. UDOT continued these media efforts through radio messages, billboard, bus-board, etc. in the spring and fall of 2009. They also carried these efforts on in 2010.

The responsibility for bicycle safety was transferred to the Office of Highway Safety during this time period, but VIPP funded LHDs to distribute 1,645 bicycle helmets in their communities.

VIPP remained the lead agency for Safe Kids Utah (SKU). SKU, through local coalitions and chapters, was active in conducting numerous interventions including: car seat checkpoints, Child Passenger Safety Week, and Safe Kids Week; and, worked with the media to promote motor vehicle safety.

The Utah Teen Driving Task Force continued to coordinate the efforts of several state, local, and private agencies working together on the issue of reducing teen motor vehicle crashes. Since

teens are the role models for their younger siblings, impacting the teens' behavior will impact the siblings'. VIPP also coordinated a statewide campaign with all LHDs in Utah to reduce deaths to teens from motor vehicle crashes. This campaign targeted 15-19 year olds since they are involved in 22% of all MVC, but only represent 7% of licensed drivers in Utah. Utah drivers in their teens are 2.5 times more likely to be in a crash than drivers of other ages. At least 212 events were conducted reaching over 35,241 teens with 21 media events promoting teen motor vehicle safety. In addition, 80 additional events were held, reaching 32,941 parents or family members of teen drivers. VIPP and the Task Force developed the third annual teen memorial booklet "You Don't Get To Say Goodbye" on teen motor vehicle-related deaths in 2009. Other LHD interventions included: education; mobilization of local partners to identify and solve traffic safety problems; strengthening law enforcement partnerships; and, permanent seatbelt reminders installed in targeted communities.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Violence and Injury Prevention Program and local health departments reached over 263,800 people through 1,942 events promoting motor vehicle safety. In addition, there were 60 media events promoting motor vehicle safety. | | | X | |
| 2. The Violence and Injury Prevention Program and local health departments promoted car seat use to over 15,500 individuals through conducting awareness activities at day care centers, schools, churches, doctors' offices, and businesses. | | | X | |
| 3. The Violence and Injury Prevention Program and local health departments distributed over 1,645 bicycle helmets and 2,126 car seats and inspected 3,683 child safety seats. | | | X | |
| 4. VIPP coordinated with LHDs, local law enforcement, and local pedestrian safety enforcement to reach 121,057 people with pedestrian safety messages at 220 events. | | | X | |
| 5. The Violence and Injury Prevention Program remained the lead agency for Safe Kids Utah. | | | | X |
| 6. The funding and training provided to local health departments for a statewide campaign to promote teen motor vehicle safety resulted in 212 events reaching over 35,200 people and 21 media events. | | | X | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

VIPP collaborates with partners, including the Teen Traffic Safety Taskforce, Coalition for Utah Traffic Safety, etc., to implement strategies to reduce motor vehicle crash (MVC) deaths among children. Staff attends the Zero Fatalities Summit to network and recertify as car seat technicians.

Funding and technical assistance are provided to each local health department (LHD) to promote bicycle, pedestrian, and occupant safety.

Car seat efforts include: partnering with LHDs to promote proper use; conducting inspections; distributing low cost seats; working with media; and, providing UDOH and partners website information. A legislator introduced a bill to render the booster seat law useless. VIPP provided a

fact sheet showing the usefulness of the law and provided booster seat data.

VIPP, the lead agency for Safe Kids Utah (SKU), oversees coalitions/chapters statewide that coordinate interventions in their communities. SKU participates in the production of booster seat rodeos and PSAs to educate the public. The SKU website is up to date and allows Twitter.

VIPP is coordinating a statewide campaign with all Utah LHDs and other partners to reduce teen MVC deaths. VIPP is beginning to contact families of teens who died in 2010 to determine their willingness to participate in the fourth Teen Memorial Booklet. The 2007 memorial booklet is recognized on the Association of Maternal and Child Health Programs' (AMCHP) website as a best practice and has received other national awards.

c. Plan for the Coming Year

VIPP will continue collaboration work and efforts with its many partners to implement strategies for reducing motor vehicle crash (MVC) deaths among children in Utah. The Child Fatality Review Committee will continue to review all child deaths, including MVCs and produce a report on child deaths with recommendations. VIPP will continue to work with the Utah Brain Injury Council to produce data and reports on MVCs as a major cause of traumatic brain injuries.

Funding, training, and technical assistance to each LHD will be provided to conduct injury prevention interventions. Small area data will be provided to each LHD to guide the development of their contract activities to the highest priorities in their health districts.

Car seat efforts will include: partnering with LHDs to promote proper use of car/booster seats; conducting car seat inspections; assisting with community training; distributing low-cost car seats; educating children (K-12); working with media; and, providing information on the Utah Department of Health (UDOH) website. VIPP will also provide a revised legislative fact sheet on booster seat use.

VIPP, as lead agency for Safe Kids Utah (SKU), will oversee coalitions statewide. A primary goal is to reduce MV crash injuries and each coalition in collaboration with their LHD will coordinate interventions in their area including car seat check points, car seat inspection appointments, distributing low cost car seats and community education. The SKU website will allow for subscriptions to an electronic newsletter and increased use of social media. A booster seat video will be released to educate the public and legislators on the value of booster seat use and the booster seat law.

VIPP will continue pedestrian safety efforts by funding LHDs to: promote pedestrian safety events (Green Ribbon Month, Safe Routes to School, and Walk to School); partner with Gold Medal Schools and community organizations; distribute educational materials; work with the media; and coordinate with enforcement agencies.

VIPP will continue to coordinate a campaign with all LHDs aimed at reducing deaths to teens, 15-19 years of age, from MVC. Multifaceted interventions will include: education; mobilizing partnerships to solve traffic safety problems; partnering with law enforcement; and installing seatbelt reminder signs in communities. The 2010 Teen Memorial Booklet will be produced and distributed statewide through Drivers Education classes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 53 | 50 | 56 | 60.5 | 69.6 |
| Annual Indicator | 49.9 | 55.6 | 60.4 | 69.5 | 58.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 58.5 | 59 | 60 | 60.5 | 61 |

Notes - 2010

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2007. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2009

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2006. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2008

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2006. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 69.6% and the Annual Indicator was 58.3%.

Provisional data from the Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services National Immunization Survey indicated that Utah's breastfeeding rates were above the national average in five measures. The measures are: ever breastfed, breastfeeding at 6 months, breastfeeding at 12 months, exclusive breastfeeding at 3 months and exclusive breastfeeding at 6 months. The U.S. national average for breastfeeding at 6 months was 43.0%. The Healthy People 2010 Objective breastfeeding objective was for 50% breastfeeding at 6 months. Utah and 13 other states met this objective.

The CDC released the Breastfeeding Report Card with 9 indicators that measure elements of breastfeeding-friendly communities. Utah's score was 64 compared to the national average score of 65. Utah fell short in the number of International Board Certified Lactation Consultants (IBCLC) per 1,000 live births. There is no state legislation mandating employer lactation support and there is no state child care center regulation that supports lactation.

The CDC also released the results of the 2007 Maternity Practices in Infant Nutrition and Care (mPINC) survey, a state specific report that suggests opportunities to improve mother-baby care at hospitals and birth centers to increase initiation and duration of breastfeeding. The survey identifies strengths in Utah facilities and needed improvements. Overall, Utah ranked 25th out of 52 states/territories. Only 17% of Utah facilities have guidelines against routine supplementation with formula, glucose water or water and only 10% have comprehensive breastfeeding policies. Only 16% provide hospital discharge phone follow-up, the opportunity for a follow-up visit, or referral to community breastfeeding support. These findings can help to guide policy and interventions for improvements.

Many programs within the Maternal and Child Health Bureau collaboratively worked to support breastfeeding. The WeeCare pregnancy program provided education and support to over 1,000 clients. The WeeCare blog, with a large percentage of content devoted to breastfeeding, was visited with 4,490 page loads. The Pregnancy Risk Assessment Monitoring System (PRAMS) included questions on its survey to assess breastfeeding exclusivity and reasons that women stop breastfeeding. These data are forthcoming. The Maternal and Infant Health Program has several breastfeeding related articles on its website.

The Pregnancy Risk Line (PRL), a resource providing information to the public and health care providers on exposures during pregnancy and lactation, responded to 3,306 callers asking about the safety of an exposure during breastfeeding. Over 80% of the callers contacted the PRL prior to use of these products, providing the opportunity for staff to prevent exposure to a harmful medicine, chemical or other agent. It also provides an opening for discussion about the need to continue many medications that can improve the health of the infant and of the breastfeeding mother. The staff made 29 presentations on the principles of lactation, use of medications/drugs, chemicals or other agents during lactation to students, health care providers and the public. At health fairs and other venues the staff educated mothers and providers on the importance of breastfeeding. Many health care professionals, women and their families worry unnecessarily about a medicine and often stop breastfeeding as a result. By providing accurate and current information the PRL can prevent unnecessary cessation of breastfeeding.

The Utah Breastfeeding Coalition held a Breastfeeding Café in Salt Lake City, and Café events in Logan and St George. The Business Case for Breastfeeding was disseminated to businesses. An in-service was attended by the State of Utah Human Resources Administrators on workplace accommodations for nursing mothers. The Coalition recognized local businesses that have workplace lactation support programs by presenting awards at the Utah Council to Promote Worksite Wellness annual conference.

The WIC Program continued to implement the new food rules that limit formula issuance and increase breastfeeding assessment and counseling. Comprehensive lactation courses of 45 hours have been attended by many local staff. The WIC Breastfeeding Peer Counselor Program expanded allowing for services throughout the state.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The WeeCare program provided breastfeeding education, telephonic support, and a blog for over 1,000 clients. | X | | | |
| 2. The Pregnancy Risk Line answered over 3,000 breastfeeding calls. | X | | | |
| 3. The Pregnancy Risk Line provided 29 presentations to students, health care providers and the public on lactation and medications. | | | | X |
| 4. The Utah Breastfeeding Coalition held a Breastfeeding Café. | | | X | |
| 5. The Utah Breastfeeding Coalition promoted Baby Friendly | | | | X |

| | | | | |
|--|--|---|--|--|
| Businesses and the establishment of worksite lactation programs. | | | | |
| 6. The WIC program implemented new food rules limiting formula issuance and increasing breastfeeding counseling. | | X | | |
| 7. The WIC Breastfeeding Peer Counselor Program expanded throughout the state. | | X | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The UBC awarded seed money to 14 worksites to set up lactation programs and will continue to advocate for more worksites. A continuing education event was held on Tongue Tie and Breastfeeding and an additional event will be scheduled on Depression and Medication Use of Breastfeeding Mothers in Utah. The American Academy of Pediatrics Breastfeeding Chair implemented breastfeeding curriculum into pediatric residency training and is planning a breastfeeding session in the regional pediatric conference.

The PRL continues to provide information on maternal illnesses and medications to assure mothers that breastfeeding most often can be continued. Staff continues to provide presentations to health care providers on the importance of breastfeeding continuation, even when medications such as antidepressants, seizure medications and pain relievers are taken. The PRL helped create and will continue to disseminate information and screening tools on postpartum depression to help mothers receive mental health support so that breastfeeding can be continued even if mothers are in need of medications.

The NFP follows newborn intensive care graduates starting at 3-months after their discharge. The dietician encourages use of breast milk through twelve months adjusted age. A resource guide is being developed to support mothers in this endeavor.

The WIC program offers a variety of trainings such as lactation courses, two day workshops, peer counseling training, and 6 more staff became IBCLCs.

c. Plan for the Coming Year

Breastfeeding will be promoted in a variety of ways.

The UBC will hold the Breastfeeding Café with a variety of educational events. Worksite breastfeeding support will be promoted by disseminating the Business Case for Breastfeeding materials and seed money grant funding to establish worksite programs. A professional continuing education event will be held. A new Community Breastfeeding Resource Guide and Baby Friendly Business Listing are planned.

The PRL will promote breastfeeding by educating at least 3,500 women regarding the safety of breastfeeding while mothers are ill or taking a medication. The staff will provide at least 30 presentations to health care providers regarding the importance of continuing breastfeeding while taking medications. The staff will participate in health fairs to promote breastfeeding. At least 3 health fairs and/or other community activities focusing on low-income and minority populations will be attended. The PRL will publish the results of a study to determine how effectively teratology education and research centers can undertake research into effects of maternal medications, lifestyle and other environmental exposures on breast fed infants. The PRL will explore and develop a plan for following-up with all breastfeeding callers to determine if the caller continued or discontinued breastfeeding after speaking with a PRL counselor.

The WIC program will offer training opportunities to staff including comprehensive lactation courses and increase the number of IBCLCs staffed. The WIC Breastfeeding Peer Counselor

Program will contribute funds and expand this program by attending national training on new curriculum, disseminating the information, and training. A virtual peer counseling program will be implemented and more peer counselors hired. All WIC staff will complete the breastfeeding curriculum "Glow and Grow" and will receive educational resources and materials. A new computer system with specific infrastructure and interface components improving breastfeeding counseling and data reporting will complete rollout and be implemented statewide. WIC will implement the food rules that limit formula issuance and increase breastfeeding assessment and counseling, will collaborate with organizations to promote breastfeeding, and celebrate World Breastfeeding Week in August.

The WeeCare program will offer breastfeeding education and support, and will update its blog with current breastfeeding resources. Data from the PRAMS breastfeeding survey questions will be available and will help provide qualitative data.

The Neonatal Follow-up Program will counsel and support mothers of newborn intensive care unit graduates in breastfeeding and/or milk expression. Referral resources will be available.

The PANO program will work to increase the number of Baby Friendly Hospitals in Utah, to educate pediatricians on the importance of breastfeeding, and to promote worksite lactation support.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 97.5 | 97.9 | 97.5 | 97.9 | 98.1 |
| Annual Indicator | 98.0 | 97.9 | 98.1 | 98.3 | 98.3 |
| Numerator | 53454 | 55113 | 55705 | 54225 | 54225 |
| Denominator | 54532 | 56320 | 56788 | 55143 | 55143 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 98.3 | 98.3 | 98.3 | 98.4 | 98.4 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2009

Performance objectives reflect a projected trend of only small increases over time in this measure due to the many factors impacting rates, such as home births.

Notes - 2009

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database

Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database

Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2008

a. Last Year's Accomplishments

Performance measure was achieved. Performance Objective was 98.1%; Annual Indicator was 98.3%.

Universal newborn hearing screening is done at all Utah birthing facilities and the pediatric specialty hospital. Utah had 55,143 births in 2009 and 98.4% of babies were screened for hearing loss. The inpatient pass rate was 95.6%, which increased to 98.8% with outpatient screenings. Homebirth screening rates increased from 35.8% in 2008 to 48.1% in 2009. Almost 400 (372) newborns were referred for diagnostic evaluation. Seventy-one (71) infants were identified with permanent hearing loss. Approximately 1.7% of Utah's 2009 newborns have not returned for outpatient/diagnostic testing, have no screening results reported, or missed newborn hearing screening, a slight improvement from 2008. Data suggest that targeted efforts must be increased to meet national EHDl goals.

Utah EHDl's focus was to decrease the number of infants lost to hearing screening follow-up/documentation and improve program success for universal hearing screening. Utah has 45 hospitals/birthing centers with newborn hearing screening programs. Nineteen facilities have 2-stage screening capability using OAE and AABR technologies. After the initial OAE screen, an AABR is often completed before discharge for infants not passing or those meeting JCIH protocols. This additional step decreased the number needing to complete audiologic evaluation. The HiTrack 4 data tracking system was upgraded by streamlining new user/facility entry, improved filter options, merging results reports and detailed options for reporting data fields for the CDC's EHDl report. HiTrack server/data were moved to a virtual system at the State Capitol in November 2009, for better access and oversight of security requirements. An increase of 12 sites was noted in 2009, resulting in 33 programs now using the system. Monthly distribution of State HiTrack reports enabled timely data corrections and earlier tracking. HiTrack reports were utilized to assess hospital issues and allowed the program to initiate action plans to address program needs.

Six lay midwife programs were added to the Homebirth Hearing Project; home birth screening improved to 48.1% for 2009, up from 11% before the start of the project. Through participation in the Utah Regional LEND Program, Montana and Wyoming are now implementing lay midwife homebirth hearing projects.

Due to budget cuts, the UDOH audiology clinic in Cedar City closed in 2009. The Price office closed July 2010. These closures will negatively affect our lost to follow-up/lost to documentation progress. Rural public health providers, primary care providers, and early intervention programs will have limited/no access to hearing and follow-up services. Traveling multidisciplinary pediatric clinics with audiology services held up to 4 times per year can provide some rescreen/follow-up support in rural areas. Additional Homebirth Hearing Project lay midwives will be trained to improve rural access.

A Family-to-Family Action Plan was updated October 2009. EHDI, Early Intervention, Parent Infant Program, and URLEND staff created goals to improve family-to-family support, advocacy, and collaboration with community resources. A parent resource notebook developed with Utah State University Communicative Disorders (COMDDE) was completed and mailed to families/children enrolled in early intervention/deaf specialist services. The notebook reviews hearing loss, communication options, professional/community support systems, intervention needs, hearing aids, FM systems, and cochlear implants. Distribution was integrated into the diagnostic/early intervention referral process when hearing loss is confirmed. A collaborative parent survey evaluation project with COMDDE was completed. A phone survey provided family feedback on the usefulness/impact of the notebook's content. Results were presented to the Newborn Hearing Screening Committee and at the National EHDI Conference in February/March 2010.

Info sessions have been co-hosted by the AAP Chapter Champion at three regional sites. A hearing loss module was written for the Utah Med Home Portal. A podcast session was created for pediatricians regarding the JCIH 2007 Position Statement changes. The podcast was added to a series of audio-recorded continuing medical education (CME) presentations for pediatricians in the region.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Encouraged/supported two-stage hospital hearing screening. | | | | X |
| 2. Improved statewide inpatient (initial screen) "pass" rate. | X | | | |
| 3. Provided equipment and hearing screening training to six lay midwife groups and initiated screening and follow-up process with those groups. | | X | | |
| 4. Increased the overall number of home birth screenings statewide. | X | | | |
| 5. Continued to address uniform standards in screening, diagnostic testing, training, and experience. | | | | X |
| 6. Updated Family-to Family Support Action Plan October 2009. | | | | X |
| 7. Completed and distributed parent resource notebook. Evaluation of content was completed and presented Newborn Hearing Screening Committee and at the National EHDI Conference. | | | | X |
| 8. Increased collaboration with community partners. | | | | X |
| 9. Updated the EHDI (HiTrack) data management and tracking system at the State EHDI office and at an additional 21 facility programs. | | | | X |
| 10. Developed physician education materials for the Utah Medical Home Portal, AAP Chapter Champion inservice presentations, and for a JCIH 2007 podcast through the University of Utah, Department of Pediatrics. | | | | X |

b. Current Activities

On-going activities include: 1) Technical support and training to hospitals/birthing facilities to address barriers, emerging issues, and program improvement. Continue targeted visits to sites with high referral rates, low diagnostic completion rates, reporting issues. 2) Hire a Loss to Follow-up coordinator. Initiate direct outreach; assist families through follow-up, diagnostics and intervention referral. 3) Provide regional training sessions and research potential benefits of using "Go-To-Meeting" for rural training and assistance. 4) Continue Birth Certificate (BC) Alert project

delayed last year due to access/linkage issues for 2009 birth data. Provide an alert message to families when a BC application link generates a missed screening or needs follow-up message. Link additional BC sites to the project. 5) Expand Homebirth Hearing project to increase homebirth screening. Increase activities to reduce the number of infants missed or lost to follow-up. 6) Update Hearing Screening Module on the MedHome portal, develop an annual Newborn Hearing and Follow-up report to primary care providers, and increase educational presentations by EHDl AAP Chapter Champion. 7) Upgrade all sites to HiTrack 4 data system to allow increased emphasis on achieving performance standards. Facilitate/beta test audiologist reports in State HiTrack through a web portal. Complete development of electronic link with the Utah School for the Deaf Parent Infant Program data system to HiTrack via CHARM.

c. Plan for the Coming Year

A number of activities are planned to sustain the success of Utah's newborn hearing screening program while formalizing and standardizing methods to track infants lost to follow-up and to support the national 1-3-6 EHDl goals. Our focus is to reduce the number of infants who are lost to follow-up after a failed hearing screening, provide access to newborn hearing screening to families who have limited access and resources, and increase tracking and reporting capabilities for these infants. A new Loss to Follow-up Coordinator will initiate direct outreach to assist families through follow-up, diagnostics and intervention referral. Parent support will be increased statewide ensuring family awareness of family support organizations. A Parent Resource Notebook will be given to all families of children diagnosed with hearing loss. Efforts will continue to assist families who may not have appropriate resources to obtain state-of-the art amplification. Families will be partners in decision making at all levels. EHDl staff will determine families' level of satisfaction with services, strive to ensure that infants with hearing loss receive ongoing care within a medical home, and conduct outreach efforts to assess the adequacy of public/private insurance to pay for needed services. A plan will be developed to assure that all children who are not screened at birth (missed screening) or who pass the screening but have at least one risk factor for late onset or progressive hearing loss receive on-going monitoring.

Enhancements to the HiTrack 4 data system will improve the quality of the EHDl data to ensure better tracking and follow-up capability for infants who fail newborn hearing screening. Integration of the EHDl tracking system with other state screening, tracking, surveillance, and health information systems that serve children by leveraging information technology and public health informatics innovations will be expanded. Efforts to link babies to a medical home and then have access to accurate information about that medical home will continue.

An audiology workshop will be held for professionals working with young children with hearing loss to increase their capacity to provide age appropriate services. "Go-To-Meeting" options for rural training and assistance will be utilized.

The role of Homebirth Hearing project lay midwives in providing hearing screening coverage will be expanded. Strategies will include developing a consortium of trained screener lay midwives and a referral strategy for those non-hospital births to access the hearing screening process.

Evaluation of hospital programs and initiation quality improvement activities will be on-going. Results and recommendations will be reported to the Newborn Hearing Screening Advisory Committee and findings will be used to plan and implement future activities.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and | 2006 | 2007 | 2008 | 2009 | 2010 |
|----------------------|------|------|------|------|------|
|----------------------|------|------|------|------|------|

| Performance Data | | | | | |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 8.6 | 10.3 | 9.1 | 9.1 | 8.3 |
| Annual Indicator | 10.3 | 9.2 | 8.4 | 6.9 | 5.9 |
| Numerator | 83200 | 76734 | 71700 | 59700 | 51700 |
| Denominator | 804569 | 834070 | 857680 | 860368 | 875077 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 5.9 | 5.9 | 5.9 | 5.8 | 5.8 |

Notes - 2010

Source: Utah Healthcare Access Survey is now combined with BRFSS.

Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2010

Denominator: IBIS Population estimates 2010

Notes - 2009

Utah Healthcare Access Survey is now combined with BRFSS.

Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2009.

Denominator: IBIS Population estimates 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: The number of children with no insurance calculated using the data from the Utah Healthcare Access Survey, 2008.

Denominator: IBIS Population estimates 2008

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 9.1% and the Annual Indicator was 6.9%.

The Division monitored coverage rates for children in the state. The improvement in children's health care coverage is due in large part to additional funding from the state legislature allowing the state CHIP program to maintain open enrollment. Because CHIP has been continuously open, more children have applied for and been enrolled in Medicaid and CHIP. Given that in 2007, 10.9% of Utah children were not insured, we have made great progress in getting eligible children enrolled in public programs.

The Division staff continued its efforts on collaborating with CHIP and Medicaid agencies. The Division worked with the CHIP Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Monitored insurance rates among children in the state. | | | X | |
| 2. Monitored number of children enrolled in Medicaid and CHIP. | | | X | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

This year we have fewer resources to work on improving rates of insured children. We are recruiting for vacant positions which will help us do some important work. We did create a new position for school health which will allow us to focus on school age children. The person hired will be able to address insurance among school age children. Families seeking health insurance for their children were higher in the previous year, but are dropping off compared to last year's enrollment numbers. Current Medicaid numbers for children enrolled were 155,432 for April 2011 compared to October 2010 at 147,074. The numbers of children enrolled in Medicaid have increased more than 8,000 children in six months. In April 2011, 37,457 children were enrolled in CHIP compared to 38,681 in October 2010.

We have continued our efforts to support UtahClicks so that families in need can apply for certain services online. Since the rollout of the eREP system, UtahClicks doesn't interface with eREP so it is not as effective in enrolling children into services.

WIC promotes referrals to Medicaid and CHIP so that those who might be eligible can apply for benefits. The UDOH leadership has determined that health care reform and Medicaid reform are top priorities for the Department. The state legislators have been very critical of the rapidly increasing costs for Medicaid benefits and are determined to find ways to reduce costs. Medicaid is currently working on a waiver to reduce costs for the program.

c. Plan for the Coming Year

When the School Health Consultant is hired, we will develop plans to better promote application for benefits among school aged children and youth. With the expansion of home visiting services, we will ensure that home visitors link families with services that they may be eligible for. Home visitors can assist families and direct them to the agencies or resources to apply for benefits that they don't currently have.

The Department has identified health care reform as one of its top priorities in May 2011. With that level of support, we will be able to better promote the need for children to have health insurance. We plan to collaborate with the Center for Health Disparities Reduction and the CHIP Program to promote outreach activities to increase Medicaid and CHIP enrollment among racial and ethnic minority populations.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 21.6 | 21.6 | 21.6 | 21.8 | 21.8 |
| Annual Indicator | 21.8 | 21.8 | 21.8 | 21.8 | 20.7 |
| Numerator | 6558 | 6558 | 6558 | 6558 | 7083 |
| Denominator | 30083 | 30083 | 30083 | 30083 | 34217 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 20.7 | 20.5 | 20.5 | 20.3 | 20.3 |

Notes - 2010

The data are from the 2010 CDC Pediatric Nutrition Surveillance. Table 2 combining the 85th- <95th and greater than or equal to 95th BMI categories.

Notes - 2009

The data are from the 2005 Pediatric Nutrition Surveillance. Table 8C combining the 85th- <95th and greater than or equal to 95th BMI categories.

Due to the failure of a WIC computer system which was implemented in March 2006, data were unable to be saved and transferred to the CDC Pediatric Nutrition Surveillance system. Thus, 2005 data are referenced because this is the last data set obtained before the failed computer system was implemented in March 2006.

Notes - 2008

The data are from the 2005 Pediatric Nutrition Surveillance. Table 8C combining the 85th- <95th and greater than or equal to 95th BMI categories.

Due to the failure of a WIC computer system which was implemented in March 2006, data were unable to be saved and transferred to the CDC Pediatric Nutrition Surveillance system. Thus, 2005 data are referenced because this is the last data set obtained before the failed computer system was implemented in March 2006.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 21.8% and the Annual Indicator was 20.7%.

The Utah WIC Program continued to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) also called SNAPEd and the Food Stamp Nutrition Education Program (FSNE) known as the Food Sense Program. WIC children who were at risk of overweight or overweight were referred to these nutrition programs for Healthy Lifestyle classes. During 2010, 131 Healthy Lifestyle classes were taught in the Utah WIC clinics. More than 7,000 WIC participants completed the classes in a WIC clinic or an EFNEP or FSNE location. During WIC management evaluations, goal setting for achieving a healthy lifestyle had been

documented. The Help Me Be Healthy educational series on healthy eating and the Baby Play, Toddler Play and Child Play physical activity series were updated for children aged 1 through 4 years. These updated educational series were distributed to all local clinics. The Program Participant Satisfaction Survey was conducted in the spring of 2010 to assess participant perception of WIC services and acceptance of the new, nutrient rich foods including whole wheat bread and tortillas, brown rice, fresh fruits and vegetables, and low fat milk. Initial analysis revealed positive results indicating that 96% reported WIC services as either excellent or good; 93% preferred to purchase fresh fruits and vegetables as opposed to canned, dried or frozen; 68% reported that their family now eats more fruits and vegetables; 48% reported to eat more whole grains, 35% said they and their family drink fewer sodas and sweetened drinks, and 26% reported engaging in more physical activity since they enrolled in WIC.

Local WIC districts were not able to conduct a community needs assessment using the WIC Healthy Living Survey due to the increased work demands associated with the User Acceptance Testing (UAT) of the new computer system entitled, VISION. The VISION system has incorporated the Value Enhanced Nutrition Assessment (VENA) process into a navigational tree structure with different areas entitled: Health/Medical, Nutrition Practices, Life Style, and Social Environment. Open ended questions that facilitate a participant centered nutrition assessment were added to each nutrition interview screen. Self-paced training modules on VENA were completed to achieve participant centered nutrition assessments and ultimately positive health outcomes. These interactive training modules included: Critical Thinking, Emotion Based Messaging, Facilitating Support Groups, Stages of Change and Motivational Interviewing.

WIC P purchased and disseminated to all local clinics, 19,000 "Sesame Street Healthy Habits for Life -- Get Healthy Now" kits and 19,000 National WIC Association (NWA) 2010 Calendars which featured a healthy recipe each month. The key Healthy Habits for Life messages included: 1) Eat 5 fruits and vegetables every day; 2) Anytime foods are so good for you, they may be eaten anytime. Anytime foods include fruits, vegetables, beans, whole grains, and low fat milk; 3) Sometimes foods are usually high in sugar, fat and salt, so enjoy them sometimes; 4) Eat together as a family, and 5) The more you move, the healthier your body is, so be active every day!

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Referrals were made to SNAPEd or Food Sense and EFNEP. | | X | | |
| 2. The 2010 WIC Participant Satisfaction Survey was conducted. | | | | X |
| 3. Help Me Be Healthy educational series was updated and distributed. | | | | X |
| 4. Baby Play/Toddler Play/Child Play activity series was updated and distributed. | | | | X |
| 5. Sesame Street Workshop Healthy Habits campaign kits were disseminated. | | | X | |
| 6. NWA 2010 Calendars featuring healthy recipes were distributed. | | | | X |
| 7. Interactive VENA training modules were completed. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

All WIC children at risk of overweight and overweight are being referred to the Healthy Lifestyle classes offered by the Expanded Food and Nutrition Education Program (EFNEP), also called

SNAPed, and the Food Stamp/SNAP Food Sense Program.

The 2010 Utah WIC Program Participant Satisfaction Survey (PSS) responses are being analyzed for the purpose of improving WIC services, updating the Utah WIC Program Authorized Foods List and enhancing participant acceptance of the new, healthy food items.

The USDA Nutrition Risk Revision 10 has been incorporated into the current computer system, the new VISION computer system and the Utah WIC Policy and Procedure Manual. The logic model approach to program planning, the Value Enhanced Nutrition Assessment process and the use of WIC data reports from the Centers for Disease Control and Prevention allow for local WIC staff to implement a comprehensive nutrition needs assessment.

Breastfeeding has been associated with reduced odds for pediatric overweight. The USDA "Grow and Glow" training which promotes and supports breastfeeding was offered for all WIC staff for a three month time frame. This training continues to be offered in all WIC clinics for newly hired employees.

c. Plan for the Coming Year

The Utah WIC Program will continue to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) also called SNAPed and the Food Stamp Nutrition Education Program (FSNE) also known as the Food Sense Program. WIC children who are at risk of overweight or overweight will be referred to these nutrition programs for Healthy Lifestyle classes.

The results of the 2010 Utah WIC Program Participant Satisfaction Survey will be used to update and revise the Utah WIC Program Authorized Foods List. In addition, these results, along with the new 2010 Dietary Guidelines, will be used to revise nutrition education materials.

The Sesame Street "Food For Thought- Eating Well on a Budget" kits will be purchased and distributed to participants in all WIC clinics. This kit contains information in 5 different areas:1) Family Food Talk offers ways for families to talk together about food and related concerns that families may have, 2) Healthy Foods on a Budget includes ideas for families on how to plan, shop, and save money, 3) Healthy Choices Anytime provides tips for children to make healthy choices anytime and anywhere, 4) Making Connections contains ways to reach out for help and support, and 5) Sesame Street Recipe Cards provide healthy recipes.

The USDA FIT WIC Program designed to reduce the prevalence of childhood obesity will be reviewed and considered for implementation in all local WIC clinics. FIT WIC Program is demonstrating positive results in the Utah County WIC Program. The 2006 WHO growth charts for children birth to 24 months which show "how children should grow" will be implemented during FY 2012. Breastfeeding will be promoted as the biological "norm" for measuring healthy growth. The charts will enable WIC clinics to assess weights for infants and children up to age 24 months utilizing standardized BMI charts for the first time.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 4.6 | 4.2 | 4.2 | 4 | 3.8 |

| | | | | | |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Indicator | 4.3 | 4.1 | 3.9 | 3.6 | 3.6 |
| Numerator | 2228 | 2285 | 2188 | 1936 | 1936 |
| Denominator | 51517 | 55063 | 55605 | 53894 | 53894 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 3.5 | 3.4 | 3.3 | 3.2 | 3.1 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008

a. Last Year's Accomplishments

This performance measure was achieved. The Performance Objective was 3.8% and the Annual Indicator was 3.6%.

During 2010, the Utah Department of Health's Tobacco Prevention and Control Program (TPCP) distributed educational brochures and tobacco cessation tools -- "onesies", diaper wipes and changing pads imprinted with smoking cessation messages - via local health departments. This project was a part of the First Time Motherhood/New Parent Initiative Grant.

The TPCP First Step Program assisted pregnant women in their smoking cessation efforts. The program has been implemented in local health departments (LHDs). The LHDs found the six session format to be too long to retain attendees and, as a result, most LHDs have discontinued use of the program. However, two local health districts chose to continue the program. The remaining LHDs referred pregnant women to the Quit Line (this can be accomplished via fax) and promoted the cessation services available through that intervention.

During 2010, the TPCP visited private provider offices to provide consultations on incorporation of tobacco cessation materials and messages into their offices. The program also promoted the TRUTH Network Tobacco Cessation Program to the private providers as well as to the WIC Program and LHDs. The TRUTH Network Tobacco Cessation Program includes the Quit Line and the Quit Line fax referral system. LHDs, private providers and WIC offices fax referrals to the

TPCP Quit Line for pregnant women interested in receiving support in their cessation efforts.

Medicaid offered tobacco cessation services to pregnant women through a variety of outreach efforts. During a pregnant woman's initial Medicaid intake, the eligibility worker screened women regarding tobacco use. A woman with a positive screen was referred to a program that contacted her every six weeks throughout her pregnancy. Medicaid also covered nicotine replacement therapy when prescribed by the woman's health care provider. During FY2010, 1,200 low-income, uninsured, or Medicaid-insured pregnant women received free counseling and prescriptions for medications to help them quit using tobacco. More than 27% of participants in the TPCP-funded Medicaid program for pregnant women quit using tobacco and 24% reduced their tobacco use.

Due to time constraints, the article on the effects of tobacco use before, during and following pregnancy was not placed on the MIHP website. It will be added during FY2011 along with a link for health care providers to educational materials and resources for professionals.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Tobacco Prevention and Control Program distributed cessation messages imprinted on "onesies", changing pads and diaper wipes to local health departments. | | | X | |
| 2. Two local health departments continued to provide the First Step Program to pregnant women using tobacco. Other local health departments referred pregnant women wishing to quit tobacco use to the Tobacco Prevention and Control's Quit Line. | | X | | |
| 3. The Tobacco Prevention and Control Program's Quit Line fax referral system provided access to cessation support services for local health departments, WIC Offices and private providers counseling pregnant women reporting tobacco use. | | X | | |
| 4. Medicaid provided tobacco cessation support to pregnant women via phone calls from at six-week intervals during pregnancy. | | X | | |
| 5. The Tobacco Prevention and Control Program made visits to private provider offices to assist them in incorporating tobacco cessation messages and materials in their practices. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Tobacco Prevention and Control Program (TPCP) continue to distribute tobacco cessation messages from the First Time Motherhood/New Parent Initiative Grant. The TRUTH Network's Quit Line fax referral system continues in use. WIC screens all enrollees for tobacco use. WIC Offices, local health departments and private providers use the system to refer pregnant clients using tobacco to the Quit Line.

The Department of Workforce Services refers pregnant Medicaid applicants to Health Program Representatives for tobacco cessation support via phone calls every six weeks throughout pregnancy. In 2011, the number of Quit Line calls covered by Medicaid for pregnant clients was increased by adding an additional call during the postpartum period to women successful in

quitting or reducing tobacco use. The TPCP initiated texting women cessation support messages during pregnancy and post-delivery. The TPCP is analyzing the impact of these changes with results to be available in 2012.

The Maternal and Infant Health Program placed an article "Tobacco Use Before, During and After Pregnancy" on their website along with a link to resources for health care providers regarding tobacco cessation. Utah Vital Records birth data and PRAMS 2009 data are not yet available to review demographic characteristics of pregnant women smoking in the last trimester and to update the IBIS indicator on third trimester smoking. Data to determine the impact of the 2010 Utah tax increase are not yet available.

c. Plan for the Coming Year

During 2012 the Tobacco Prevention and Control Program (TPCP) will continue to utilize its TRUTH Network Tobacco Cessation Program's Quit Line as a primary source of education and support to pregnant women in their tobacco cessation efforts. The Quit Line fax referral system will continue to provide ready access for local health departments, WIC Offices and private providers to Quit Line services for their clients needing support in their cessation efforts.

Despite the end of the First Time Motherhood/New Parent Initiative Grant, the distribution of "onesies", changing pads and diaper wipes imprinted with tobacco cessation messages will continue by TPCP as long as supplies remain. The main distribution sites will be WIC Offices and through Medicaid. If funding is available, Medicaid may purchase additional changing pads and diaper wipes for their pregnant clients using tobacco.

The Medicaid eligibility workers will continue to screen all enrollees for tobacco use. Pregnant women using tobacco will be referred to Medicaid Health Program Representatives (HPR). With consent of the woman, a HPR will contact the woman by phone every six weeks during her pregnancy to support her cessation efforts. The woman will also be referred to the TPCP's Quit Line. A woman successful in either quitting or reducing tobacco use will receive an additional phone contact two to three months following delivery to reduce the risk of relapse. Medicaid will continue to provide coverage for nicotine replacement therapy when prescribed by the woman's provider.

In 2011 the number of calls to the Quit Line covered by Medicaid for pregnant women using tobacco was increased through the addition of a postpartum follow-up call to women successful in either quitting their tobacco use or in reducing it. To determine the impact of this addition, the TPCP is conducting a study to determine the effectiveness of this intervention. Analysis of the study results and a report will be available in 2012.

In 2011, the TPCP began providing supportive tobacco cessation messages to pregnant women during their pregnancies via text messaging. Text messaging is utilized, with the client's consent, to establish the woman's due date. Women successful in reducing or quitting tobacco use will receive an additional text message two to three months following delivery to encourage her cessation efforts and to reduce the risk of relapse. This intervention will be continued during 2012.

The Maternal and Infant Health Program will maintain on its website the article on tobacco use during the perinatal period along with the link for health care providers to cessation resources.. Vital Records and PRAMS data will be utilized to analyze the demographic characteristics of women using tobacco during the third trimester of pregnancy and the IBIS Indicator for third trimester smoking will be updated.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 13.9 | 13.2 | 13.2 | 10.6 | 11 |
| Annual Indicator | 10.4 | 10.6 | 11.5 | 12.1 | 12.1 |
| Numerator | 22 | 23 | 25 | 26 | 26 |
| Denominator | 212391 | 216313 | 216682 | 215470 | 215470 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 12.1 | 12 | 12 | 11.9 | 11.9 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2009
 Denominator: IBIS Population estimates for 2009 (UPEC, GOPB).

Given that the indicator was higher than the objective, we changed the subsequent objectives due to the shift upward in actual statistics. Obviously many factors impact this measure, but in order to be realistic about what we can accomplish, we increased the projected objectives to reflect the most recent data we have.

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2009
 Denominator: IBIS Population estimates for 2009 (UPEC, GOPB).

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2008
 Denominator: IBIS Population estimates for 2008.

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 10.6 and the Annual Indicator was 12.1.

The Children's Mental Health Promotion Specialist resigned from the UDOH in January 2010 and due to a hiring freeze, this position has not been filled.

The Utah Department of Health Violence and Injury Prevention Program (VIPP) continued to provide data collection and analysis services on Utah suicides (suicide fatalities, suicide

emergency room visits, and suicide hospitalizations). VIPP released the Utah Violence and Injury Small Area report which included suicide data. The Division's Medical Director and a VIPP representative attended and participated on the Child Fatality Review Committee related to child death review, domestic abuse and child abuse.

The Utah National Alliance on Mental Illness (NAMI) continued to provide the Hope For Tomorrow Program, a mental health education program which brings together the combined efforts and insights of mental health professionals, educators, and other experts to help parents, teachers, students and communities understand mental illness. The program focuses on educating students about mood disorders, substance use disorders and eating disorders.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provided data collection and analysis services. | | | | X |
| 2. Released the Utah Violence and Injury Small Area report. | | | | X |
| 3. Utah NAMI continued to provide the Hope For Tomorrow Program. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Utah Department of Health Violence and Injury Prevention Program (VIPP) continues to provide data collections and analyses services pertaining to Utah suicides. They track suicide data for children under 18 years in the Child Injury Fatalities in Utah, 2005-2007 report. This report is expected to be released in April 2011. VIPP has developed a fact sheet on suicides which is available on its website.

<http://www.health.utah.gov/vipp/pdf/FactSheets/suicide%202007.pdf>

This fact sheet is in the process of being updated with 2005-2009 data and is expected to be released in the spring of 2011.

The Division's Medical Director and a VIPP representative continue to attend the Child Fatality Review Committee related to child death review, domestic abuse and child abuse.

The Utah National Alliance on Mental Illness continues to provide the Hope For Tomorrow Program. This is a Mental Health Education Program which brings together the combined efforts and insights of mental health professionals, educators, and other experts to help parents, teachers, students and communities understand mental illness. The program focuses on educating students about mood disorders, substance use disorders and eating disorders.

The Utah Suicide Prevention Council, which is organized by the Utah Division of Health and Human Services, is not currently meeting. There are plans to reconvene the council in the future. Once the Council reconvenes, the UDOH will designate a representative to participate.

c. Plan for the Coming Year

The Violence and Injury Prevention Program (VIPP) will continue to provide data collection and analysis services pertaining to Utah suicides among youth aged 15-19. The Utah Department of Health VIPP Program will develop a draft plan to address the suicide prevention and awareness

within the UDOH and among partners. Funding is available for a position school health consultation who will be hired as soon as we find a suitable candidate. One of the responsibilities of this position will be to participate in youth suicide prevention activities with partners. Until resources are available, a detailed plan cannot be implemented to address this important issue.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 83 | 80 | 84 | 81 | 82 |
| Annual Indicator | 84.4 | 79.9 | 81.3 | 78.3 | 78.3 |
| Numerator | 475 | 460 | 469 | 440 | 440 |
| Denominator | 563 | 576 | 577 | 562 | 562 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 80.5 | 81 | 81.5 | 82 | 82.5 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 7 level III hospitals.

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 7 level III hospitals.

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 82% and the Annual Indicator was 78.3%.

The percentage of very low birth weight (VLBW) infants delivered at tertiary care hospitals (neonatal care facilities equipped to care for high risk neonates) has remained close to 80% in Utah over the past several years. This percentage falls below the Healthy People 2010 Objective Target of 90% and the new Healthy People 2020 Objective Target of 82.5%. It is important to continue to work to on this measure because when infants are delivered at the appropriate facility with the capabilities to care for high risk infants, their outcomes are improved.

In 2009, 562 infants were born weighing 1500 grams or less to Utah resident mothers. This number represents an incidence of 1.04% of all births. Of these infants, 440 were born at tertiary hospitals, and 122 were born at non-tertiary hospitals. There may be circumstances in which a delivery of a VLBW infant at a tertiary center is not possible such as a precipitous (very rapid) delivery. An additional circumstance in which a VLBW infant is appropriately delivered outside of a tertiary level facility may be when an infant has a condition that is incompatible with extra-uterine life and resuscitation will not be attempted. However, the majority of VLBW deliveries are more appropriately performed at a tertiary level hospital.

The designation of the seven tertiary hospitals in Utah remained unchanged and consistent with previous assessments on this performance measure since 2007. On the 2009 Perinatal Levels of Care Survey, ten hospitals identified their neonatal services as being Level III (tertiary care). Using the American Academy of Pediatrics Guidelines for Levels of Neonatal Care, only 3 hospitals actually meet the criteria for tertiary neonatal care. A meeting among public health officials and partners of the ten hospitals that self-designate as tertiary care hospitals is being planned to dialogue and clarify findings from the survey and to establish an agreed- upon criteria which may be uniformly applied in level of care designation for the care of VLBW neonates.

An analysis of the 2008 VLBW infants that were not delivered in tertiary care hospitals was performed. In each case, it appeared that appropriate decisions were made in dealing with circumstances such as a precipitous delivery with an abruption or ruptured membranes before the age of viability. These births occurred in multiple non-tertiary hospitals and no single hospital appeared to be an outlier.

The demonstration grant "Patient Safety and Medical Liability Reform" was not awarded to the Utah Department of Health's Division of Family Health and Preparedness, which would have been utilized in a statewide perinatal quality care collaborative.

The Division of Family Health and Preparedness programs continue to provide education and resources on achieving good health pre-conceptionally, having a healthy pregnancy, and adequate pregnancy spacing, in efforts to reduce the incidence of prematurity, the primary cause of VLBW infants. Other programs within the Division provide direct services to help these VLBW children live more normal healthy lives.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. A meeting among public health officials and hospital partners is planned to establish criteria to uniformly designate neonatal levels of care in Utah. | | | | X |
| 2. Analysis of 2008 very low birth weight infants occurring outside of tertiary care hospitals showed were appropriate and there were no outliers. | | | | X |

| | | | | |
|---|---|--|--|--|
| 3. The Division of Family Health and Preparedness Programs provide direct services, education and resources for women, their families, and providers in Utah. | X | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The meeting of the hospital stakeholders to discuss the neonatal levels of care should lead to an ongoing collaboration and clarification of the designation of tertiary hospitals providing neonatal care. This will help to update and more accurately designate the hospitals that offer tertiary neonatal care and those that are non-tertiary. The goal is to optimize the care for the most vulnerable newborns and assure that women and their obstetric providers have clear information about where to receive the most appropriate care should they be faced with this critical decision.

An analysis of 2009 live births of infants weighing less than 1500 grams to Utah residents born outside of tertiary hospitals is planned.

The Perinatal Mortality Review Committee continues to review infant deaths due to perinatal conditions to identify potential interventions and systems improvements to prevent future deaths.

Efforts are ongoing to educate women and their families on the known risk factors for having a VLBW infant and ways to mitigate these risk factors. The Maternal & Infant Health Program is disseminating information on the use of 17- P to reduce the incidence of preterm labor in women who have had a previous premature delivery, which includes information on the newly FDA approved medication named Makena.

c. Plan for the Coming Year

The proportion of VLBW infants that are delivered in tertiary care hospitals will continue to be measured. The designation of tertiary neonatal care facilities will be updated following the meeting of stakeholders. Results of the meeting will be disseminated to the various stakeholders that include the American Academy of Pediatrics and the Utah Hospital Association.

Programs within the Maternal and Child Health Bureau will continue to educate about known risk factors and especially lifestyle factors that can be modified, in efforts to decrease the incidence of VLBW infants in Utah. We will also promote the message that VLBW infants need to be delivered at tertiary care hospitals to improve their chances of a healthier outcome. The Perinatal Mortality Review Committee will continue to review VLBW infant deaths to identify potential interventions to prevent future deaths.

Programs within the Children With Special Health Care Needs Bureau will continue to offer direct services to children and families affected by VLBW.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------------------|-------------------------|--------------|
| Annual Performance Objective | 78.2 | 79 | 78.6 | 79 | 79.1 |
| Annual Indicator | 79.0 | 79.4 | 79.1 | 71.6 | 71.6 |
| Numerator | 42237 | 43728 | 43977 | 38562 | 38562 |
| Denominator | 53475 | 55063 | 55605 | 53894 | 53894 |
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 71.7 | 71.8 | 71.9 | 72 | 72.1 |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2008

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 79.1% and the Annual Indicator was 71.6%.

Utah Vital Records began using the 2003 birth certificate to collect 2009 data. As a result, 2009 data cannot be compared with data from previous years. While it appears there has been a decrease in the percent of women entering first trimester prenatal care, the extent of decline cannot be determined due to the change in data collection. In 2009, there was a high percentage of missing data (10%) which also impacted the accuracy of the performance measure's data. Most missing data related to the lack of the date of the last menstrual period (LMP) in the medical record. In an effort to reduce missing data, if only the day was missing, the fifteenth of the month was entered. This reduced the amount of missing data to 5.2%. However, if month and/or year were also missing, the LMP could not be calculated.

In an effort to promote early entry into prenatal care, the Division of Family Health and Preparedness provided oversight for 26 agencies acting as Qualified Providers in the Prenatal Presumptive Eligibility Program (PE) - (Baby Your Baby Program [BYB]). These 26 QPs provided PE determination at 57 sites throughout the state. Negotiations were underway at the close of

FY2010 to add another community health center in rural Utah and the Intermountain Health Care Hospitals as QPs in an effort to increase access to enrollment in PE.

During 2010, BYB applications were submitted via paper applications or Utah Clicks, an online application system that permits women and families to apply not only for BYB but also for services through Baby Watch, Children with Special Health Care Needs, Early Head Start and Head Start. In SFY 2010, 5,921 applications were submitted via Utah Clicks of which 3,072 (51.9%) were approved. This represents a decreased in submitted applications from SFY 2009 of 7,160 submissions. This decrease in online applications may be related to the FY2009 withdrawal of Medicaid from Utah Clicks as they transitioned into their electronic system -- eREP.

Due to funding cuts and contracting issues, in 2010 the BYB Campaign was unable to promote early prenatal care via television or radio ads. However, by the close of FY2010, a new Baby Your Baby Keepsake targeting Native American women had been developed and scheduled for distribution in FY2011. The campaign continued to provide the standard Baby Your Baby Keepsakes and distributed 26,755 English and 3,353 Spanish Keepsakes in FY2010. Baby Your Baby Keepsakes encourage early and continuous prenatal care. The campaign also distributed 4,280 English and 1,690 Spanish postcards to raise awareness of financial help available through the program.

The Division continued to provide limited funds to support the efforts of the Salt Lake Community Health Centers, Inc. to provide early and continuous prenatal care for unfunded women seen at their clinics throughout Salt Lake County.

The Maternal and Infant Health Program (MIHP) continued development of classes for women incarcerated at the state prison who are preparing for release back into the community. These classes are part of the prison's YPREP Program (Your Parole Requires Extensive Preparation). The MIHP classes will focus on preconception, prenatal and postpartum care. Through collaboration with the Pregnancy RiskLine and Sexually Transmitted Diseases (STD) Programs at UDOH and Planned Parenthood Association of Utah additional classes on substance use in pregnancy, STDs, normal female reproductive physiology and contraception will be provided.

The March of Dimes' Teddy Bear Den continued to promote early and continuous prenatal care by offering points to women entering early prenatal care. These can be redeemed at the Den for infant care products. In 2010 an increased number of women were served of which 85 to 90% were of Hispanic ethnicity.

The MIHP supported "text4baby", a campaign sponsored by the National Healthy Mothers, Healthy/Babies Coalition, by posting a link on the MIHP website to the campaign's website. In addition, text4baby marketing posters were disseminated to local health departments and appropriate community based organizations to promote the campaign.

The Utah PRAMS analysis of data on inadequate prenatal care among homeless women was incorporated into a UDOH health status update and was also presented at the 2010 Maternal Child Health Epidemiology Conference as a poster.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provided support for the Presumptive Eligibility Program (Baby Your Baby) to enhance early entry into prenatal care for low income women. | | X | | |
| 2. Distributed Baby Your Baby Keepsakes that promote early and continuous prenatal care and postcards regarding financial | | | X | |

| | | | | |
|--|--|--|---|---|
| assistance available via Baby Your Baby for low income women. | | | | |
| 3. Continued to provide limited financial assistance to Salt Lake Community Health Centers for unfunded prenatal care. | | | | X |
| 4. Developed classes for incarcerated women at the state prison preparing for release into the community in an effort to promote healthier lifestyles, an awareness of preconception health and family planning options. | | | | X |
| 5. Promoted "text4baby" through linkage on the Maternal and Infant Health Program's website to the campaign's website and dissemination of posters. | | | X | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
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| 10. | | | | |

b. Current Activities

The Maternal and Infant Health Program (MIHP) continues to support the Presumptive Eligibility (PE) Program including signing of a Memorandum of Agreement (MOA) with Intermountain Health Care to provide PE to qualifying women seeking pregnancy-related care via that system's emergency rooms. An MOA for PE determination was also signed with Green River Medical Center, a community health center in rural Utah.

A small amount of funding for under/uninsured women seeking prenatal care from Salt Lake Community Health Center, Inc. has continued.

Distribution of the Native American version of the Baby Your Baby Health Keepsake should occur by the end of FY2011. The Baby Your Baby Campaign is also developing contracts to reinstate public outreach via TV and radio spots during FY2012 that will promote early and continuous prenatal care.

YPREP (Your Parole Requires Extensive Preparation) classes for women preparing for release from the state prison have been presented. Classes on sexually transmitted diseases (STD); substance use before and during pregnancy and while breastfeeding; and on preconception health, pregnancy and postpartum care have been provided by the STD Program, MIHP and Pregnancy RiskLine Programs at UDOH. Planned Parenthood Association of Utah presented classes on normal female reproductive physiology and contraception. It is hoped that these classes will be retained as a permanent part of the YPREP Program.

c. Plan for the Coming Year

The Maternal and Infant Health Program (MIHP) will continue to provide supervision of Presumptive Eligibility (PE) / Baby Your Baby sites throughout the state to promote early entry into prenatal care. The eighteen Intermountain Healthcare hospital emergency rooms that became Qualified Providers of PE in FY2011 will be oriented to the PE Program site by site beginning with a trial roll-out at one of the system's Salt Lake County locations.

In an effort to improve reporting of entry into prenatal care on birth certificates, the MIHP will collaborate with the Utah Office of Vital Records and Statistics to promote further training of hospital personnel involved in completion of birth certificates. The program will also assist in the development of electronic record transfer system within Intermountain Healthcare hospitals.

The MIHP will collaborate with local health departments, community health centers, hospitals and other appropriate agencies to promote the national "text4baby" campaign. Through delivery of

three, free, text messages per week to pregnant women, early and continuous prenatal care is stressed along with other helpful pregnancy and new mother tips. Messages are sequenced to according to the pregnant woman's due date. Information encouraging women to sign-up for this free program can also be provided through posters and flyers at health fairs and via TV and radio spots.

To disseminate evidence-based information on a variety of perinatal topics, the MIHP will collaborate with other perinatal organizations in both the acute care and public health sectors to develop a maternal and child health special interest group within the Utah Public Health Association.

The MIHP will continue to provide YPREP (Your Parole Requires Extensive Preparation) classes to women incarcerated in the state prison prior to their release. These classes, provided in collaboration with the Pregnancy RiskLine, Sexually Transmitted Disease Program and Planned Parenthood Association of Utah will inform the women of resources for family planning and prenatal care and encourage them to adopt a healthier lifestyle both while incarcerated and after their release. The MIHP will also seek out opportunities to provide information on healthy lifestyles and the importance of early prenatal care to incarcerated female teens.

Provided adequate funding is available, the MIHP will continue to provide limited funding for under/uninsured women seeking prenatal care via the Salt Lake Community Centers, Inc.

The MIHP will collaborate with the Office of Health Disparities Reduction to develop cultural and linguistically appropriate campaigns for the Pacific Islanders and African American communities that encourage early entry into prenatal care and emphasize the importance of remaining in care throughout pregnancy.

D. State Performance Measures

State Performance Measure 1: *Percent of women of reproductive age (18-44 years) who report that they take a multivitamin pill or supplement containing at least 400mcg of folic acid daily.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------------------------------|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | 37.6 |
| Numerator | | | | | 52274 |
| Denominator | | | | | 138948 |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 38 | 39 | 40 | 41 | 42 |

Notes - 2010

This is one of the new SPMs identified during 2010 Needs Assessment . Data based on Utah Behavioral Risk Factor Surveillance System, 2010

Notes - 2009

This is one of the new SPMs identified during 2010 Needs Assessment

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
| 3. | | | | |
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b. Current Activities

The Utah Birth Defect Network (UBDN) continues to monitor the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Specifically, neural tube defects (NTDs) are monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

The Pregnancy Risk Line (PRL), receives over 10,000 calls per year, collaborates with the international Organization of Teratology Information Specialists (OTIS). PRL answers questions about medicines and exposures during pregnancy and breastfeeding. The PRL has consults with 19% of non-pregnant callers regarding multivitamin use.

In conjunction with the Power Your Life (PYL) social media campaign, free multivitamins were handed out to non-pregnant women at WIC. 5,774 bottles of vitamins were distributed as well as information within WIC. Through the PYL website over 10,000 power bags were distributed, which included a 3-month supply of vitamins and a reproductive life plan magazine.

Seven folic acid questions were asked on the 2010 BRFSS statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

Activities for Birth Defect Prevention Month and Folic Acid Awareness Week occurred in January 2011. Joint news release with PRL, and information packets were sent to OB/GYN offices with messages about folic acid and preconception health.

c. Plan for the Coming Year

The Utah Birth Defect Network (UBDN) will continue to monitor the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Specifically, neural tube defects (NTDs) will be monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

The UBDN will make the request for the folic acid question to be put on the 2012 BRFSS

statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

Activities will be planned around January Birth Defect Prevention Month and Folic Acid Awareness week.

From a baseline of 19%, 50% of non-pregnant callers and callers in early pregnancy as well as breastfeeding callers will be asked if they are taking a multivitamin with folic acid. If callers are not consuming a vitamin with folic acid, counselors will educate on the importance of the vitamin. Non-pregnant callers not yet taking folic acid will be offered and sent a free bottle of multivitamins containing folic acid. PRL will train counselors to respond to calls and enter data consistently.

PRL will increase the number of non-pregnant callers by incorporating social media activities that educate on the importance of taking folic acid for women of childbearing age. PRL will educate professionals on the importance of folic acid through presentations to pharmacy students and other pre-professionals and professionals.

State Performance Measure 2: *The percentage of Primary Cesarean Section Deliveries among Low Risk women giving birth for the first time.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------------------------------|------|------|------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 17.8 | 17.8 |
| Numerator | | | | 2695 | 2695 |
| Denominator | | | | 15150 | 15150 |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 17 | 16 | 15 | 14 | 13.5 |

Notes - 2010

This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Notes - 2009

This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| | |
|-------------------|---------------------------------|
| Activities | Pyramid Level of Service |
|-------------------|---------------------------------|

| | DHC | ES | PBS | IB |
|---|-----|----|-----|----|
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
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| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Maternal and Infant Health Program (MIHP) began tracking the number of cesarean births to low risk (singleton, full term, vertex presentation) primigravidas (first time mothers). The data source is birth certificates as filed with Utah's Office of Vital Records and Statistics.

The MIHP has also begun tracking numbers of elective labor inductions to assess any correlation with the increasing cesarean rate. The source for this information is Utah PRAMS (Pregnancy Assessment Monitoring System) data. The MIHP will also compare the reasons given for a cesarean delivery per the maternal self-report in PRAMS with the medical information provided on the birth certificate regarding the indication(s) for the cesarean.

The MIHP is exploring a long term goal of establishing a statewide perinatal quality improvement collaborative, which would include a consensus set of maternity performance and quality indicators. The MIHP and the Maternal and Child Health Bureau (MCHB) are now inviting interested partners to discuss discrepancies noted (per a statewide MCHB survey) among hospitals self-designating as Level III providers of neonatal intensive care. It is hoped that these upcoming discussions will be a springboard for continuing growth of collaborations among hospital administrators, providers and public health officials in establishing and assuring maternity quality measures. Models from other states are already well-established and available for study.

c. Plan for the Coming Year

In FY 2012, the MIHP will continue to collect data from birth certificates from Utah's Office of Vital Records and Statistics on the number of cesarean births to low risk women. Data will continue to be collected from the PRAMS surveys on elective induction of labor, and be compared with the medical information on the birth certificate regarding indications for the cesarean. Data will also be collected from the Office of Health Care Statistics (OHCS) on rates of pulmonary embolus and hemorrhage related to pregnancy, and correlated with rates of cesarean birth.

The MIHP and other Utah Department of Health (UDOH) representatives will be involved in all meetings related to discussion of Levels of Care designation for Neonatal Intensive Care Units (NICUs). Partnerships will be cultivated with the broad range of stakeholders who will be involved, with the eventual goal of wider applications of consensus-chosen measures of quality and quality improvement for maternal and newborn care. The initial community-wide meeting to begin the Levels of Care discussion will be in late May 2011 and be ongoing after that until agreement on standards is reached.

Medicaid funds one-third of all prenatal and delivery care in Utah. The MIHP will explore the idea of incorporating perinatal quality performance measures into Medicaid's quality improvement activities. This will happen via conversations with Medicaid's Bureau of Managed Care staff.

State Performance Measure 3: *The percentage of live births born before 37 completed weeks gestation.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 9.8 | 9.8 |
| Numerator | | | | 5272 | 5272 |
| Denominator | | | | 53894 | 53894 |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 9.7 | 9.6 | 9.5 | 9.4 | 9.3 |

Notes - 2010

This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Notes - 2009

This is one of the new SPMs identified during 2010 Needs Assessment.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2009

a. Last Year's Accomplishments

This is a new SPM identified and selected during MCH 2010 Needs Assessment.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|---------------------------------|-----------|------------|-----------|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The MIHP continues activities around progesterone supplementation (17P) for the prevention of recurrent preterm birth. Information cards were disseminated to NICUs, WIC offices, and Community Health Clinics. A poster display was presented at health fairs and professional meetings. The screening tool that was developed to identify women at risk was disseminated.

During these activities, the FDA approved 17P under the name Makena. The approval was accompanied by a dramatic price increase, leading the MIHP to temporarily suspend its promotion activities. Later in the year, the FDA said it would allow compounded pharmacies to continue to mix the drug at the lower cost. As a result, the MIHP will resume its promotion of 17P.

The MIHP brochure on the danger signs of pregnancy, geared towards helping women understand the sign and symptoms of preterm labor, was placed on the MIHP website for public access.

As being overweight or obese raises a woman's risk for preterm birth, the MIHP continues to collaborate with Physical Activity and Nutrition staff to increase the number of reproductive aged women who are at a healthy weight. A MIHP staff member provided a Check Your Health segment, talking about the importance of being at a healthy weight prior to pregnancy.

To provide information on late preterm births in Utah, the MIHP authored a two page "Health Status Report" on the topic. This report was distributed via the Department's web site and through the Utah Medical Association.

c. Plan for the Coming Year

As being overweight or obese raises a woman's risk for preterm birth, the MIHP will continue to collaborate with UDOH staff to increase the number of reproductive aged women who are at a healthy weight. The Physical Activity and Nutrition (PANO) program will work to implement strategies developed in the Utah Nutrition and Physical Activity plan. Specifically, MIHP staff will continue to participate in the PANO Health Care Work Group, which will work to educate providers on calculating a patient's body mass index at visits and counsel patients who are not at an optimal weight.

As induction is hypothesized to be contributing to the increases in late preterm birth rates, the MIHP will use PRAMS data to analyze reasons for induction and examine outcomes of induced deliveries.

The MIHP will continue to educate providers and women at risk for recurrent preterm birth on the use of 17 alpha hydroxyprogesterone. Data from the Utah PRAMS survey will be used to see if women at risk for recurrent preterm birth were offered 17P during their pregnancies and comparing outcomes of those who did and did not receive the medication.

The MIHP will work with the March of Dimes to explore potential venues for distribution of their "A Healthy Baby is Worth the Wait" materials.

As optimal maternal health in the preconception period raises the chances of a healthy pregnancy outcome, the MIHP will continue the "Power Your Life" campaign. This campaign educates women on being at optimal health in their reproductive years, specifically educating women on the benefits of folic acid consumption, tobacco cessation, abstinence from alcohol use, being at a healthy weight and other positive health behaviors.

In a recent analysis of late preterm births in Utah, we found that rates of late preterm birth were significantly higher for women with short interpregnancy intervals. The MIHP will disseminate materials on spacing pregnancies via health fairs and through the "Power Your Life" website, which contains a specific section on pregnancy spacing.

The MIHP will convene a time limited work group, comprised of public health and clinical professionals, to review Utah data on late preterm births and look for opportunities for public

health interventions.

State Performance Measure 4: *The percentage of Medicaid eligible children (1-5) receiving any dental service.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | 37.5 |
| Numerator | | | | | 32945 |
| Denominator | | | | | 87885 |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 39 | 40 | 41 | 42 | 43 |

Notes - 2010

This is one of the new SPMs identified during 2010 Needs Assessment.

Numerator: Medicaid CMS 416, FFY2010

Denominator: Medicaid CMS 416, FFY2010

Notes - 2009

This is a new measure identified during 2010 Needs Assessment

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|---------------------------------|-----------|------------|-----------|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
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b. Current Activities

The Oral Health Program (OHP) is working closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. The

educational video "A Healthy Smile for a Healthy Baby" was distributed to dentists, physicians and other health care providers. We continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. Oral health education material is posted on the OHP website and is being promoted.

The OHP collaborates with staff in Medicaid to expand current CHEC outreach programs and promote the CHEC dental case management system. In addition, the OHP works with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an enhanced benefit procedure during CHEC well child exams.

The OHP continues to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services by identifying and eliminating barriers.

c. Plan for the Coming Year

The Oral Health Program (OHP) will work closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. We will continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. The oral health education material that is posted on the OHP website will be updated and further promoted.

The OHP will collaborate with staff in Medicaid to expand current CHEC outreach programs and promote the CHEC dental case management system. In addition, the OHP will work with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an optional procedure during CHEC well child exams.

The OHP will also continue to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services by identifying and eliminating barriers.

The OHP is in the process of trending utilization data from the Medicaid 416 report for the past 6 years. This will help in identifying counties and local health departments which may need additional technical assistance to address access to dental care for children. The OHP will seek to identify grants to fund projects which will improve oral health care for underserved children.

State Performance Measure 5: *The percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings in their practice.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | | |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

Notes - 2010

This is a new SPM identified during 2010 Needs Assessment. State is currently working on developing a new survey tool as a data source for this measure. As a result, no projections are set for this measure.

Notes - 2009

This is a new SPM identified during 2010 Needs Assessment.

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
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b. Current Activities

This is a new state performance measure as of FY 2011. Developmental screening is recognized as an essential process to assure the early and appropriate diagnosis of children with developmental delays.

Presently, the Utah Medicaid program bundles the codes for well child checks and developmental screening. Past requests to have these services unbundled have been unsuccessful. With the current recognition of the importance of medical homes, developmental screening and increasing incidence of ASD, recent discussions with Medicaid have been more positive and hopeful. Unbundling of these services would allow MCH to monitor the developmental screens are billed through Medicaid. It would also encourage providers to perform developmental screens as reimbursement would be independent of the well child check.

Baby Watch/Early Intervention Program (BW/EIP) hired a graduate student to do a feasibility study for implementation of a formal ASD screening into each early intervention program. Although many were interested in implanting either the ASQ or the M-CHAT, many were reluctant stating that there were not sufficient referral centers to evaluative those with positive screens. In addition, there were concerns raised that it might require them to provide services that they were not able to. The discussion was welcomed and BW/EIP is hopeful that such screening may eventually be implemented into many if not all EI programs in Utah.

c. Plan for the Coming Year

The Division will continue to meet with and encourage Medicaid to unbundle the well child check and developmental screening codes. The Division will assist Baby Watch Early Intervention Program in their efforts to implement developmental screening in their programs.

The Division will continue to review the efforts made by the Bureau of Child Development in educating child care providers.

Utah will be exploring development of a survey for primary care providers/medical homes to both establish a baseline of current practice of developmental screening as well as monitoring this in future years.

Efforts will be being made to coordinate developmental screening services for parents and providers by working closely with The Children's Center of Salt Lake, Help Me Grow of United Way in Utah County, Division of Substance Abuse and Mental Health, as well as Community Mental Health Clinics and Early Intervention providers around the state.

It is projected that within the next year, a minimum of 20 early care and education programs throughout the state will be providing ASQ screening with an estimate of at least 500 up to several thousand children benefiting from this screening.

The Developmental Screening Coordinator of the Child Care Licensing Program will be developing a statewide developmental screening program. An ASQ developmental screening training that has been developed will be in the beginning phases of being offered to early care and education providers around the state. Attendees will receive the ASQ kit for their center or program.

Child Care Licensing Program will track statistics on screenings conducted. Data will be analyzed and utilized to modify the program as needed. The Bureau of Child Development will complete literature review off developmental screening tools and surveys. The Bureau of Child Development will organize an advisory group to review survey template. They will also develop and finalize a developmental screening survey and distribute to all UAAP and UAFP members. Based on the survey results, the Bureau of Child Development will develop a strategic plan for increasing the percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings.

State Performance Measure 6: *The percentage of students who smoked cigarettes; smoked cigars, cigarillos, or little cigars; or used chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 10.7 | 10.7 |
| Numerator | | | | 22575 | 22575 |
| Denominator | | | | 210982 | 210982 |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 10.6 | 10.5 | 10.4 | 10.3 | 10.2 |

Notes - 2010

This is a new SPM identified during 2010 Needs Assessment.

Numerator: YRBS, 2009
 Denominator: YRBS, 2009 and Population estimates (UPEC, GOPB)

Notes - 2009

This is a new SPM identified during 2010 Needs Assessment.

Numerator: YRBS, 2009
 Denominator: YRBS, 2009 and Population estimates (UPEC, GOPB)

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
| 3. | | | | |
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b. Current Activities

Health Communication Interventions: The Utah Tobacco Prevention and Control Program (TPCP) uses a variety of media outlets and messages to counter tobacco industry promotions that glamorize tobacco products. FY11 TV and print ads to prevent youth tobacco focus on revealing tobacco industry strategies to promote addiction.

Cessation Interventions: The TPCP offers tobacco cessation services for youth through telephone counseling (Utah Teen Tobacco Quit Line) and group programs for youth cited for tobacco possession (Ending Nicotine Dependence).

Community Interventions: The TPCP partners with local health departments and school districts to strengthen tobacco-free policies in schools and communities and to improve prevention education. The TPCP ensures that schools and communities have access to accurate information about new addiction-forming tobacco products such as dissolvable tobacco, e-cigarettes, and hookahs. The TPCP-sponsored anti-tobacco youth scene One Good Reason provides peer-to-peer education and grassroots marketing with youth groups at increased risk for tobacco use.

Evaluation: The TPCP uses focus groups to pre-test counter-marketing concepts with susceptible youth, as well as follow-up surveys to evaluate anti-tobacco campaigns. For cessation interventions, the TPCP tracks enrollment, satisfaction and quit rates. Community interventions are assessed through standardized surveys for policies, educational strategies, and public opinion on tobacco-related topics.

c. Plan for the Coming Year

The Utah Tobacco Prevention and Control Program (TPCP) will continue to use the Centers for Disease Control and Prevention's Best Practices to decrease tobacco use among youth. In addition to media messages that aim at revealing tobacco industry manipulation, the TPCP's counter-marketing campaign will develop and distribute graphic messages about tobacco's devastating health effects. The TPCP will continue to use focus groups and telephone surveys to pre-test and evaluate media messages. The TPCP will further explore online options for youth focused anti-tobacco advertising and research.

In addition to enhancing smoke-free norms and policies through community partnerships, the TPCP's community interventions will increasingly focus on youth access to tobacco products. The local health department-led tobacco retailer education and compliance check program will be expanded to include reviews of retail-based tobacco advertising practices near schools and of tobacco pricing strategies.

One Good Reason, Utah's tobacco-free youth scene will continue to partner with local youth groups to provide peer-to-peer anti-tobacco marketing and information to high risk youth at concerts, extreme sports events, and other youth gatherings. One Good Reason will continue to assist TPCP with gathering data on youth opinions about a variety of tobacco products and marketing techniques.

Since 2002, nearly half of Utah's 41 school districts have participated in special projects to develop and enforce comprehensive school tobacco policies. School districts were selected based on high tobacco use rates in their areas. In FY2012, the school tobacco policy projects will be part of a comprehensive evaluation led by the TPCP's independent evaluation contractor. The evaluation will assess enforcement of tobacco-free spaces and events, access to quit services and prevention education, community and family involvement in tobacco-free school initiatives, as well as changes in tobacco-related norms and school-district level tobacco use rates.

To track trends in use of a variety of traditional (cigarettes, cigars, chewing tobacco) and emerging tobacco products (dissolvable tobacco, Snus, hookah, e-cigarettes, new tobacco flavors) the TPCP will analyze YRBS and Prevention Needs Assessment data from the 2011 Utah School Health And Risk Prevention (SHARP) survey project. With increasing restrictions on cigarette smoking due to the risks of secondhand smoke exposure, the TPCP will specifically watch for any increases in use of smokeless tobacco products such as chewing tobacco, spit tobacco, dissolvable tobacco, hookah, and e-cigarettes. The TPCP will distribute findings among partners and work with partners to develop interventions if use of new and/or traditional tobacco products increases among certain youth demographics.

State Performance Measure 7: *The percent of youth during the last 12 months who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|------------------|------------------|-------------|
| Annual Performance Objective | 28.2 | 28 | 25.9 | 25.9 | 25.5 |
| Annual Indicator | 28.2 | 25.9 | 25.9 | 26.0 | 26.0 |
| Numerator | 434 | 499 | 499 | 408 | 408 |
| Denominator | 1540 | 1926 | 1926 | 1569 | 1569 |
| Data Source | | | See footnote for | See footnote for | See |

| | | | | | |
|-----------------------------------|-------------|-------------|-------------|-------------|-------------|
| | | | source | source | footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 25.9 | 25.9 | 25.8 | 25.8 | 25.7 |

Notes - 2010

Numerator: YRBS, 2009
Denominator: YRBS, 2009

Notes - 2009

Numerator: YRBS, 2009
Denominator: YRBS, 2009

Notes - 2008

Numerator: YRBS, 2007.
Denominator: YRBS, 2007.

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 25.9% and the Annual Indicator was 26.0%.

The Children's Mental Health Promotion Specialist resigned from the UDOH in January 2010 and due to a hiring freeze, this position has not been filled.

The Utah Department of Health Violence and Injury Prevention Program (VIPP) continued to provide data collection and analysis services pertaining to Utah suicides (suicide fatalities, suicide emergency room visits, and suicide hospitalizations). In February 2010 VIPP released the Utah Violence and Injury Small Area report which included suicide data. A children's nurse health consultant, whose main responsibilities would have been youth suicide, was not able to be hired due to budget restraints.

The Divisions' Medical Director and a VIPP representative attended and participated on the Child Fatality Review Committee related to child death review, domestic abuse and child abuse.

The Utah National Alliance on Mental Illness (NAMI) continued to provide the Hope For Tomorrow Program. This is a Mental Health Education Program which brings together the combined efforts and insights of mental health professionals, educators, and other experts to help parents, teachers, students and communities understand mental illness. The program focuses on educating students about mood disorders, substance use disorders and eating disorders.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Participated on the Utah Suicide Prevention Council. | | | | X |
| 2. Provided data collection and analysis services. | | | | X |
| 3. Released the Utah Violence and Injury Small Area report. | | | X | |
| 4. Utah NAMI continued to provide the Hope For Tomorrow Program. | | X | | |
| 5. Will continue efforts to address suicide once resources are available. | | | | X |
| 6. | | | | |

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b. Current Activities

The Utah Suicide Prevention Council, which is organized by the Utah Division of Health and Human Services, is not currently meeting. There are plans to reconvene the council in the future. Once the Council reconvenes, the UDOH will designate a representative to attend and participate.

The Utah Department of Health Violence and Injury Prevention Program (VIPP) continues to provide data collections and analyses services pertaining to Utah suicides. They track suicide data for children under 18 years of age in the Child Injury Fatalities in Utah, 2005-2007 report. This report is expected to be released in April 2011. VIPP has developed a fact sheet on suicides which is available on their website.

<http://www.health.utah.gov/vipp/pdf/FactSheets/suicide%202007.pdf> . This fact sheet is in the process of being updated with 2005-2009 data and is expected to be released in the spring of 2011.

The Utah National Alliance on Mental Illness (NAMI) continues to provide the Hope For Tomorrow Program. This is a Mental Health Education Program which brings together the combined efforts and insights of mental health professionals, educators, and other experts to help parents, teachers, students and communities understand mental illness. The program focuses on educating students about mood disorders, substance use disorders and eating disorders.

c. Plan for the Coming Year

The Utah Department of Health, MCH Bureau will work with the VIPP Program to develop a draft plan to address the suicide prevention and awareness within the UDOH and among partners. If funding becomes available, a position will be established for a children's nurse health consultant. One of the responsibilities of this position will be to participate in youth suicide prevention and mental health promotion activities with partners and the Suicide Prevention Council. The UDOH will continue to send a representative to the Suicide Prevention Council until the school health position is filled. Until resources are available, a detailed plan cannot be established to address this important issue.

The Violence and Injury Prevention Program will continue to provide data collection and analysis services pertaining to Utah suicides among youth aged 15-19.

State Performance Measure 8: *Percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past 7 days.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 47.3 | 47.3 |
| Numerator | | | | 99795 | 99795 |
| Denominator | | | | 210982 | 210982 |
| Data Source | | | | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |

| | | | | | |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 47.5 | 47.5 | 47.6 | 47.6 | 47.7 |
|------------------------------|------|------|------|------|------|

Notes - 2010

This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: YRBS, 2009

Denominator: YRBS, 2009

Notes - 2009

This is a new SPM

Numerator: YRBS, 2009

Denominator: YRBS, 2009

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
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b. Current Activities

The Utah Department of Health (UDOH), Physical Activity, Nutrition, & Obesity Program (PANO) is currently working on the following programs for helping to increase healthful eating and physical activity to prevent and control obesity and other chronic diseases among Utah youth.

- (1) The Gold Medal School Program helps elementary schools set up policy and environmental supports that make it easier for students and staff to be physically active and eat healthy food.
- (2) The "Unplug 'n Play" program encourages students and their families to limit TV and other screen time to less than two hours per day.
- (3) Walk to School Day is promoted each year in October to encourage students and their parents to walk to school safely. The goal is to encourage regular walking or cycling to school throughout the year.
- (4) Height and weight trends are being tracked in a sample of elementary students to see how Utah students compare to the U.S.
- (5) Action for Healthy Kids brings partners together to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies.
- (6) The "A Healthier You Legacy Awards Program" is a collaborative effort of the UDOH and community partners. The Program recognizes the efforts of communities, schools, and worksites

to increase opportunities for their constituents to participate in activities pertaining to nutrition, physical activity, and healthy behaviors.

c. Plan for the Coming Year

The Utah Department of Health (UDOH), Physical Activity, Nutrition, & Obesity Program (PANO) will continue to work on programs to promote increased healthful eating and regular physical activity to prevent and control obesity and other chronic diseases among Utah youth. Most of the PANO program activities will center around policy, systems, and environmental changes at the state level, but also provide technical assistance to Local Health Departments to implement community level specific change, supported by individual behavior change programs. The following list of activities represents those that will continue to be implemented.

(1) The Gold Medal School Program will continue to help elementary schools set up policy and environmental supports that make it easier for students and staff to be physically active and eat healthy food. This program is designed to create policy and environmental changes to support behavior change. Schools voluntarily participate in the program, and to date 382 schools from 39 out of 41 districts have participated in some manner. The UDOH partnered with the Utah State Office of Education, the Utah Parent Teacher Association, Intermountain Health Care, and Action for Healthy Kids in the development and implementation of this program.

(2) The "Unplug 'n Play" program will also continue to be implemented. This program encourages students and their families to limit TV and other screen time to less than two hours per day. Recent years have included contests between schools to track the greatest proportion of students who turned off their television for a week, and surveys of school media use policies.

(3) Walk to School Day will be promoted in October to encourage students and their parents to walk to school safely. The goal is to encourage regular walking or cycling to school throughout the year, but the UDOH has recently begun partnering with the Utah Department of Transportation to promote Walk More in Four, a program to promote walking in the four weeks prior to International Walk to School Week/Day.

(4) Height and weight trends will be tracked in a sample of elementary students to see how Utah students compare to the U.S. Students in selected schools within the 1st, 3rd, and 5th grades. This evaluation will identify Utah specific childhood obesity data that is representative of elementary school students statewide.

(5) The Action for Healthy Kids coalition will continue to meet with the goal to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies.

(6) The "A Healthier You Legacy Awards Program" is a collaborative effort of the UDOH and community partners. This program will continue to recognize the efforts of communities, schools, and worksites to increase opportunities for their constituents to participate in activities pertaining to nutrition, physical activity, and healthy behaviors.

State Performance Measure 9: *The percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 12 | 12 | 12 | 12 | 11 |
| Annual Indicator | 11.5 | 11.1 | 10.6 | 10.4 | 5.2 |
| Numerator | 2403 | 2371 | 2333 | 2305 | 1190 |
| Denominator | 20821 | 21362 | 21978 | 22080 | 22745 |

| | | | | | |
|-----------------------------------|-------------|-------------|-------------------------|-------------------------|--------------|
| Data Source | | | See footnote for source | See footnote for source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 5.5 | 5.5 | 5.5 | 6 | 6 |

Notes - 2010

Numerator: The number of children served in the rural area based on the Mega West billing system, 2010.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

Notes - 2009

Numerator: The number of children served in the rural area based on the Mega West billing system, 2009

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

Notes - 2008

Numerator: The number of children served in the rural area based on the Mega West billing system. 2008

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 11% and the Annual Indicator was 5.2%.

Flat Federal funding, drastic State budget cuts and an increasing rural population continued to present major challenges in maintaining service delivery and achieving the performance measure. Budget issues led to the need for staff reductions and an inability to maintain the same level of service as previous years. Although good portions of some services were cut, special attention was given to determining the most effective changes and cuts to make, in order to ensure the continued service provision of the most viable types of care in the most underserved areas. Despite these funding problems, efforts were made to continue to focus on providing the highest level of care possible to the children in rural areas of Utah. The Bureau of Children with Special Health Care Needs (CSHCN) continued contractual agreements with local health departments and with Intermountain Health to provide clinics at six different sites throughout the state. The contracts provided for RN nurse care coordinators and clerical support staff to schedule clinics, manage care coordination services, arrange tests, collect reports and maintain and manage patient charts, as well as office and clinic space. CSHCN provided training and support in the areas of care coordination, patient and chart management, community and tele-health staffing procedures, and workload management. CSHCN continued to provide ongoing support and training in regard to client database software, as well as billing programs used by the local sites to manage scheduling and patient information, in addition to chart tracking and management procedures and protocols. Contracts with the Department of Pediatrics, at the University of Utah Hospital were renegotiated and extended to provide consistent pediatric, sub-specialty evaluation services for these clinics as well.

The Bureau continued the use of our referral form, available on-line, to be used to solidify close coordination with primary providers. CSHCN was able to maintain its efforts to support the statewide Medical Home effort, and provided close contact and coordination with local primary care medical home providers surrounding optimal care for children. The Bureau continued to

support and facilitate collaboration and coordination between the rural clinics and pertinent CSHCN programs often involved the special populations served by the clinics, which included Neonatal Follow-up Program, Hearing, Speech and Vision Services; Fostering Healthy Children and Baby Watch Early Intervention programs. CSHCN continued its agreement with Intermountain Health, the primary health care provider in the State, to allow for access to their electronic health records (EHR) system, in addition to launching an exploratory process to look at securing and implementing our own EHR.

CSHCN continued its provision, albeit on a smaller scale due to staff reductions, of long-distance clinical health care and community staffing using tele-health videoconferencing technology in place through established video conferencing networks, thus, enhancing and supplementing services to rural children with special needs.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Engaged in strategic planning and reorganization of Bureau staff and resources in response to drastic State budget reductions. | | | | X |
| 2. Continued contractual agreements to provide clinics at six different rural sites. | X | | | |
| 3. Local RN and office support staff provided clinic coordination, scheduling, management, chart maintenance, and follow-up for each clinic. | X | | | |
| 4. CSHCN continued support and training for all outlying staff covering care coordination, patient and chart management, community and tele-health staffing procedures and general clinic management. | | | | X |
| 5. CSHCN continued to support and assist local clinics in coordination with the statewide Medical Home effort, other pertinent CSHCN programs, and care management efforts with local primary care providers. | | | | X |
| 6. Maintained ongoing use of referral form available on-line, to better facilitate communication and coordination with primary health providers. | | X | | |
| 7. Continued an agreement to gain access to electronic medical records maintained by the primary health care system in the State. | | | | X |
| 8. Initiated exploration of securing and implementing our own Electronic Health Record/Billing system. | | | | X |
| 9. Continued use of tele-health technology to provide long-distance care, coordination and staffing, optimizing the care for rural children with special needs. | X | | | |
| 10. | | | | |

b. Current Activities

State budget cuts and flat Federal funding continues to take a toll on abilities to provide services to the rural communities. Even with staff and service reductions, CSHCN Bureau is continuing its efforts to provide optimal care and services to rural children with special health care needs through specialty clinics and tele-health technology.

CSHCN contracts with local health departments and other agencies to conduct itinerant clinics in six sites in the state. Close scrutiny of the need for, and provision of, clinical services continues to

support changes leading to greater efficiency and cost-containment. In response to tightening funding from all sources, the Bureau is set to embark on a more targeted strategic planning effort, in May 2011, to focus on maximizing our provision of services to the most needy of children and families. Additionally, joint efforts with our contract partners are being made to facilitate greater efficiency and production thru those collaborations.

Through the use our on-line referral form, CSHCN continues to promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, working with local primary care medical home providers to coordinate the care and access to resources for children. To ensure better care coordination, increased access to private electronic health (EHR) records was continued, along with the formal exploration of our own EHR system to be implemented statewide.

c. Plan for the Coming Year

Flat Federal and decreased State funding, combined with an increase of population in some rural area and an on-going shortage of pediatric sub-specialists, continues to present challenges in providing needed care for Utah's Special Needs Children. Regardless of the loss of staff and services due to these challenges, the Bureau of CSHCN will continue to contract with local health departments and other entities to conduct itinerant clinics in six sites across the state. CSHCN will continue ongoing needs assessment and targeted strategic planning in order to evaluate the need for, and to maintain the services most in demand at those sites with increasing populations. Further exploration of consolidation of clinic sites that only serve a small population of children will continue. Through these contracts, local registered nurse care coordinators and clerical staff will schedule and conduct clinics, provide care coordination services, arrange tests, collect reports and maintain medical charts. CSHCN will provide ongoing consultation and support on care coordination issues to contract staff, along with training in these areas. CSHCN looks to implement a new electronic health records (EHR) system used at each site to schedule clinics, collect patient data, records maintenance and billing, providing all pertinent staff training, assistance and consultation as needed.

CSHCN will promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, and will work closely with local primary care medical home providers to further enhance our referral process and use of the referral form to better coordinate the care and access to resources for children. Additionally, rural nurses will continue to collaborate, and be assisted in doing so, with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children Program and the Hearing, Speech and Vision Services. These efforts will provide opportunities for community providers to join and interact with CSHCN clinical staff regarding specific care management issues. An ongoing Quality Improvement process will be continued as well.

The CSHCN Bureau will continue its efforts to provide optimal care and services to rural children with special health care needs through tele-health technology, looking to expand in this area as a cost saving method. Collaboration and contracting with entities from the University of Utah will be renegotiated to optimize the use of their sub-specialists at our clinics. Additionally, CSHCN, along with implementing our own EHR, will increase it efforts to collaborate with the CHARM, UHIN, CHIE and private EHR entities to move toward clinical information sharing between viable systems.

State Performance Measure 10: *The percentage of children (birth -17) eligible for Medicaid DM who are eligible for SSI.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and | 2006 | 2007 | 2008 | 2009 | 2010 |
|----------------------|------|------|------|------|------|
|----------------------|------|------|------|------|------|

| | | | | | |
|-----------------------------------|-------------|-------------|-------------|------------------------------|--------------|
| Performance Data | | | | | |
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 75.0 | 75.0 |
| Numerator | | | | 3821 | 3821 |
| Denominator | | | | 5093 | 5093 |
| Data Source | | | | See footnote for data source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| Annual Performance Objective | 85 | 90 | 90 | 90 | 90 |

Notes - 2010

This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Medicaid Report: PACMIS MR655 Part D, Utah Cases Served Statewide by Program Type and eREP Report ER-M-MP 650 Statewide Served by Benefit Type, "Number of CHILDREN served by Program combined DWS, DHS and Health".

Denominator: SSA, Social Security Record (Characteristic Extract Record Format), 100% Data "Number and percentage distribution of children in Utah receiving Federally Administered SSI payments, by selected characteristics, Dec 2009".

Notes - 2009

This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Medicaid Report: PACMIS MR655 Part D, Utah Cases Served Statewide by Program Type and eREP Report ER-M-MP 650 Statewide Served by Benefit Type, "Number of CHILDREN served by Program combined DWS, DHS and Health".

Denominator: SSA, Social Security Record (Characteristic Extract Record Format), 100% Data "Number and percentage distribution of children in Utah receiving Federally Administered SSI payments, by selected characteristics, Dec 2009".

a. Last Year's Accomplishments

This is a new State Performance Measure selected during 2010 MCH Needs Assessment. "Last Year's Accomplishments" section is not applicable. State would be reporting such information next year (FY13 Application).

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. This is a new SPM identified and selected during 2010 MCH needs assessment. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In 2010, CSHCN conducted a survey of over 1000 Utah families of children with special health care needs. The survey collected information about the challenges, barriers and needs in supporting their child with special needs. Initial review showed that financing of health care was one of the families' top needs and concerns. The survey information will be used to develop information and education about resources for funding of health care services including the potential eligibility for the Medicaid disability category.

Although many families have a commercial or private insurance plan the restrictions on the amount or scope of benefits create many unmet needs for children with special health care needs. Comprehensive health coverage for a child with special needs is critical to detect health problems, prevent deterioration of health and maximize the child's potential to survive and thrive. Utah Family Voices Family to Family Health Information Center provides information about Medicaid disability category and potential eligibility is provided to families who contact the center for information about concerns with health care financing issues. The staff participates with Medicaid by being a member of their Medical Care Advisory Council. The Family Involvement and Leadership program was established in the CSHCN bureau. The program coordinator and parent partners reviewed and collected existing information and education for consumers about SSI and the Medicaid disability category.

c. Plan for the Coming Year

The Family Involvement and Leadership program at CHSCN and Utah Family Voices will review and revise fact sheets and brochures, and use these to provide accurate information at display booths through the state at ongoing health fairs provided for families of children with disabilities and special health care needs. The information will also be provided through the various workshops for families and professionals about the resources that exist for health care financing. A presentation at the annual Family Links conference will include key information about Medicaid and SSI, focusing on the disability category and the link between the potential eligibility of both of the programs to help meet the health care needs of children.

Key information about the disability category of Medicaid will be included in newsletters of the Family to Family Health Information Center as well as the partner disability and advocacy organizations. The fact sheets will be distributed to participating Medical Home projects in the state and to the multidisciplinary trainees involved in the Utah Regional Leadership Education in Neurodevelopmental program educate about the needs and potential resource for the families they serve.

Utah Family Voices will provide information and education to families about effective record keeping in efforts to help the Medicaid Review Board determines the eligibility of their child. The staff at the Bureau of CSHCN and Family Voices will include information about getting interpretation for families who not speak English or who are deaf and refer to the available application in Spanish.

The staff will work with the Division of Workforce Services in identifying community intake workers that have extensive knowledge about the Medicaid disability category. The efforts of identifying key intake workers throughout the state to refer to will enable families to get timely information and an application completed to help with the potential eligibility of essential services for children with special health care needs.

The Bureau of CSHCN will collaborate with Medicaid and the Disability Determination Services to collect accurate data, which will then be compared to data received from reports of children who receive Social Security Income. The comparison data will help ensure that more families of children with special health care needs are aware of the disability category of Medicaid and

increase the Medicaid enrollment of children who are eligible for SSI.

E. Health Status Indicators

Introduction

Health Status Indicators are helpful in identifying problems and the trends over time. Program planning is guided by the data. These measures are important as they:

Provide information on the State's residents - The HSIs provide data that we review to determine whether we have a problem with a specific indicator or not, for a specific populations, such as mothers, children or adolescents. It helps us identify a specific issue for a specific population we serve.

Assist in directing public health efforts - The HSIs provide data for comparison with previous years' data to identify areas of need that may require new public health efforts, enhanced efforts or ones that we no longer need to continue. As an emerging issue arises, we can direct our efforts to the emerging issue as needed.

Serve as a surveillance or monitoring tool - The trends for a HSI allows us to review several years of data to determine whether we are making progress in the right direction or if we are needing to adapt public health efforts to improve the indicator. If progress is not happening, then we can examine the various factors related to the indicator that we might impact versus those we cannot.

Function as an evaluative measure - Many of the HSIs relate to National Performance Measures and can be used to evaluate the effectiveness of our public health strategies. We can monitor the trends to note progress or regression, however, one has to be careful in drawing conclusions of cause and effect versus association between two factors.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 6.9 | 6.7 | 6.8 | 7.0 | 7.0 |
| Numerator | 3710 | 3669 | 3784 | 3780 | 3780 |
| Denominator | 53475 | 55063 | 55605 | 53894 | 53894 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah experienced a slight rise in the percentage of low birth weight (LBW) births in 2009 (6.8%-7.0%). While this is of some concern, Utah remains below the national percentage of LBW births (8.2%). Level MCH Block grant funding and a lack of State General funding limit the program's ability to address LBW rates. However, Utah was one of the recipients of MCHB's First Time Motherhood/New Parent Initiative funding awards which enabled the program to implement the Power Your Life preconception social marketing campaign. In addition, Utah will receive over \$825,000 in teen pregnancy prevention funds for a five year period beginning in 2011. Since teens are at higher risk of having premature or low birth weight infants, preventing teen pregnancy may impact rates of LBW.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The Power Your Life social marketing campaign kicked off in July 2010. The campaign targets young women in Utah (special emphasis on younger, racial/ethnic minority women) with important preconception messages. The focal point of the campaign is an interactive website where women can learn about how to achieve optimal health before they conceive. Mass media messages were implemented to drive the target audiences to the website. There is abundant recent research indicating the link between optimal preconception health and improved pregnancy outcomes. In addition, contracts for Abstinence Education and Comprehensive Teen Pregnancy prevention programs are being implemented in 2011 which is expected to reduce the rate of teen births in Utah and may have an impact on our LBW rates.

c) Any interpretation of what the data mean?

The percent of live births weighing less than 2,500 grams in Utah has increased slightly over the past decade (2000-6.7% to 2009 7.0%). Several subpopulations of Utah women have higher rates; for example younger and older women experienced high rates of LBW; women aged 15-19 had a rate of 8.6% in 2009, women over 35 years or older had a rate of 8.8% compared to women age 20-34 years (6.7%). In addition, Utah Hispanic women had a rate of 7.6% in 2009 compared to non-Hispanic women (6.8%). Also, women who reported very short interpregnancy intervals (0-6 months) had a LBW rate of 9% in 2009 compared to women with interpregnancy intervals between 6 and 24 months (4.6%). Lastly, Utah women of color experienced higher rates of LBW than Utah White women (6.9%): Black (9.1%), American Indian (7.3%), Asian (10.3%), Hawaiian or Other Pacific Islander (8.6%).

In Utah Hispanic, Asian and Black/African American populations are growing at faster rates compared to state population as a whole. Since these populations experience higher rates of LBW than non-Hispanic White populations which may be one factor contributing to the increasing rate. Also, while the non-Hispanic teen birth rates are declining, Utah has experienced very high and increasing rate of teen births among Hispanic teens which is likely also contributing to

increasing rates of LBW births.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 5.4 | 5.3 | 5.2 | 5.2 | 5.2 |
| Numerator | 2784 | 2812 | 2791 | 2736 | 2736 |
| Denominator | 51922 | 53510 | 53882 | 52164 | 52164 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Please see HSI #01A, a.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status indicator?

The American College of Obstetricians and Gynecologists recommends the use of 17 alphahydroxyprogesterone (17P) beginning in the second trimester of a singleton pregnancy for women with a history of previous preterm birth. The Maternal and Infant Health Program (MIHP) has worked with multiple partners over the past year to promote the use of 17P for the prevention of recurrent preterm birth in singleton pregnancies. Pregnant women who have had a previous spontaneous preterm birth, particularly in the immediate preceding pregnancy, should be offered progesterone supplement beginning at 16-20 weeks of gestation. The MIHP began a campaign to increase awareness among women who have delivered a preterm infant about the option for progesterone supplementation (17P). Information cards were developed and printed for dissemination across the state. The same information was placed on the MIHP website. A

poster display on 17P was developed and presented at health fairs and professional meetings. A screening tool was developed to identify women who might benefit from information on 17P and was developed for utilization by staff at community health centers, presumptive eligibility workers, and Medicaid Health Program Representatives. The MIHP worked with staff in the Medicaid program to quickly identify pregnant Medicaid applicants at risk for repeat preterm birth that would benefit from 17P education and referral.

c) Any interpretation of what the data mean?

The percent of singleton live births weighing less than 2,500 grams in Utah has remained stable over the past decade (2000-5.2%, 2009-5.2%). However, the percentage of multiple births in Utah has risen slightly over the past decade (2000-2.8% to 2009-3.2%). A recently published Utah PRAMS data report indicates that from 2004 to 2008, 9.5% of women who indicated they were trying to get pregnant said they received some type of infertility treatment to help them get pregnant. This treatment is likely a contributing factor to the increase in the percentage of multiple births in Utah which may be contributing to our increasing rates of LBW births.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 1.1 | 1.0 | 1.0 | 1.0 | 1.0 |
| Numerator | 563 | 576 | 577 | 562 | 562 |
| Denominator | 53475 | 55063 | 55605 | 53894 | 53894 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

The rate of very low birth weight (VLBW) births has remained relatively stable over the past

decade (2000-1.1, 2009-1.0). These infants are extremely fragile with high rates of mortality and long term morbidity, which places extreme burden on the state in terms of costs and resources. Several years ago the Department considered a legislative funding priority for a program targeting women who delivered a VLBW birth during the interconception period with case management and intensive interventions to reduce her risks of having a repeat VLBW birth. The concept did not make the Department's final list of funding priorities due to budget shortfalls during the economic downturn.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Utah was granted First Time Motherhood/New Parent Initiative funding from HRSA's MCHB to implement a social marketing campaign about the importance of preconception health to healthy birth outcomes. The campaign, "Power Your Life, Power Your Health" kicked off in July of 2010 with TV and radio advertisements, an interactive website and dissemination of educational materials at community cultural events. The centerpiece of the campaign is the website where women can enroll to receive free vitamins and access a reproductive life planning tool. It is hoped that addressing wellness and reducing risks prior to pregnancy will decrease our rates of VLBW and LBW in Utah.

c) Any interpretation of what the data mean?

As previously mentioned, the rate of very low birth weight (VLBW) births has remained relatively stable over the past decade (2000-1.1, 2009-1.04). As with LBW births, several subpopulations of Utah women have higher rates; for example younger and older women experienced high rates of VLBW births for the period of 2007 - 2009; women aged 15-19 had a rate of 1.6% ,women over 35 years or older had a rate of 1.5% compared to women age 20-34 years (0.94%). In addition, Utah Hispanic women had a rate of 1.23% compared to non-Hispanic women (1.0%). Women who report a pre-pregnancy BMI in the obese category experienced higher rates of VLBW births (1.5%) compared to women in the normal pre-pregnancy BMI category (0.83%). Lastly, Utah women of color experienced higher rates of VLBW births than Utah White women; (1.0%); Black (1.94%), American Indian (1.44%), Asian (1.49%), and Hawaiian or Other Pacific Islander (1.6%).

A high percentage of VLBW infants do not survive. The 2008 birth weight specific mortality rate for VLBW infants was 216/1000 births. While 37% mortality is high, it is certainly in line with published outcomes for these very fragile infants. The biggest risk for mortality is in infants under 500 grams as evidenced by the mortality rate of 944.44/1000 births). The largest percentage of VLBW infant deaths are due to Perinatal Conditions (n=99 of 125). These cases are reviewed in our Perinatal Mortality Review Program and findings from reviews indicate that major contributors include an array of social determinants of health.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 |
| Numerator | 403 | 428 | 436 | 399 | 399 |
| Denominator | 51922 | 53510 | 53882 | 52164 | 52164 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and | | | | | |

| | | | | | |
|---|--|--|--|-------|-------------|
| 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Notes - 2008

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Please see HSI #02A, a.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The previously mentioned interventions to promote the use of 17P and the importance of preconception health through the Power Your Life campaign are hoped to have an effect on the rates of VLBW births as well as the LBW births.

c) Any interpretation of what the data mean?

The percent of singleton live births weighing less than 1,500 grams in Utah has remained relatively stable over the past decade (2000-0.82%, 2009-0.76%). The largest percentage of VLBW multiple births is seen in twin gestations with a VLBW rate of 8.06%. However, while the number of higher order multiple live births is quite low (2009 triplets n=157, quadruplets n=10), the rates of VLBW births are significantly higher (triplets-34.4%, quadruplets- 80%). Utah PRAMS data (2008) indicate that approximately 34% of twin gestations and 100% of higher order multiple births were conceived through assisted reproductive technologies.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|--------|--------|--------|--------|--------|
| Annual Indicator | 7.1 | 7.6 | 7.6 | 6.9 | 6.9 |
| Numerator | 49 | 54 | 55 | 51 | 51 |
| Denominator | 686219 | 708557 | 723026 | 736615 | 736615 |
| Check this box if you cannot report the | | | | | |

| | | | | | |
|---|--|--|--|-------|-------------|
| numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.
Office of Vital Records and Statistics death data, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2009

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics death data, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2008

Data reported are the most recent data available.
Office of Vital Records and Statistics death data, UDOH, 2008
Denominator: IBIS Population estimates for 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah has 14 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing injury among children.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Safe Kids is continually looking to attract new partners with similar goals for ages birth -14. Allied partners, outside of state/local government, have also been helpful when advocating for new laws and when bills are introduced in the legislature.

The VIPPP has produced a Small Area Injury Report that breakdown death, hospitalization and ED data further within local counties for leading causes of unintentional injuries.

c) Any interpretation of what the data indicate?

Utah's mortality rate of unintentional injuries to children has decreased slightly, but not statistically significantly since 2005. This decrease can be attributed to new laws and educational campaigns. However, Utah also gathers ED data and this combined with hospitalization data continues to give partners a good understanding of where problems exist.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 2.9 | 3.2 | 4.6 | 2.2 | 2.2 |
| Numerator | 20 | 23 | 33 | 16 | 16 |
| Denominator | 686219 | 708557 | 723026 | 736615 | 736615 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Office of Vital Records and Statistics death data, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2009

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics death data, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2008

Data reported are the most recent data available.

Office of Vital Records and Statistics death data, UDOH, 2008
Denominator: IBIS Population estimates for 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah has 14 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing motor vehicle related deaths and injury among children.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Safe Kids is continually looking to attract new partners with similar goals for ages birth -14. Allied partners, outside of state/local government, have also proven to be helpful when advocating for new laws and when bills are introduced in the legislature.

c) Any interpretation of what the data indicate?

There are too few child motor vehicle fatalities to determine a statistically significant increase or decrease in the data from year to year. However, Utah also gathers ED data which, combined with hospitalization data, continue to give partners a good understanding of where problems exist. The VIPP has produced a Small Area Injury Report that breaks down data further within local counties for leading causes of MV related fatalities.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 18.8 | 18.5 | 13.2 | 13.1 | 13.1 |
| Numerator | 86 | 85 | 60 | 59 | 59 |
| Denominator | 456465 | 459013 | 455836 | 451656 | 451656 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data reported are the most recent data available.

Office of Vital Records and Statistics death data, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2009

Data reported are the most recent data available.

Office of Vital Records and Statistics death data, UDOH, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2008

Data reported are the most recent data available.

Office of Vital Records and Statistics death data, UDOH, 2008
Denominator: IBIS Population estimates for 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

The Utah Teen Driving Safety Task Force, co-chaired by staff from the Violence and Injury Prevention Program, was formed in 2007 to better coordinate activities and resources of the many partners. Local health departments, law enforcement, highway safety, children's hospital, youth groups, and many other partners, have worked hard to educate teens and get them to adopt safe driving behaviors that they will continue to practice as they get older. This focus on teen drivers has also been a priority for local health department contracts with the UDOH for over five years. All participating partners are operating using one slogan and outreach campaign.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The Utah Teen Driving Safety Task Force continues monthly meetings to better coordinate activities as well as resources. The Task Force tries to provide a different approach or twist to the annual Don't Drive Stupid Campaign in order to engage more teens. This year a teen video contest for a PSA was conducted and the Teen Memorial booklet was distributed statewide to Driver's Education Classes.

c) Any interpretation of what the data indicate?

The number of licensed teenage drivers continues to grow in Utah. Despite this trend, the rate of MV fatalities among those aged 15-24 has decreased 46% from 24.4 per 100,000 in 1999 to 13.1 per 100,000 in 2009.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 132.9 | 139.2 | 124.6 | 124.6 | 124.6 |
| Numerator | 912 | 986 | 901 | 918 | 918 |
| Denominator | 686219 | 708557 | 723026 | 736615 | 736615 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data based on Hospital Discharge Database.
 Numerator: Hospital Discharge Database Injury Query Module, 2009
 Denominator: IBIS Population estimates for 2009

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=45371 & rate=6159.4 per 100,000

Notes - 2009

Data based on Hospital Discharge Database.
 Numerator: Hospital Discharge Database Injury Query Module, 2009
 Denominator: IBIS Population estimates for 2009

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=45371 & rate=6159.4 per 100,000

Notes - 2008

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah continues to be one of the states with the highest number of young children per family. LHD contracts require an active role in the Safe Kids coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing injury among children. Work continues to address this trend with the Safe Kids Coalitions/Chapters around the state despite level funding over this same time period.

Annual educational efforts and advocating for changes in laws continue to remain the focus for ages birth-14.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Safe Kids is continually looking to attract new partners as well as funding to address the needs of those aged birth-14. The VIPP has produced a Small Area Injury Report that breaks death, hospitalization and ED data down further within local counties for leading causes of unintentional injuries.

c) Any interpretation of what the data indicate?

The non-fatal rate of injuries among children has decreased since 2001. During that 9 year time period the rate of non-fatal injuries among children has decreased 31% from 898 per 10,000 in 2001 to 616 per 10,000 in 2009 (based on combined hospital discharge and ED data). Decrease in rate was also observed since 2007 based on hospital discharge data alone (139.2 to 124.6 per 100,000).

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 36.7 | 41.4 | 33.3 | 19.4 | 19.4 |
| Numerator | 252 | 293 | 241 | 143 | 143 |
| Denominator | 686219 | 708557 | 723026 | 736615 | 736615 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data based on Hospital Discharge Database Only.
 Numerator: Hospital Discharge Database Injury Query Module, 2009
 Denominator: IBIS Population estimates for 2009

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=1984, denominator=736615, & rate=269.3 per 100,000

Notes - 2009

Data based on Hospital Discharge Database Only.
 Numerator: Hospital Discharge Database Injury Query Module, 2009
 Denominator: IBIS Population estimates for 2009

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=1984, denominator=736615, & rate=269 per 100,000

Notes - 2008

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah leads all states with the number of young children per family. Utah has 14 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families despite level funding during this time period. Safe Kids members have been good advocates for any necessary changes in laws focused on preventing injury among children; they have also been crucial in protecting the booster seat law from attempts to weaken it.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The UDOH, Safe Kids, and other traffic safety partners are continuing to improve MV related safety. Efforts include moving toward a primary seatbelt law for all ages and defending threats to weaken the booster seat law.

c) Any interpretation of what the data indicate?

Utah has seen a decrease in the non-fatal MV rate of injuries to children since 1999. During that 11 year time period, the rate of non-fatal MV injuries has decreased 46% from 501.7 per 100,000 in 1999 to 269.3 per 100,000 in 2009 (based on combined hospital discharge and ED data). The rate of non-fatal MV injuries decreased 42% between 2008 and 2009 (33.3 to 19.4 per 100,000 based on hospital discharge data).

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 130.1 | 128.3 | 122.2 | 70.9 | 70.9 |
| Numerator | 594 | 589 | 557 | 320 | 320 |
| Denominator | 456465 | 459013 | 455836 | 451656 | 451656 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Notes - 2010

Data based on Hospital Discharge Database Only.
 Numerator: Hospital Discharge Database Injury Query Module, 2009
 Denominator: IBIS Population estimates for 2009

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=5419, denominator=451656, & rate=1199.8 per 100,000

Notes - 2009

Data based on Hospital Discharge Database Only.
 Numerator: Hospital Discharge Database Injury Query Module, 2009
 Denominator: IBIS Population estimates for 2009

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=5419, denominator=451656, & rate=1199.8 per 100,000

Notes - 2008

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

The Utah Teen Driving Safety Task Force, co-chaired by staff from the Violence and Injury Prevention Program (VIPP), was formed in 2007 to better coordinate activities as well as resources of the many partners. Local health departments, law enforcement, and many other partners have worked hard to educate teens and young adults to adopt safe driving behaviors. A focus on teen drivers has also been a priority in local health department contracts with the UDOH for over five years. All participating partners are operating under one slogan and outreach campaign.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The Utah Teen Driving Safety Task Force continues monthly meetings to better coordinate activities as well as resources. The Task Force tries to provide a different approach or twist to the annual Don't Drive Stupid Campaign in order to engage more teens. This year a teen video contest for a PSA was conducted and the Teen Memorial booklet was distributed statewide to Driver's Education Classes.

c) Any interpretation of what the data indicate?

The non-fatal rate for MV injuries for those aged 15-24 has decreased significantly since 1999. During that 11 year time period, the non-fatal MV injury rate has decreased 50% from 2400 per 100,000 to 1200 per 100,000 for those aged 15-24 (based on hospital discharge & ED data). The VIPP combines hospital discharge data and ED data to monitor the trend and to get a better picture of where problems exist. Using hospital discharge data alone we also observed a decrease from 122.2 per 100,000 in 2008 to 70.9 per 100,000 in 2009.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 11.2 | 12.4 | 12.9 | 13.4 | 14.0 |
| Numerator | 1196 | 1412 | 1435 | 1451 | 1543 |
| Denominator | 107209 | 113614 | 110841 | 108205 | 110053 |

| | | | | | |
|---|--|--|--|-------|-------|
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2010
Denominator: IBIS Population estimates for 2010

Notes - 2009

Data reported are the most recent data available.

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2009
Denominator: IBIS Population estimates for 2009

Notes - 2008

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2008.
Denominator: IBIS Population estimates for 2008.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff and duties within the Bureau of Epidemiology have improved services with a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community. The Utah Department of Health coordinates with public and private providers offering STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 and 20-24.

Centers for Disease Control funding for prevention, testing, treatment, and local health department support remains steady. Limited state funding for an STD awareness campaign will continue through June 30, 2011.

Centers for Disease Control funding for prevention, testing, treatment, and local health department support remains steady, and limited state funding for an STD awareness campaign continues.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

This indicator assists UDOH programs in monitoring trends in rates which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Limited state funding provides the capacity to maintain an STD awareness campaign aimed at youth, parents and health care providers. This unique campaign creates additional opportunities for access to information and resources; however, this funding will be eliminated as of June 30, 2011. Other changes in organization at the UDOH provide new opportunities for collaboration between programs. As programs continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections that other programs and staff have already made, as well as strengthen our efforts to reach these populations state-wide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c) Any interpretation of what the data indicate?

Data for 2010 indicate a chlamydia rate of 14.0 per 1,000 females aged 15 through 19 years old, a 4.5% increase since 2009 when the rate was 13.4 per 1,000 females aged 15-19 years old. The 2010 case increase may be due to several reasons, including data management issues that have not been identified and chlamydia testing has increased.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 4.5 | 5.0 | 5.0 | 4.9 | 5.5 |
| Numerator | 2183 | 2471 | 2567 | 2493 | 2847 |
| Denominator | 484264 | 496192 | 511628 | 510434 | 519153 |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Notes - 2010

Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2010

Denominator: IBIS Population estimates for 2010

Notes - 2009

Data reported are the most recent data available.

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2009

Denominator: IBIS Population estimates for 2009

Notes - 2008

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2008.

Denominator: IBIS Population estimates for 2008.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff and duties within the Bureau of Epidemiology have improved services. There is now a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community. The Utah Department of Health coordinates with public and private providers offering STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 and 20-24.

Centers for Disease Control funding for prevention, testing, treatment, and local health department support remains steady. Limited state funding for an STD awareness campaign will continue through June 30, 2011.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

This indicator assists UDOH programs in monitoring trends in rates which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Limited state funding provides the capacity to maintain an STD awareness campaign aimed at youth, parents and health care providers. This unique campaign creates additional opportunities for access to information and resources; however, this funding will be eliminated as of June 30, 2011. Other changes in organization at the UDOH provide new opportunities for collaboration between programs. As programs continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections other programs and staff have already made, as well as strengthen our efforts to reach these populations state-wide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c) Any interpretation of what the data indicate?

Data for 2010 indicate a chlamydia rate of 5.5 per 1,000 females aged 20 through 44 years, a 12% increase from 4.9 per 1,000 females aged 20-44 years in 2009.

This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

| CATEGORY TOTAL POPULATION BY RACE | Total All Races | White | Black or African American | American Indian or Native Alaskan | Asian | Native Hawaiian or Other Pacific Islander | More than one race reported | Other and Unknown |
|---|--------------------------------|--------------|--|--|--------------|--|--|----------------------------------|
| Infants 0 to 1 | 53894 | 46242 | 615 | 696 | 963 | 355 | 194 | 4829 |
| Children 1 | 219829 | 200283 | 4702 | 4033 | 4322 | 2159 | 4330 | 0 |

| | | | | | | | | |
|------------------------|---------|---------|-------|-------|-------|-------|-------|------|
| through 4 | | | | | | | | |
| Children 5 through 9 | 249845 | 225462 | 5167 | 4106 | 4633 | 2380 | 8097 | 0 |
| Children 10 through 14 | 219460 | 199755 | 4179 | 3257 | 3737 | 2033 | 6499 | 0 |
| Children 15 through 19 | 217728 | 199033 | 3694 | 3812 | 3798 | 2103 | 5288 | 0 |
| Children 20 through 24 | 249994 | 231046 | 3241 | 3847 | 5180 | 2166 | 4514 | 0 |
| Children 0 through 24 | 1210750 | 1101821 | 21598 | 19751 | 22633 | 11196 | 28922 | 4829 |

Notes - 2012

Birth Data 2009

IBIS Population Estimates, 2009

Narrative:

This table shows the Utah population for infants and children (< 25 years) by age and race. Tracking this indicator allows us to monitor population size, demographic changes, and which sub-group is experiencing the most growth. This information helps in planning appropriate program activities and interventions.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

| CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported |
|--|---|-------------------------------------|-----------------------------------|
| Infants 0 to 1 | 44122 | 8768 | 1004 |
| Children 1 through 4 | 179817 | 40012 | 0 |
| Children 5 through 9 | 206886 | 42959 | 0 |
| Children 10 through 14 | 186547 | 32913 | 0 |
| Children 15 through 19 | 189028 | 28700 | 0 |
| Children 20 through 24 | 222096 | 27898 | 0 |
| Children 0 through 24 | 1028496 | 181250 | 1004 |

Notes - 2012

Narrative:

Utah's Hispanic population increased from 9% in 2000 to 12% of the population in 2008. This represents an increase of 33%. Mexicans continue to be both the largest and fastest growing group of Hispanics in the state. MCH programs partner with various health programs and other state agencies to ensure linguistically and culturally appropriate services are available for this population.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

| CATEGORY Total live births | Total All Races | White | Black or African American | American Indian or Native Alaskan | Asian | Native Hawaiian or Other Pacific Islander | More than one race reported | Other and Unknown |
|--------------------------------------|------------------------|--------------|----------------------------------|--|--------------|--|------------------------------------|--------------------------|
| Women < 15 | 36 | 24 | 0 | 0 | 0 | 0 | 0 | 12 |
| Women 15 through 17 | 995 | 705 | 16 | 36 | 9 | 5 | 2 | 222 |
| Women 18 through 19 | 2366 | 1787 | 47 | 69 | 19 | 26 | 13 | 405 |
| Women 20 through 34 | 45177 | 39339 | 491 | 532 | 738 | 283 | 162 | 3632 |
| Women 35 or older | 5320 | 4387 | 61 | 59 | 197 | 41 | 17 | 558 |
| Women of all ages | 53894 | 46242 | 615 | 696 | 963 | 355 | 194 | 4829 |

Notes - 2012

Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2009

Narrative:

This table shows the resident births by maternal age and race. In 2008, there were a total of 55,605 births in Utah. This represents an eight percent increase in numbers from 2005 (51,517). The birth data allow us to analyze trends in birth rates as well as birth outcomes among different racial and ethnic groups. For example, the percentage of LBW was much higher among infants born to black women compared to infants born to white women (13.0% vs 6.7%).

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

| CATEGORY Total live births | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported |
|--------------------------------------|-------------------------------------|---------------------------------|-------------------------------|
| Women < 15 | 13 | 23 | 0 |
| Women 15 through 17 | 512 | 473 | 10 |
| Women 18 through 19 | 1545 | 783 | 38 |
| Women 20 through 34 | 37831 | 6525 | 821 |
| Women 35 or older | 4221 | 964 | 135 |
| Women of all ages | 44122 | 8768 | 1004 |

Notes - 2012

Narrative:

The percentage of Utah births by Hispanic women have increased over the last few years. In 2008, Hispanic birth accounted for 17% of all births. Analyzing birth data shows that Hispanic females ages 15-19 continue to have the highest teen birth rate in Utah.

MCH programs and LHD have increased staff who are bilingual in order to meet the needs of the

growing Spanish speaking population they serve. More materials and resources have been translated and made available for this high-risk sub-population.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

| CATEGORY Total deaths | Total All Races | White | Black or African American | American Indian or Native Alaskan | Asian | Native Hawaiian or Other Pacific Islander | More than one race reported | Other and Unknown |
|---------------------------------|------------------------|--------------|----------------------------------|--|--------------|--|------------------------------------|--------------------------|
| Infants 0 to 1 | 281 | 235 | 5 | 1 | 5 | 1 | 0 | 34 |
| Children 1 through 4 | 46 | 37 | 1 | 0 | 2 | 1 | 0 | 5 |
| Children 5 through 9 | 31 | 29 | 1 | 0 | 0 | 0 | 0 | 1 |
| Children 10 through 14 | 27 | 22 | 1 | 0 | 0 | 0 | 0 | 4 |
| Children 15 through 19 | 118 | 106 | 1 | 3 | 1 | 1 | 0 | 6 |
| Children 20 through 24 | 158 | 138 | 1 | 4 | 3 | 3 | 0 | 9 |
| Children 0 through 24 | 661 | 567 | 10 | 8 | 11 | 6 | 0 | 59 |

Notes - 2012

Office of Vital Records and Statistics, Infant Mortality database. UDOH, 2009

Office of Vital Records and Statistics, Death Certificate database. UDOH, 2009

Office of Vital Records and Statistics, Death Certificate database. UDOH, 2009

Office of Vital Records and Statistics, Death Certificate database. UDOH, 2009

Office of Vital Records and Statistics, Death Certificate database. UDOH, 2009

Office of Vital Records and Statistics, Death Certificate database. UDOH, 2009

Narrative:

A total of 675 deaths occurred among infants and children (< 25 years of age) in Utah in 2008. The highest proportion of deaths was accounted by infants (39.1%) followed by children 20 -- 24 (25.6%). The infant mortality rate for 2008 was 4.7 per 1000 live births. The rate has declined from last year (5.2 per 1000 live births).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

| CATEGORY Total deaths | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported |
|---------------------------------|-------------------------------------|---------------------------------|-------------------------------|
|---------------------------------|-------------------------------------|---------------------------------|-------------------------------|

| | | | |
|------------------------|-----|-----|----|
| Infants 0 to 1 | 211 | 49 | 21 |
| Children 1 through 4 | 38 | 8 | 0 |
| Children 5 through 9 | 27 | 4 | 0 |
| Children 10 through 14 | 17 | 10 | 0 |
| Children 15 through 19 | 98 | 20 | 0 |
| Children 20 through 24 | 128 | 29 | 1 |
| Children 0 through 24 | 519 | 120 | 22 |

Notes - 2012

Narrative:

Of the 763 deaths among children (birth through 24 years of age), Hispanic ethnicity accounted for 16.2% or 109 deaths. Hispanic children less than 25 years of age comprised only 14.2% of the Utah population in this age group.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

| CATEGORY Misc Data BY RACE | Total All Races | White | Black or African American | American Indian or Native Alaskan | Asian | Native Hawaiian or Other Pacific Islander | More than one race reported | Other and Unknown | Specific Reporting Year |
|--|--------------------------------|--------------|--|--|--------------|--|--|----------------------------------|--|
| All children 0 through 19 | 960756 | 870775 | 18357 | 15904 | 17453 | 9030 | 29237 | 0 | 2009 |
| Percent in household headed by single parent | 18.8 | 92.7 | 1.4 | 1.4 | 2.1 | 0.8 | 1.7 | 0.0 | 2009 |
| Percent in TANF (Grant) families | 1.2 | 67.0 | 4.8 | 4.1 | 1.3 | 0.7 | 0.1 | 22.0 | 2008 |
| Number enrolled in Medicaid | 212806 | 192866 | 4065 | 3533 | 3873 | 2000 | 6469 | 0 | 2010 |
| Number enrolled in SCHIP | 64534 | 59100 | 826 | 920 | 1131 | 540 | 0 | 2017 | 2010 |
| Number living in foster home care | 2843 | 2376 | 204 | 176 | 31 | 35 | 8 | 13 | 2010 |
| Number enrolled in food stamp program | 273188 | 243512 | 8009 | 8507 | 5440 | 3701 | 4019 | 0 | 2010 |
| Number enrolled in WIC | 75598 | 68250 | 2016 | 1887 | 1509 | 1936 | 0 | 0 | 2010 |
| Rate (per 100,000) of juvenile crime arrests | 6734.8 | 6685.0 | 15494.7 | 7212.7 | 9039.3 | 9039.3 | 0.0 | 0.0 | 2009 |

| | | | | | | | | | |
|--|-----|-----|-----|-----|-----|-----|-----|-----|------|
| Percentage of high school drop-outs (grade 9 through 12) | 3.4 | 2.0 | 3.7 | 5.7 | 2.3 | 3.1 | 0.0 | 0.0 | 2010 |
|--|-----|-----|-----|-----|-----|-----|-----|-----|------|

Notes - 2012

2009 data from IBIS Population Estimates Module.

For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, American Community Survey. Utah, Selected Social Characteristics in the United States: 1-Year Estimates 2009. IBIS population data for 0-19, 2009.

Numerator is derived by adding Male / Female householder, no spouse present, with children under 18.

The denominator is IBIS population data for 0-19, 2009.

1.2% represent 6,635 Families or 11,800 Children.

Data source: http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/caseload_current.htm

TANF race and ethnicity from most recent FY2008 Report to Congress at:

<http://www.acf.hhs.gov/programs/ofa/character/FY2008/indexfy08.htm>

2010 data from the CMS 416 (0-20) report. Race / ethnicity proportions from the 2010 MCH Service Report (1-21).

2010 data from UDOH CHIP. FFY2010.

2010 data from Utah Department of Human Services (DHS), Current Count Data, February 2011.

2010 data from UDOH WIC Program (REPORT 1003).

2009 data from UBCI, Proportions based on IBIS Race / ethnicity Query Module.

2009-2010 school year data from USOE Data Assessment and Accountability, Single year Drop-out Rates.

2010 data from DCFS, March/1/2011.

Narrative:

These data allow MCH programs to be aware of how children (birth -- 24 years of age) of different racial & ethnic groups are enrolled in various state programs (WIC, TANF, CHIP, Medicaid, foster care) and determine the need for additional program activities. Enrollment in various state assistance programs may be considered a proxy measure for low income. Given the economic downturn, the enrollment in public assistance programs is likely to increase, which will strain public resources.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

| CATEGORY | Total NOT | Total | Ethnicity Not | Specific |
|-----------------|------------------|--------------|----------------------|-----------------|
|-----------------|------------------|--------------|----------------------|-----------------|

| Miscellaneous Data BY HISPANIC ETHNICITY | Hispanic or Latino | Hispanic or Latino | Reported | Reporting Year |
|--|--------------------|--------------------|----------|----------------|
| All children 0 through 19 | 807404 | 153352 | 0 | 2009 |
| Percent in household headed by single parent | 87.0 | 12.3 | 0.0 | 2009 |
| Percent in TANF (Grant) families | 78.0 | 22.0 | 0.0 | 2008 |
| Number enrolled in Medicaid | 178842 | 33964 | 0 | 2010 |
| Number enrolled in SCHIP | 46124 | 16393 | 2017 | 2010 |
| Number living in foster home care | 2179 | 658 | 6 | 2010 |
| Number enrolled in food stamp program | 227078 | 46110 | 0 | 2010 |
| Number enrolled in WIC | 46075 | 29523 | 0 | 2010 |
| Rate (per 100,000) of juvenile crime arrests | 6501.8 | 13346.7 | 0.0 | 2010 |
| Percentage of high school drop-outs (grade 9 through 12) | 3.4 | 5.5 | 0.0 | 2010 |

Notes - 2012

Narrative:

These data allow MCH programs to be aware of how children (birth -- 24 years of age) of different racial & ethnic groups are enrolled in various state programs (WIC, TANF, CHIP, Medicaid, foster care) and determine the need for additional program activities. Enrollment in various state assistance programs may be considered a proxy measure for low income. Given the economic downturn, the enrollment in public assistance programs is likely to increase, which will strain public resources.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

| Geographic Living Area | Total |
|--|--------|
| Living in metropolitan areas | 728155 |
| Living in urban areas | 870218 |
| Living in rural areas | 45146 |
| Living in frontier areas | 45392 |
| Total - all children 0 through 19 | 960756 |

Notes - 2012

Narrative:

Based on 2008 population estimate, a total of 939,708 children from birth through 19 years of age reside in Utah. The majority of children (90.8%) live in urban areas. Less than five percent (4.7%) of children live in rural areas, and the remaining 4.6 percent reside in frontier areas. The greatest shortage of health care professionals for the state is in rural and frontier areas. Only 16 of the state's 29 counties have an OB/GYN. Long-distance travel is prohibitive of obtaining adequate prenatal care.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|----------------|-------|
|----------------|-------|

| | |
|-------------------------------|-----------|
| Total Population | 2847897.0 |
| Percent Below: 50% of poverty | 3.3 |
| 100% of poverty | 10.8 |
| 200% of poverty | 33.9 |

Notes - 2012

Population estimate, 2010 (IBIS)

Based on BRFSS, 2010 (OPHA special analysis)

Based on BRFSS, 2010 (OPHA special analysis)

Based on BRFSS, 2010 (OPHA special analysis)

Narrative:

According to 2008 Healthcare Access Survey, 9 percent of Utah residents were living at or below the 100% federal poverty level. Almost 31 percent were living at or below 200 percent of federal poverty level. With the economic recession, there is potential for the percentage of the population in poverty to surge. MCH programs will face challenges in allocating its limited funding and resources to ensure that the needs of the most vulnerable populations are met.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---------------------------------|----------|
| Children 0 through 19 years old | 960756.0 |
| Percent Below: 50% of poverty | 4.2 |
| 100% of poverty | 13.0 |
| 200% of poverty | 37.7 |

Notes - 2012

Population estimates, 0 - 19 yrs old, 2009

Based on BRFSS 2010 (OPHA special analysis)

Based on BRFSS 2010 (OPHA special analysis)

Based on BRFSS 2010 (OPHA special analysis)

Narrative:

More than one in ten Utah children ages birth through 19 (11.2%) lives at or below 100% of the federal poverty level. Children may suffer the impact of the economic recession at both the public and individual level. Children in poverty may be less likely to have routine health care, proper nutrition, and opportunities for mental enrichment.

F. Other Program Activities

The State Title V agency is involved in many activities that address the needs of mothers and children in the state. With the reorganization of the Department, we have new opportunities to integrate programs that serve mothers and children, to explore new opportunities and to develop new relationships internally and externally. Many of the activities that we engage in have been described in other sections of the Annual Application and Report and the Five Year Needs Assessment documents.

//2012/ We focus on areas of MCH that are not necessarily included in the Performance Measures or our state priorities, such as preconception health and health care, promotion of healthy spacing between pregnancies, review of maternal mortality cases, school health, and others. We are concerned about the lack of focus on the health of mothers because the main focus seems to be on infants. We promote the importance of the mother's health as it directly relates to her own health status, but also the health of any infant she has. We have worked on the Level NICU issue in an attempt to provide information about hospitals that self designate as Level III when they do not meet the criteria for such designation. Our concern is patient safety - that of the mother and the newborn. If a high risk mother delivers at a facility that is not equipped to care for an infant that is in need of Level III neonatal care, we have done a great disservice to the community. We work to promote the awareness that high risk women need to deliver at a facility that has capacity in maternal-fetal medicine as well as neonatal intensive care capacity. //2012//

We work closely with the Baby Your Baby Program to promote healthy pregnancies and well children. Through several federal grants, we have had the opportunity to build infrastructure in autism, birth defects, First-Time Motherhood, evidence based home visiting, genetics, leadership, and many others.

The Department's Center for Multicultural Health has been working with Title V programs to address health disparities among minority populations/communities living in Utah. The Center has expanded staff capacity to better understand different communities in our state which has been beneficial for us as well as the communities. We interface with the Department's Native American Liaison to discuss ways we can better meet the needs of the Native American populations.

In 2001, legislation was passed to allow a mother not wanting to keep her newborn baby to drop the baby off at a hospital with no questions asked. The Legislation was crafted to help reduce the possibility of infant death due to a mother "discarding" her baby in a dumpster or other places, often leading to the infant's death. The Adolescent Health Coordinator works with the sponsor of the bill and representatives of various agencies to track the progress in assisting women who feel they are not able to care for a baby. Several press conferences have been held, print materials and a hotline have been implemented to address this serious problem. ***//2012/ The legislator who sponsored the original bill was able to get ongoing state general funds to support the work required to promote the program and to support a hotline. The funding will be contracted to a community based private not for profit organization that will be responsible for running the program. The contract has been awarded to the YWCA, a local not for profit organization that had been operating the "hotline". Now, they will be responsible for public awareness activities, distribution of brochures, web site maintenance. //2012//***

The Division participates on numerous advisory committees sponsored by other state agencies or private agencies to enable the Title V programs collaborate with vital external partners in their work. Examples include the Child Abuse Prevention Council, Child Care Licensing, and so on. In general the state title V agency has exerted concerted effort to increase its collaborative efforts with private providers, professional associations and its agency partners to address the health needs of mothers and children, including those with special health care needs.

As our data capacity has been enhanced, we have expanded our ability to "research" various

issues impacting mothers and children in the state. For example, MCH staff is looking at prescription overdose deaths among women who had a pregnancy within the 12 months prior to death. We use data to identify problems and associated factors, strategies to address the issues and tracking to measure progress in our work. Expansion of data capacity has enabled programs to conduct surveys, compile data that are important in identifying a health issue and related factors.

/2012/ The new WIC information system will be rolled out by fall of 2011 which will greatly enhance our ability to link other data bases to it. We look forward to when we can use WIC data to review outcomes and health issues for women and children enrolled in WIC. //2012//

/2012/ The Department of Health has initiated an effort to look into accreditation for the agency. Several meetings have already been held and we believe that our work will play an important role in the process. //2012//

G. Technical Assistance

For Utah's Technical Assistance Needs, please see Form 15.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

| | FY 2010 | | FY 2011 | | FY 2012 | |
|--|-----------|-----------|----------|----------|-----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | 6013898 | 3705505 | 6013353 | | 5967609 | |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | 567502 | 1263658 | 1424947 | | 2521991 | |
| 3. State Funds <i>(Line3, Form 2)</i> | 23484900 | 22398950 | 12431500 | | 12581700 | |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | 4548728 | 3257004 | 4337379 | | 3257004 | |
| 5. Other Funds <i>(Line5, Form 2)</i> | 13234300 | 10697300 | 11254500 | | 10259000 | |
| 6. Program Income <i>(Line6, Form 2)</i> | 8475400 | 8193000 | 6542100 | | 6404800 | |
| 7. Subtotal | 56324728 | 49515417 | 42003779 | | 40992104 | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | 63537300 | 63707300 | 56604500 | | 60298300 | |
| 9. Total <i>(Line11, Form 2)</i> | 119862028 | 113222717 | 98608279 | | 101290404 | |

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2010 | | FY 2011 | | FY 2012 | |
|---|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | 6691853 | 5804468 | 5894708 | | 5870240 | |
| b. Infants < 1 year old | 7444465 | 6317659 | 6318827 | | 5910108 | |
| c. Children 1 to 22 years old | 22621976 | 19183095 | 12667704 | | 11751736 | |
| d. Children with | 15530885 | 14834457 | 15484711 | | 15726864 | |

| | | | | | | |
|---|----------|----------|----------|--|----------|--|
| Special Healthcare Needs | | | | | | |
| e. Others | 2767349 | 2400075 | 664829 | | 575156 | |
| f. Administration | 1268200 | 975663 | 973000 | | 1158000 | |
| g. SUBTOTAL | 56324728 | 49515417 | 42003779 | | 40992104 | |
| II. Other Federal Funds (under the control of the person responsible for administration of the Title V program). | | | | | | |
| a. SPRANS | 0 | | 0 | | 0 | |
| b. SSDI | 80200 | | 89500 | | 95000 | |
| c. CISS | 140000 | | 104100 | | 124000 | |
| d. Abstinence Education | 288000 | | 0 | | 319000 | |
| e. Healthy Start | 0 | | 0 | | 0 | |
| f. EMSC | 0 | | 0 | | 0 | |
| g. WIC | 44042500 | | 45088500 | | 49939600 | |
| h. AIDS | 0 | | 0 | | 0 | |
| i. CDC | 10275800 | | 1382100 | | 1293300 | |
| j. Education | 7177100 | | 8432900 | | 8527400 | |
| k. Other | | | | | | |
| See Notes | 1533700 | | 1507400 | | 0 | |

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

| | FY 2010 | | FY 2011 | | FY 2012 | |
|---|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Direct Health Care Services | 11181494 | 9836115 | 10036795 | | 9742362 | |
| II. Enabling Services | 19487351 | 16848654 | 18134409 | | 17510487 | |
| III. Population-Based Services | 14772033 | 12878405 | 5575435 | | 5253125 | |
| IV. Infrastructure Building Services | 10883850 | 9952243 | 8257140 | | 8486130 | |
| V. Federal-State Title V Block Grant Partnership Total | 56324728 | 49515417 | 42003779 | | 40992104 | |

A. Expenditures

Please see notes related to each Form.

B. Budget

The Division of Family Health and Preparedness (FHP) is organized to address specific maternal and child health needs through a partnership between State agencies and the public and private sector to form a coordinated statewide system of health care. FHP's Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year (July 1 -- June 30).

The amount of state funds that will be used to support Maternal and Child Health programs in FY11 is shown in the budget documentation of the state application. We assure that the FY89 maintenance of effort level of State funding at a minimum will be maintained in FY11

[sec.505(a)(4)].

For each four federal dollars a minimum of three state dollars is specifically designated as match. FHP allocates a total of \$12,431,500 of state funds appropriated by the Legislature for MCH activities. A total of \$5,787,000 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of \$5,578,725. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and combined with other federal and private funding to expand and enhance MCH programs and activities. Programs including Pregnancy Riskline, Fostering Healthy Children, and Baby Watch/Early Intervention, benefit from this use of the state funds. FHP receives private funding which is used to enhance selected programs or projects such as WEE Care and Pregnancy Riskline. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities.

FHP assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

FHP will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

FHP will allocate funds under this title fairly among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. There are a number of program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as WIC, Newborn Screening, and Baby Watch/Early Intervention.

The Department negotiates contracts with each of the twelve local health departments encompassing many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and perinatal, sudden infant and childhood death tracking. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff provide local health departments specific data to assist them in determining community needs. Local health department staff and state staff jointly develop an annual plan to address these needs. Annual reports are required from each local health department to monitor MCH activity and document their achievement in impacting the health status indicators for their local MCH populations.

In FY11, the state budget for FHP was reduced by approximately \$1.4 million. Included in these cuts was a \$1 million reduction to the CSHCN Bureau budget. In addition to these budget cuts the Department underwent an internal re-organization this past year. Many of the programs within the Division of Community and Family Health were transferred to the Division of Disease Control and Prevention. These programs included all of the Health Promotion Bureau, as well as the

Immunization Program. This re-organization resulted in over \$15 million dollars of funding being transferred to the Division of Disease Control and Prevention. As shown in the FY11 budget, these transfers impact State Funds, Other Funds, and Program Income. These transfers also have significant impact on the budgets categories for Children 1 to 22 Years Old, Others, and Population Based Services. It is not known at this time if additional state budget cuts will be necessary in the upcoming year.

Despite the ongoing budget challenges, the Division continues to allocate all available resources (MCH Block Grant funds, state funding, Medicaid, other private and public grants, and local funds) to most effectively address the changing maternal and child health needs throughout the state.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.