



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

**State Narrative for
Utah**

**Application for 2015
Annual Report for 2013**



Document Generation Date: Wednesday, July 09, 2014

Table of Contents

| | |
|---------------------------------------------------------------------------------------------------|-----|
| I. General Requirements | 4 |
| A. Letter of Transmittal..... | 4 |
| B. Face Sheet | 4 |
| C. Assurances and Certifications..... | 4 |
| D. Table of Contents | 4 |
| E. Public Input..... | 4 |
| II. Needs Assessment..... | 6 |
| C. Needs Assessment Summary | 6 |
| III. State Overview | 9 |
| A. Overview..... | 9 |
| B. Agency Capacity..... | 25 |
| C. Organizational Structure..... | 36 |
| D. Other MCH Capacity | 40 |
| E. State Agency Coordination..... | 43 |
| F. Health Systems Capacity Indicators | 50 |
| Health Systems Capacity Indicator 01: | 51 |
| Health Systems Capacity Indicator 02: | 52 |
| Health Systems Capacity Indicator 03: | 53 |
| Health Systems Capacity Indicator 04: | 54 |
| Health Systems Capacity Indicator 07A:..... | 56 |
| Health Systems Capacity Indicator 07B:..... | 57 |
| Health Systems Capacity Indicator 08: | 58 |
| Health Systems Capacity Indicator 05A:..... | 60 |
| Health Systems Capacity Indicator 05B:..... | 61 |
| Health Systems Capacity Indicator 05C:..... | 62 |
| Health Systems Capacity Indicator 05D:..... | 63 |
| Health Systems Capacity Indicator 06A:..... | 64 |
| Health Systems Capacity Indicator 06B:..... | 64 |
| Health Systems Capacity Indicator 06C:..... | 65 |
| Health Systems Capacity Indicator 09A:..... | 66 |
| Health Systems Capacity Indicator 09B:..... | 67 |
| IV. Priorities, Performance and Program Activities | 69 |
| A. Background and Overview | 69 |
| B. State Priorities | 71 |
| C. National Performance Measures..... | 72 |
| Performance Measure 01:..... | 73 |
| Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated | 75 |
| Performance Measure 02:..... | 76 |
| Performance Measure 03:..... | 80 |
| Performance Measure 04:..... | 84 |
| Performance Measure 05:..... | 87 |
| Performance Measure 06:..... | 91 |
| Performance Measure 07:..... | 94 |
| Performance Measure 08:..... | 97 |
| Performance Measure 09:..... | 101 |
| Performance Measure 10:..... | 104 |
| Performance Measure 11:..... | 107 |
| Performance Measure 12:..... | 111 |
| Performance Measure 13:..... | 114 |
| Performance Measure 14:..... | 117 |
| Performance Measure 15:..... | 120 |
| Performance Measure 16:..... | 123 |

| | |
|------------------------------------------------------------------------------------------------------|-----|
| Performance Measure 17:..... | 126 |
| Performance Measure 18:..... | 128 |
| D. State Performance Measures..... | 131 |
| State Performance Measure 1: | 131 |
| State Performance Measure 2: | 134 |
| State Performance Measure 3: | 136 |
| State Performance Measure 4: | 138 |
| State Performance Measure 5: | 141 |
| State Performance Measure 6: | 143 |
| State Performance Measure 7: | 146 |
| State Performance Measure 8: | 149 |
| State Performance Measure 9: | 151 |
| State Performance Measure 10: | 154 |
| E. Health Status Indicators | 157 |
| Health Status Indicators 01A:..... | 157 |
| Health Status Indicators 01B:..... | 158 |
| Health Status Indicators 02A:..... | 159 |
| Health Status Indicators 02B:..... | 161 |
| Health Status Indicators 03A:..... | 162 |
| Health Status Indicators 03B:..... | 163 |
| Health Status Indicators 03C:..... | 164 |
| Health Status Indicators 04A:..... | 166 |
| Health Status Indicators 04B:..... | 167 |
| Health Status Indicators 04C:..... | 169 |
| Health Status Indicators 05A:..... | 171 |
| Health Status Indicators 05B:..... | 172 |
| F. Other Program Activities..... | 173 |
| G. Technical Assistance | 175 |
| V. Budget Narrative | 177 |
| Form 3, State MCH Funding Profile | 177 |
| Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds..... | 177 |
| Form 5, State Title V Program Budget and Expenditures by Types of Services (II)..... | 178 |
| A. Expenditures..... | 178 |
| B. Budget | 178 |
| VI. Reporting Forms-General Information | 181 |
| VII. Performance and Outcome Measure Detail Sheets | 181 |
| VIII. Glossary | 181 |
| IX. Technical Note | 181 |
| X. Appendices and State Supporting documents..... | 181 |
| A. Needs Assessment..... | 181 |
| B. All Reporting Forms..... | 181 |
| C. Organizational Charts and All Other State Supporting Documents | 181 |
| D. Annual Report Data | 181 |

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, 2012. 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 January 2012; expires January 31, 2015.

E. Public Input

Public Input Process FY2015

Public input is a valued part of the annual MCH Block Grant application process. In April 2014, the Utah Maternal and Child Health Bureau announced to the public and stakeholders through various mechanisms that the Utah Department of Health, Division of Family Health and Preparedness was soliciting public input for FY15 MCH Block Grant Application. The Utah Department of Health is the designated Title V agency for Utah.

Newspaper Ads/Public Notices

Public notices were published in major newspapers throughout the state on 4/16/14. The announcement noted 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. The public notices announce that the proposed program activities related to annual goals for the Fiscal Year 2015 MCH Block Grant Application and Report 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 FY2015 Annual Goals webpage. The webpage outlined the proposed activities targeted for the three MCH populations (pregnant women & infants, children & youth, and children & youth with special health care needs). An email containing this web URL was sent to an extensive list of stakeholders including: parents, consumers, health care providers, academia, community-based advocacy organizations, community health clinics, local health departments, and various government agencies requesting input and feedback.

We have continued to make modifications in the web application to enhance system usability. The online comments were accepted between April 16 and May 20, 2014. We have received valuable feedback on community needs and emerging issues as well as reaffirmation of the importance of current program activities. Same as last year, we used web reporting tool Google Analytics to report our web trends. We had 234 entrances, 179 users, 590 pageviews, and 401 unique pageviews during the public comment period. Since the Google Analytics changed its information mechanism, we are reporting entrances instead of visits.

UBID System

We have made several modifications to our Utah Block Grant Information Database (UBID) system. This customized system was developed by the Data Resources Program and was intended to make the coordination and collection of required information from 36 individuals from various public health programs more efficient. The UBID system allowed us to capture and maintain information in one single location. This year we have developed a UBID 2.0 Step by Step User Manual to assist our block grant contributors with data and narrative entry to this system. We held trainings on the use of the UBID system. We also have added features where users now can populate the text box with previous year's narrative and make necessary edits. Users now can export their entry or submission to a word document for future record keeping. The system checks for the character length of each section to assure that length limits were met.

Announcement Flyers/Newsletters

To increase public awareness about MCH program activities, the UDOH news media person was contacted to put the announcement on UDOH main public website. 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 in the Department throughout the state. Flyers requesting input were posted throughout the UDOH Building.

Other Outreach Methods

UDOH staff 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 2014 Annual Plan. This year we have received comments related to 21 out of 28 performance measures (75%). Comments were incorporated into the plan as appropriate.

In addition, MCH Bureau sponsored various meetings (HUB, UWNQC, and Women's Health Coalition) of key stakeholders, including local health department staff, community health center, UDOH staff from programs that relate to mothers and children, and community based organizations, such as Planned Parenthood of Utah, and March of Dimes. We reviewed the Performance Measures that we did not attain and discussed the performance measures that we did attain to inform how the current strategies can keep those measures moving in the right direction even further. The comments and suggestions generated at that meeting were shared with staff responsible for the measures to incorporate as appropriate into the Annual Plan for FY2015.

We have received a lot of positive feedback on the meetings this year and feel good about the level of feedback and engagement of stakeholders.

II. Needs Assessment

In application year 2015, 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 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 for the 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 selected 10 measures.

Utah's ten priorities for FY11-15:

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. Utah's population is more diverse than originally thought at the time of the FY2011 Grant submission. Every population group grew during 2000 -2010. For example the Hispanic population grew almost 78%, Black population grew almost 66%, the Native Hawaiian/Pacific Islander population grew 62%, Asian by 49%, and Native American/Alaskan Native population grew by almost 11%.

b. During the 2011 Legislative Session, the Department lost additional funding, though not at the drastic levels experienced in the previous years. The economy seems to be picking up slowly and revenue projections are positive. Title V programs did not sustain additional state cuts, allowing us to stabilize our CSHCN clinics. We are currently cutting back on some services, such as pediatric neurology in the outlying areas.

c. We have continued to review data and discuss ways to address the State Performance Measures. We are 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 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 stage of the review, having covered the grant requirements, work to produce the grant, staff paid by the grant and their responsibilities. We have 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.

d. Several actions that we have taken to operationalize the plans: we have a position that is dedicated to training on the Ages and Stages tool for child care providers. As we make inroads there, we want to expand 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 to address health issues such as medication administration in schools, school nursing, etc. We believe that this position is critical in identifying and addressing the health of the school age population, especially the few school nurses we have. In the FY2011 grant federal review, comment was made about why certain measures were dropped and others added. The youth suicide, measure was questioned and is covered in 2 ways: the National PM and the State PM of youth feeling sad or hopeless. We were unsure why the question was asked as we believe it is covered, though not identified as a state priority. We clearly stated that if an issue was included in covered the national PM, we would not prioritize it since we are required to do so.

/2013/ Needs Assessment Summary

a. Utah's economic picture is improving -decreased unemployment rates and increased insured children. Utah had a surplus for the budget, but the bulk of the money for public health went to Medicaid growth.

b. We have no changes in our priorities and do not plan any until the next needs assessment. We are engaging the local health departments in planning for the 2013 application as well as other partners. The Grant has undergone close scrutiny by the Governance Committee which delegated a detailed review to 6 local staff and 6 state staff. The committee reviewed the guidance requirements, grant and needs assessment documents, budget allocations, LHD contracts, etc. The workgroup consensus was the Department was meeting the grant requirements and that the funding allocation did not need to change unless funding levels changed. However, the Governance Committee questions the current allocation of funding to LHDs suggesting that funding for a state position could go to LHDs for direct services. The challenge is explaining the pyramid of services and expectation that states invest in infrastructure and population based services. We believe that state staff has a greater impact on the "system" compared to the impact of LHD direct services. We will continue to work with the Governance Committee so that they can better understand the grant and its requirements.

c. This year we directly involved the local health departments and other partners in the grant planning. We invited interested local staff to participate.

d. Each year we review state data, trends and accomplishments to identify areas needing improvement, especially in areas we are not progressing in the right direction. We adjust program activities to move towards better impact. For the FY2013 grant, we focused specifically on the seven Performance Measures that we did not achieve the previous year to develop better or different strategies. This year we are focusing a great deal of energy on "healthy babies" which we have defined as preconception to age 5 so that we can focus on the health of the woman before pregnancy and her child's health through early childhood as a critical period of development. The effort is called "Healthy Utah Babies" or HUB. The prematurity prevention efforts will be included in this work. //2013//

/2014/ We have no changes from previous year. We continue our work on the "Healthy Utah Babies" initiative and are in the process of working with key partners to form a Utah Women and Newborn Quality Collaborative to address pregnancy outcomes for mothers and babies. We will co-sponsor a MOD Prematurity Symposium in fall of 2013. //2014//

/2015/Needs Assessment Summary

Utah's 2013 total population count was 2,900,872, representing a 1.6% growth from 2012 compared to a national population increase of 0.7%. This growth ranks Utah as third among states for population growth. Utah's population continues to become more diverse due to migration into the state of many diverse populations, such as refugees from Somali, Sudan, and other countries. We have no changes in our priorities. The grant is subject to review by the Governance Committee, but we do not anticipate problems there. When we mention the idea of re-examining the funding allocations, most local Health Officers are reluctant to pursue that task. We do continue to monitor our activities to ensure we are making progress on promotion of the health and well being of the maternal and child populations, including those with special health care needs. Our focus on "Healthy Utah Babies" has led to a number of meaningful activities that should improve outcomes for mothers, babies and young children.//2015//

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 Capital, in between. The Wasatch Front comprises only 4% of the state's land mass, but 75% of the state's population. The rest of the population resides in the remaining 96% of the state's landmass comprised of 12 rural counties of more than six, but less than 100 persons per square mile and 13 frontier counties of less than six persons per square mile. Utah's population density is 33.95 persons per square mile compared to 88.08 persons per square mile nationally, Utah ranks 41st for its population density.

Population Demographics

In 2010 Utah's population was 2,763,885, an increase of 23.8% from 2000, compared to the U.S. rate of 9.7%. Utah ranked third among states for its population growth rate. While Utah is predominately white and non-Hispanic (80.3%), it is becoming more diverse with 13% report being Hispanic, 2% of Asian descent, 1.2% American Indian or Alaskan Native, 1.0% Black and 0.9% Native Hawaiian or Pacific Islander and 2.7% reporting more than two races. The population of every racial and ethnic group grew at a higher rate than the overall state population. The state's ethnic and racial diversity is increasing, although its minority share of 19.6% is much lower than the nation at 36.3%. /2014/Utah's population growth of 1.5% ranks the state fifth compared to the nation at 0.7%.//2014//

/2015/ Utah's 2013 total population count was 2,900,872. This represents a population increase of 46,001 people or 1.6% from 2012, ranking Utah third among states in population growth. Utah grew more than twice as fast as the nation from 2012 to 2013. The total 2013 population count for the United States was 316,128,839. This represents a population increase of 2,255,154 people or 0.7% from 2012. //2015//

Refugee populations in Utah are growing, along with the Hispanic populations, with resultant increasing need for language translation services and greater cultural awareness. The changing demographics in Utah challenge the health care system's ability to adequately address the needs of diverse populations. The Department actively participates in a Refugee Health Advisory Board to address critical health issues for refugee populations.

/2013/Utah typically grows faster than the nation after recessions, a pattern noted with the current recovery. National employment grew 0.9% in 2011 compared to 2.3% for Utah with an unemployment rate ranking 16th at 7.4% compared to 8.0% in 2010. Economic growth is expected to accelerate during 2012. Employment is forecast to increase 2.7% for the year. Housing permits are forecast to move up slightly from historic lows.//2013//

Cultural Diversity

Culture is more than country of origin or color of skin; it incorporates numerous different cultural factors, such as religion, language, poverty, education, family structure, etc. As Utah's population becomes more diverse, we see more populations of people who speak languages that are less well known to many Americans, populations with many varied cultural beliefs about health, health care, health practices, etc. These differences present challenges in delivering health care services and education about the health care system.

A significant culture in Utah is the Mormon population because Utah's predominant religion (LDS) 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. 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 (LDS or Mormon) which greatly influences Utah culture and daily life.

The overall 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. Of particular concern is meeting health care needs of the Hispanic population due to the increasing number of residents 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 Multicultural 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 sub-populations in the state. /2012/State legislators have been committed to ensuring that illegal immigrants are banned from public services. Most public health services for children have been exempted.//2012//

/2012/Legislation passed in 2011 requires that an adult applying for public benefits must provide proof of legal status before receiving services. In addition, legislation was passed that created a guest worker program, which probably is in conflict with federal policy, but was proposed as a state answer to a federal issue. Governor Herbert presented the state plan to national policy makers as a possible solution to immigration issues. //2012// /2013/The law excludes services to children and youth.//2013//

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. Many families remain skeptical about applying for any government programs for fear they will be reported to the U.S. Citizenship and Immigration Services (CIS) or that their immigration status will be affected. The 2006 and 2007 Utah Legislators 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 driver's license, state funded programs and in-state college tuition all passed. The legislative sentiment is not supportive of undocumented workers in the state. CIS 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.

Household Size

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. /2013/Utah's household size is smaller than previously at 3.1 but still ranked as highest in the country.//2013// /2014/In 2011 Utah's household size was the highest in the nation at 3.13 persons.//2014// The percent of Utah family households with children are 21.5% higher than the nation, 39.1% vs. 30.7%. Households comprised of single mothers with children are lower in Utah than the nation, 5.5% compared to 7.4%. Utah ranks 1st highest for child dependency ratio at 51.8 vs. 37.7 nationally. /2014/nw 53.0 vs. 38.2 nationally. Utah's ranking by the Kids Count data is 2nd for family and community due to the relatively low proportion of Utah children living in single-parent families (21%) and low percent of Utah children who live in families where the household head lacks a high school diploma (9%).//2014// **/2015/ Non-family households (either a householder living alone or with other, unrelated, persons) constituted less than a quarter (24.3%) of Utah households in the 2010 decennial census. The 2012 American Community Survey (ACS) now estimates this at 25.6%. Also in 2010 the proportion of single householders with children was 7.7%, the 2012 ACS now estimates this at 8.0%. The likelihood that the household was headed by a single female declined slightly, owing to a small increase in the proportion of single male householders with children.//2015//**

Utah's Economy

The current economic situation in Utah is improving. Fortunately Utah has not been impacted by the recession 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. For Utah the employment rate grew 3.2% compared to the U.S. growth of 0.4% in 2012. While employment increased during 2012, Utah's unemployment rate also improved to 5.7%, lower than the 2011 rate. //2012// /2014/According to the Kids Count data, more Utah kids live in poverty, more parents lack secure employment and more teens can't find jobs than in the previous year. The percentage of families that struggle with a high housing cost burden increased. //2014// **/2015/Utah's unemployment rate was 4.3% during November 2013, lower than the unemployment rate of 5.3% the previous November. The national unemployment rate was 7.0% in November 2013 lower than the November 2012 rate of 7.8%. //2015//**

Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger resulting in 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. /2013/ The 2010 ACS reported median household income in Utah of \$54,744, ranking Utah 14th highest in the nation. The national median household income was \$50,046. //2013// /2014/Utah's median household income was \$58,438 in 2011 ranking the state 11th. //2014// However, due to larger families in Utah, the per capita income ranked the state 45th lowest in the nation at \$18,905. /2013/Utah's 2010 average per capita personal income was \$32,473, a 1.8% change from 2009. //2013// /2014/Utah's per capita personal income of \$33,509 ranked the state 47th among states. //2014// **/2015/Utah's average annual pay grew 1.5% to reach \$41,245 in 2013. Annual pay is forecast to increase 2.5% to \$42,276 in 2014. Average annual pay for the nation in 2013 was \$52,389 and is forecast to be \$53,796 in 2014, an increase of 2.7%. /2015/ \$58,341 vs. \$51,017 for median household income. //2015//**

Utah's 2008 poverty rate (100% FPL) is well below the national average, 7.6% vs. 13.2% nationally. For children under age 18, almost 9% (8.8%) of Utah children live in poverty compared to 19.0% nationally. /2013/Utah's poverty rate has risen to 13.2% ranking Utah 17th lowest compared to national rate of 15.3% in 2010. Utah is 11th lowest for child poverty rate at 15.7%, below the nation at 21.6%. //2013// /2014/According to recent Kids Count data, Utah ranks 11th for economic well-being due to the fact that 16% of Utah children live in poverty (compared to 23% nationally) and 25% have parents who lack secure employment. While Utah's proportion of children living in poverty is well below the national figures, between 2007 and 2011, the proportion has grown from 11% to 16%. The number of children whose parents lack full-time jobs was nearly 20% higher than it was five years ago. //2014// **/2015/According to the American Community Survey (ACS), an estimated 15.1% of Utah children aged 17 or under (approximately 131,900 Utah children) were living in poverty in 2012. According to the American Community Survey (ACS), approximately 12.8% of all Utah residents, or 360,000 Utahns, were living in poverty in 2012. //2015//**

| Year | State Rank | Value |
|------------------------|------------|---------|
| Population Growth Rate | 5th | 1.5% |
| Fertility Rate | 1st | 2.38 |
| Life Expectancy | 10th | 80.2 |
| Median Age | 1st | 29.9 |
| 2012 | | |
| Household Size | 1st | 3.14 |
| | | 2012 |
| Economic | State Rank | Value |
| Employment Change | 7th | 2.2% |
| | | Year |
| | | Nov. 13 |

| | | | |
|--------------------------------------|------|-------------|---------|
| Unemployment Rate | 4th | 4.3% | Nov. 13 |
| Median Household Income 2012 | 13th | \$58,235 | 2010- |
| Average Annual Pay Per Capita | 37th | \$41,300 | 2012 |
| Personal Income 2012 | 47th | \$34,601 | |
| Social Indicators | | | |
| Total Personal Income (% Change) 4th | 5.2% | Q3 12-Q3 13 | |
| Poverty Rate 2012 | 8th | 10.7% | 2010- |
| Educational Attainment | | | |
| Persons 25+ w/high school degree | 10th | 91.0% | 2012 |
| Persons 25+ w/bachelor's degree | 16th | 30.7% | 2012 |

/2015/According to the Governor's Office, Utah typically grows more rapidly than the nation after recessions, a pattern that is continuing in the current recovery. For the U.S., employment grew 1.6% in 2013, compared to 3.3% for Utah. Though housing stabilized home-building is not leading the economy as it does during a typical recovery. The Governor's Office anticipates that in the upcoming year, Utah's job growth is expected to increase at 3.1%, compared to the nation at 1.7%. The unemployment rate is expected to decrease to 4.2%. In contrast to the early stages of the recovery, housing will provide noticeable support to the expansion. Repeating its leading role from 2012, construction employment will grow 9.4% in 2013.//2015//

Education

Based on the 2008 American Community Survey, Utah had a significantly higher percent of its population with a high school diploma at 90.6% vs. 85% nationally among individuals 25 years and older. /2013/Utah ranked 7th at 90.6%/2013// Utah's population is similar to the nation for population with a bachelor's or higher degree (29.3% in Utah compared to 27.7% of the U.S.). 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. /2014/ Utah ranked No. 30 in education according to the most recent Kids Count data due to the fact that 60% of Utah children do not attend preschool, 67% of fourth-graders are not proficient in reading, and 65% of eighth-graders are not proficient in math. Utah's educational attainment ranks the state at 14th with 90.3% of persons 25+ with a high school degree. In 2011 elementary school class size varied between 22 --27 students per teacher and in high school the ratio was 30:1. Utah legislators are not supportive of public preschool programs, resulting in the low proportion of children attending preschool. //2014//

The high school dropout rate in Utah is lower than the U.S. at 3.1% of youth aged 16 to 19 years vs. 4.4% nationally 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%.

/2015/ Utah's statewide graduation rate for 2013 was 81%, an increase by 3% points from 2012 to 2013. Among Utah adults aged 25 and over in 2012, 91.0% were high school graduates or higher and 30.7% had a bachelor's or advanced degree.//2015//

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. /2014/National average for educational expenditure per student was \$11,665 compared to Utah's ranking as the lowest at \$7,217.//2014//

/2013/In 2010 more than 570,000 students were enrolled in public education, an increase of 2.3% from 2009. Students are becoming increasingly diverse and score respectably on national tests compared with their peers in other states. In FY2009, Utah's public education expenditure compared to total personal income was 4.2%, ranking Utah 34th of states. Utah ranks 18th for individuals with a Bachelor's degree at 29.3%. Student enrollment continues to grow at Utah colleges and universities. In 2010, enrollment grew 6.2%. Enrollment in higher education is projected to increase in the next decade. //2013// /2014/More than 600,200 students were enrolled in public schools in 2012.//2014//

Health Status of Utah Mothers and Children

/2014/Life expectancy in Utah is ranked 3rd longest in the nation at 78.7 years. In Utah, life expectancy at birth for males increased from 72.4 years in 1980 to 78.1 years in 2010, and for females from 78.6 to 82.2 years. In comparison, life expectancy at birth in the U.S. rose from 70.0 to 75.7 years for males, and 77.4 to 80.8 years for females. Utah's ranking for health of its children as cited in the most recent Kids Count data is 14th, a drop from the previous year of 11th. Utah's birth rate in 2011 was 18.2 per 1,000, compared to a U.S. rate of 12.7 per 1,000. Utah's general fertility rate was 83.6 per 1,000, compared to the U.S. rate of 63.2 per 1,000. Utah's mothers generally practice healthy behaviors which are reflected in pregnancy outcomes. Utah has already met the Healthy People 2020 goals related to weight before pregnancy, folic acid consumption, smoking and alcohol consumption prior to pregnancy, teen pregnancy, low birth weight, preterm birth, cesarean sections, and infant mortality. Two areas where Utah has not met Healthy People objectives are prenatal care and maternal mortality. While prenatal care rates are improving, maternal mortality is on the rise and is of concern to the State.//2014// **/2015/In Utah, life expectancy at birth for males increased from 72.4 years in 1980 to 78.4 years in 2011, and for females from 78.6 to 81.9 years. In comparison, life expectancy at birth in the U.S. rose from 70.0 to 76.3 years for males, and from 77.4 to 81.1 years for females (2011 preliminary data).//2015//**

The median age of Utah's population is 29.5 years, ranking Utah as the youngest in the nation. Utahns are generally healthy as noted in the state life expectancy ranking. Since we have only a small proportion of individuals in the state who smoke, drink alcohol, use illicit drugs, the majority of Utahns don't suffer from the results of these behaviors. Obesity is probably one of our worst contributors to chronic disease, rather than due to smoking or alcoholism.

The overall health of women of childbearing ages is generally good, although, like other states, we are seeing an increase in obesity rates, diabetes and heart disease in the entire population. Utah ranked first for births among women between the ages of 15 -50 years for a birth rate of 20.16 per 1000 population in 2008 compared to 14.3 per 1000 nationally (2007). /2013/Utah's 2010 birth rate fell to 18.3, the lowest in 20 years. Utah continues to have the highest general fertility rate at 87.1 (2009) compared to US rate of 66.7 (2009).//2013// Utah's regular fertility rate has dropped to 36.6. Utah continues to have the youngest population in the nation with a median age of 28.7 in 2008 compared to 36.8 nationally. /2013/Utah continues as the youngest state with a median age of 29.2, compared to the national at 37.2.//2013//

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 percent of children with overweight BMI (23.1%) compared to that national rate of 31.6%, and a higher percent 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 nation in children having preventive medical visits (80.2% vs. 88.5% nationally); however, Utah scored slightly higher than the nation in the percent of children who received preventive dental visits (79.1% vs. 78.4%).

/2014/Utah children's health overall is better than children nationally. According to the recently released Kid Count data, Utah ranked 14th for health with 7% of babies born low birth weight, and 11% of Utah children lacking health insurance. In the most recent data from the National Survey of Children's Health 2011/2012, Utah children fare better than their national counterparts in all but 7 areas out of 28 total. The areas that Utah children do not do as well as their national peers are: missed school days, uninsured children, lacking consistent coverage, receiving a preventive medical or dental visit, developmental assessment screening, receipt of mental health services in children with problems, and fewer children whose families sing or tell stories to their children.//2014//

/2012/The Commonwealth Fund's State Scorecard report for 2009 ranked Utah 23rd among states on overall child health status. 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 aged 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 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 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//

/2013/The 2011 America's Health Report ranked Utah healthy in several areas ranking in the top 3 in 8 of 22 measures. Utah was 1st for cancer deaths and prevalence of smoking; 2nd for binge drinking, obesity and preventable hospitalizations; 3rd for adult diabetes, infant mortality and cardiovascular deaths. Utah ranks 5th in overall patient quality in hospital services. According to a CMS Hospital Compare report Utah has high patient satisfaction and performs better in areas such as heart attack, heart failure, pneumonia and surgical care. Survival rates are higher and percentage of patients being readmitted to the hospital is down.//2013// /2014/The America's Health Rankings Report ranked Utah as the 7th healthiest state in the nation. Among the core measures, Utah was first for adult smoking, diabetes, and cancer deaths, second for sedentary lifestyle, fourth for infant mortality, and eighth for children living in poverty. Among the supplemental measures, Utah ranked first for youth smoking, third for youth obesity, and 15th for teen births.//2014//

Insurance Coverage

Based on the Utah 2008 Health Access Survey (UHAS), 11.9% of Utah's population reported no health insurance, 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 aged 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 June 2011. The percent of uninsured Utahns showed little change from the previous year with 301,700 (10.6%) of the

population lacking health insurance. The data represent a slight improvement from 2009 when 314,300 (11.2%) of the population, had no coverage. The change from 2009 to 2010 was not statistically significant. The uninsured rate of children eligible for the Children's Health Insurance Program (age birth-18 with parents' income up to 200% FPL) remained relatively steady at 12.3% compared to 16.3% in 2008 when the program was permanently opened. Of adults aged 19-26, 28.6% were uninsured, the highest of any age group. Obviously women of childbearing age are represented in this group.//2012//

/2013/The percentage of uninsured children up to age 18 currently is estimated to be 7.9% and for adults, the uninsured percentage is 13.4% according to data released in August 2012. Differences in methodology may account for some of the differences compared to previous years.//2013// /2014/Using new methodology, the percentage of uninsured children was 8.1%, an increase from 7.9%. For adults, the uninsured rate was 16.0%. However, according to the Kids Count data recently released, 16% of Utah children have no health insurance. //2014//

/2015/An estimated 376,600 Utahns (13.2%) were without health insurance coverage in 2012. This is not statistically different than the previous year's rate of 13.4%. In 2011, approximately 8.1% of Utah children aged 0 to 18 years had no health insurance coverage. This represents a slight increase from the previous year (7.0%), though this change was not statistically significant.

The 2011 Behavioral Risk Factor Surveillance System (BRFSS) estimated that approximately 70% of uninsured children in Utah were income eligible for health care services through CHIP or Medicaid programs. Eligibility determination requires a review of circumstances in addition to income. The crude percentage of Utah adults who reported being unable to see a doctor in the past 12 months due to cost was 16.7% in 2011. This percentage was the highest for adults aged 25-34 (22.3%) and lowest for Utah adults aged 65 and older (5.2%). Utah adults with low incomes had a higher rate of reporting cost as a barrier to health care than those with higher incomes as did those without health insurance versus the insured.//2015//

In 2005 Governor Huntsman sponsored a state summit to discuss issues related to a state plan to address the increasing rates of uninsured. The Governor and the state legislature are leading an effort to develop a health care reform package to address the growing population of uninsured.

/2013/In 2011 Governor Herbert hosted the "Health Innovation Summit" with stakeholders and policy makers to map out principles for health system reform in Utah and highlight two major achievements of Utah's health system reform --the Utah Health Exchange and the new blueprint for a modernized Medicaid program. These reforms are still under development, but the Governor expects them to contribute significantly to improved health systems. /2014/The Governor sponsored another health summit in the fall 2012 which focused on business approaches to health care. The state has been developing plans for health care reform before the ACA was passed. Utah has a small health insurance exchange, "Avenue H", which Secretary Sebelius has approved, in part, as meeting the requirements for state health care exchanges.//2014//

Utah's Public Health System

Utah's public health system consists of 13 autonomous health departments, the State Department of Health and 12 local health departments. Half of the 12 local health departments are multi-county districts covering large geographic areas. Many districts include both rural and frontier areas within their service region. Many local health departments have been gradually moving away from direct services, recognizing that they do not have the capacity to provide primary care in their communities. They instead have shifted focus to the core public health services.

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality

health care; and promoting healthy lifestyles.

The Department strives to improve the lives of all Utahns. We work with our partners to create healthy and safe communities and eliminate health disparities as part of a comprehensive public health system. We use data-driven, evidence-based interventions to promote healthy lifestyles and behaviors; detect and prevent injury and disease; and improve access to quality health care for all people of Utah, including the state's most vulnerable populations. We monitor the health of the population by collecting, analyzing, and sharing data.

The Division of Family Health and Preparedness houses the State Title V programs. The mission of the Division is to assure care for many of Utah's most vulnerable citizens. The division accomplishes this through programs designed to provide direct services, and to be prepared to serve all populations that may suffer the adverse health impacts of a disaster, be it man-made or natural.

//2014/The Department has embarked on a 4-year strategic plan with 4 goals:

1. Healthiest People...

The people of Utah will be the healthiest in the country.

2. Health in Health Reform...

Health reform will be compassionate, humane, and cost-effective. The focus is on the health of all the people of Utah by increasing access to care, expanding use of evidence based prevention interventions, and improving quality.

3. Transform Medicaid... Utah Medicaid will be a respected innovator in employing health care delivery and payment

reforms that improve the health of Medicaid clients and keep expenditure growth at a sustainable level.

4. A Great Organization...

The UDOH will be recognized as a leader in government and public health for its excellence in performance. The organization will continue to grow its ability to attract, retain, and value the best professionals and public servants.

The first goal of the UDOH Strategic Plan is a strategy for healthy births, called Healthy Utah Babies (HUB). This initiative covers the preconception period through pregnancy and after, to children up to age 5. HUB incorporates a life course perspective. The effort includes the UDOH ASTHO/MOD Challenge to reduce preterm births, promotion of preconception health, breastfeeding promotion, and universal developmental screening using evidence based tools. HUB has provided an opportunity to broaden collaboration with chronic disease programs and others.//2014//

Health Care Services

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.

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 which includes a clinic for the homeless and migrant health clinics, and a number of free clinics.

Each local health department determines which services they provide for mothers and children in

their district. In the past we had required the local agencies to conduct an assessment of health care needs for mothers and children. The assessments were used by some districts in redefining their focus for services, while others were not much engaged in the process. We now ask the local health departments to identify two to three top health care needs for mothers and children, set goals, describe activities to reach the goals and track trends.

Local health departments 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.

//2013/One of the difficulties faced by local health departments, especially those covering rural and frontier areas, is the small amount of local funding for public health. When you have few people living in large areas of the state, there are limited local funds to provide public services and it seems as though public health loses out in the funding distribution.//2013//

Services available through LHDs vary 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 services each provides, the range of services reported varied from 15-23 services out of 24 possible. Services provided by all twelve local health departments include: immunizations, injury prevention, Presumptive Eligibility, tobacco cessation during pregnancy and breastfeeding. The services with the fewest local health departments providing: 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// //2014/ as part of the upcoming five-year needs assessment, we will survey local staff to identify services provided and review the changes. //2014//

Community health centers throughout the state and the Wasatch Homeless Clinic in Salt Lake City provide primary care to underinsured and uninsured MCH populations. Utah now has eleven CHCs with six centers located in rural areas of the state. Utah Farm Worker clinic operates under Salt Lake Community Health Centers, Inc. at its clinic site Brigham City in Northern Utah. 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.

Access to low-cost maternal and child health care services provided by community health centers is problematic in rural areas of the state since they span such large geographic areas. Fortunately 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. //2014/Native Indian women and children in Southeastern Utah may have to travel to Tuba City, Arizona to a new facility, Blue Mountain Hospital, for services if Indian Health Services is to pay for their care.//2014// While the local health departments in all of these areas receive Title V funds, demand for services far

outstrips the amount of funding available.

Medicaid and CHIP

Utah has been at the forefront of health care reform since before 2002 when the Department was approved for a waiver to establish the PCN. In 2002, then Secretary of Health and Human Services, Tommy Thompson, authorized 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.

/2014/The Governor has yet to decide whether Utah will expand Medicaid. He has indicated that his decision will be announced sometime this fall. //2014//

/2015/The State Legislature did not pass any legislation in the 2014 Session related to Medicaid Expansion. The Governor proposed a Utah plan to expand insurance coverage without Medicaid expansion. He plans to present his plan to CMS later this year.//2015//

Medicaid has a waiver program for children who are technology dependent which covers nurse case management services as well as home care. This program is administered by Title V in the Bureau of Children with Special Health Care Needs. /2014/As of 2012, more than 11,000 enrollees were covered under PCN.//2014//

Since 1995 through 2012, Medicaid participants living in Utah's urban counties had 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. Throughout this period of managed care, the Utah Department of Health's Medicaid agency contracted with several managed health plans to provide services to Medicaid participants, including children with special health care needs, in Utah's urban counties. Medicaid participants in all but three rural counties are enrolled in a Prepaid Mental Health Plan for behavioral health services.

The enrollment numbers for Medicaid have 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//

/2014/Current enrollment numbers for Medicaid, CHIP and PCN are down from previous years, perhaps reflecting a better economy in the state. Unemployment numbers are down indicating that more people have been able to find jobs. Medicaid reported that almost 6,000 women enrolled in prenatal Medicaid in 2012.//2014//

/2014/Factors contributing to the growing percentage of uninsured children in Utah include: 1) limited outreach to families to enroll children in Medicaid or CHIP, reflecting only a 70% enrollment versus other states' enrollment of 95%. 2) Utah's policy to require children who are legal immigrants to wait five years to enroll in Medicaid or CHIP, 3) Utah policy that restricts the 12 continuous months of Medicaid when status changes. 3) Utah's income eligibility restrictions to lowest possible income. //2014//

/2013/Medicaid is converting its health plan products to an ACO model in 2013 with 5 health plans contracting with Medicaid. It will be interesting to track the benefits of such a system. With the Medicaid mandates of the ACA being ruled unconstitutional, it will be interesting to track

Utah's approach because many legislators are opposed to putting more state funds into Medicaid.//2013//

/2014/ACOs went into effect January 1, 2013 for Medicaid participants along the Wasatch Front, an area that includes about 75% of the state's population. We will be interested in seeing the effect the ACO model has on health outcomes.//2014//

Medicaid income eligibility for pregnant women and children to age 6 is set at 133% FPL. For children 6 or older, the income eligibility is 100% FPL. Since the income eligibility level for Utah's Prenatal Medicaid program has not increased from the original 133% FPL 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. 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. /2014/ With the ACA changes set to go into effect in 2014, the qualifying poverty level will be raised to 138% for pregnant women and the asset test will be discontinued.//2014//

Utah CHIP Program began in 1999 with an income eligibility of 200% of the FPL for children from birth to 18 years. In the beginning years, the Program has suffered from budgetary limitations and has had to cap enrollment to stay within its budget. Since opening of the program through 2008, the state legislature had not appropriated enough funding for the program to maintain open enrollment. After inadequate increases for several years, 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. CHIP services include: well-child exams, immunizations, dental care, mental health services, prescriptions, hearing and eye exams, provider visits, and hospital and emergency room care.

/2013/As of August 2011, more than 39,000 children were enrolled in CHIP, with approximately 41% living at less than 100%FPL; almost 38% between 101%-150%FPL with the remainder with incomes between 151% to 200%FPL.//2013// /2014/In December 2012 more than 35,000 children were enrolled in CHIP.//2014//

Hospital Systems in Utah

Utah's hospital system is comprised largely of the Intermountain Healthcare hospitals. The University of Utah Hospital is a single facility providing tertiary care. Other hospitals, mainly the smaller ones, are owned by various hospital systems such as HCA (MountainStar), Iasis and LifePoint. We have a total of 54 hospitals in the state, with 42 being delivering hospitals, 2 being children's hospitals.

The hospital health care system for MCH populations is well developed in Utah, with several large Maternal-Fetal Medicine Centers, ten self-designated Level III NICUs, and two tertiary children's hospitals (Primary Children's Medical Center and Shriners Hospital).

We have reviewed data from all birthing hospitals to evaluate which hospitals meet the criteria for a tertiary center. We would like to promote the importance of having 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-affiliated 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 intensive care centers. The discussion was lively and the

outcome of the meeting was that a smaller group of representative of the NICUs will meet to develop guidelines for Level III NICUs.//2012// /2013/MCH continues meetings with hospital representatives to discuss issues related to designation and capacity of the NICUs in the state and review of outcomes.//2013// /2014/ MCH continues meeting with the NICU representatives. Upon release of the new "Levels of Neonatal Care" guidelines from the AAP, a draft of "Utah Guidelines for Neonatal Care Services" was developed and is under current review.//2014//

DFHP staff interfaces with faculty and staff from these centers through various efforts, including Perinatal Mortality Review, Child Fatality Review, Perinatal Taskforce, clinical services, joint projects, and other committee work and through the Neonatal Follow-up clinic that supports graduates from all of the NICUs. 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.

Health Care Provider Shortages

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. The HPSA maps in the Appendix illustrate areas of the state with shortages of various provider types. 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. /2013/The University of Southern Nevada, a private dental school, in Salt Lake City, enrolled first year students in fall 2011. In April 2012, the University of Utah announced the opening its dental school in fall 2013.//2013//

/2014/The American Medical Association data indicate that Utah ranks last in the country for primary care physicians with only 58.4 active primary care physicians per 100,000 people. The national average is 79.4 primary care physicians per 100,000 people. The Utah Legislature passed legislation to increase the annual class of students admitted to the University of Utah medical school by 40 more students, bringing the annual class size to 122 students. The increase in class size does not guarantee an increase in primary care physicians, however, as they generally have lower incomes than other areas in medicine. //2014//

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 for prenatal Medicaid. 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.

Presumptive eligibility for prenatal Medicaid had been problematic in the state for a number of years, especially in the urban areas with limited access sites. In 2001 Baby Your Baby by Phone was instituted enabling women to apply more easily than in person. 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.

/2013/As of July 1, 2012, Medicaid will oversee the Presumptive Eligibility/BYB process. A recent audit revealed a concern about administering the program through 3 different Divisions, with no apparent responsible Division. With retirement of one of the MCH staff who had overseen much of the program, it afforded us an opportunity to transition the oversight responsibilities to Medicaid. We will be able to use the Title V funds from this position in a more effective manner.//2013//

/2014/ In response to the audit findings, the Maternal and Infant Health Program transferred responsibility for the oversight of PE sites to Medicaid. The transition has gone smoothly, freeing up staff time for other MCH activities.//2014//

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 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//

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. /2014/ A sticking point with providers is that the well child clinic visits paid by Medicaid are inclusive of developmental screenings, However, given the low provider reimbursement rates, there is concern about the proportion of pediatric providers doing formal developmental screenings.//2014//

/2013/ Of great concern is the lack of funding for Medicaid dental services. Adults, other than pregnant women, are not able to get dental care coverage through Medicaid.//2013// /2014/ With the likelihood of State Legislators turning away from Medicaid expansion, Utah will continue to see its population of uninsured rise. //2014//

CSHCN

Most specialty and sub-specialty pediatric providers are located along the Wasatch Front, including the state's tertiary pediatric care centers, University of Utah, 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, Utah's large 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 Medical Center has a Neonatal Intensive Care Unit.//2012//

CSHCN Services

The CSHCN Bureau provides direct clinical services to several thousand children and youth with special health care needs. Services are available at the main Salt Lake City office, as well as satellite offices in Ogden and Provo. In addition, itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty centers (mentioned above) 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 developmental/behavioral disorder school aged children and youth and to children with complex orthopedic issues. Many of the children now seen in clinics are those with ASD.

/2015/During rural clinics, the Oral Health Program Specialist, an RDH, goes with the CSHCN team to provide dental education and fluoride varnish application to children in the clinics. She invites local volunteer oral health professionals to join her in providing education, applying fluoride varnish to the children and giving out toothbrushes, when available. They also make sure the family members have a dental home. During one rural clinic, the oral health team found pre-teen child with several abscessed teeth. The girl was in a great deal of pain, so the team arranged treatment by a local dentist.//2015//

/2015/The Department is negotiating with the University of Utah to expand access to the CSHCN clinics. The state funding cuts during the recession have not been restored, leaving the clinics unable to meet the needs of children and youth with special health care needs, especially in the rural areas of the state. The University is interested in developing a Developmental Center for services for children to provide developmental assessment and diagnosis as well as eventually expanding the Neonatal Follow up Clinic to be inclusive of broader eligibility as a graduate of a NICU, and a follow-up clinic for subspecialties, including cardiac and others. In the short term, the UofU is interested in expanding the eligibility criteria beyond the current 1250 grams for the Neonatal Follow-up Program. //2015//

/2013/The CSHCN Bureau Director and medical director worked with the largest private insurer in the state to gain reimbursement for ancillary services provided in CSHCH clinics with mixed success. They have agreed only to reimburse services provided in most rural locations. CSHCN completed its 3-year HRSA Autism System Development grant and is in its last year of CDC's "Learn the Signs Act Early" grant. CSHCN has worked with community partners and the public to revise the Autism State Plan and CSHCN continues to organize the multiagency Utah Autism Initiative Committee. CSHCN now has a designated autism coordinator. An Autism Treatment

Account was established with \$1M in state funds. /2014/Additional funding has also been received to fund ABA therapy from Zions Bank Corp and Intermountain Healthcare.//2014//

The law includes three components: Medicaid waiver, the Autism Treatment Fund and a pilot with the Public Employees Health Plan, each of which will provide an array of treatment services, to include ABA therapy, for 2 year old up to age 6, diagnosed with ASD. Outcomes will be evaluated in two years which may determine the future of state funding.//2013//

/2015/Unfortunately, the 2014 Legislature did not extend ATA funding. The ATA Advisory Committee is notifying the families that children served by the ATA will not receive services under this account after June 30, 2014. However, the children may be eligible for the Medicaid Autism Waiver program after July 1st. Unfortunately Medicaid is not able to give children in the program priority enrollment as it requires a state plan amendment which requires legislative approval. The number of children in the ATA would fill all of the available spots for the next open enrollment period.//2015//

Utah's Title V programs are working toward the six CSHCN core components of: 1) family and professional partnership at all levels of decision-making; 2) access to comprehensive evaluation and diagnosis; 3) adequate public and/or private financing of needed services; 4) early and continuous screening for children; 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 CYSHCN 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 CYSHCN. /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 many areas.//2012// /2014/Additional reductions are anticipated.//2014//

Families continue to face formidable barriers in accessing services and coordinating care for their CYSHCN. /2012/To mitigate these problems for families, CSHCN works closely with the Family to Family Health Information Center and Utah Family Voices. The Bureau also has a small contract with the Utah's Parent Training and Information 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 Medical Home Portal website, Telehealth, traveling multidisciplinary clinics, the Fostering Healthy Children Program, community based case management teams, Baby Watch/Early Intervention and collaboration with Utah Family Voices and the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) grant. These initiatives are described in greater detail elsewhere in this document. /2013/CSHCN collaborated with the Medicaid Infrastructure Grant to provide training on transition to adulthood to Medical Homes throughout Utah.//2013//

/2014/All CSHCN clinics have implemented a new electronic billing and health record system. Lay midwives are also being trained successfully to reduce the number of children lost to hearing screening by screening their own births. Training and equipment have been provided by CSHCN

through other HRSA grants.//2014//

As the Title V block grant is reduced by establishment of categorical funding streams, we face additional financial obstacles particularly when the law requires the Department to provide certain services or personnel without funding, such as the State Dental Director, newborn hearing screening, and so on. While Utah is not suffering the degree of economic down turn 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.

Addressing the Needs of a Diverse Population

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 (OHD) in order to put more emphasis on disparities which may occur among populations not necessarily defined by race or ethnicity.//2012//

OHD 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 OHD has provided cultural competence training for both state and local public health staff. OHD is in the process now of identifying key health issues of each of the sub-populations 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. /2014/ OHD established a Birth Outcomes group to look at adverse pregnancy outcomes. As a result of this group, four culturally and language appropriate videos titled "for Me, for Us" were developed to discuss healthy weight, access to health care, and healthy births. The videos targeted African Americans, Pacific Islanders, Hispanics, and the broader general population. The videos were made available on You Tube in English, Spanish, Tongan, and Samoan. //2014//

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. That position resides in the same Division as the MCH/CSHCN/CD Bureaus.

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.

//2014/The Governor has not yet announced his decision about Medicaid expansion. A report released recently during the Medicaid Expansion Options Community Workgroup meeting provides information for Utah policy makers as they consider whether to expand the state's Medicaid program under the Affordable Care Act (ACA). The report, produced by Boston-based Public Consulting Group (PCG), does not make recommendations on how the state should proceed, but rather analyzes the costs and benefits associated with five potential expansion scenarios. The PCG report estimates over the next 10 years the mandatory changes will:

- Increase Medicaid enrollment by 60,202 adults and children
- Increase Medicaid service and administration costs by \$762 million (due to federal matching money, the state share of this increase will be \$213 million)
- Generate an additional \$20 million in state tax revenues
- Generate an additional \$16 million in county tax revenues
- Generate \$516 million statewide in economic impact, create 747 new jobs.

The remaining four scenarios modeled in the PCG report all assume the state will expand its Medicaid program. The PCG report estimates over the next 10 years the costs and benefits of the full expansion scenario (traditional Medicaid benefits for adults earning up to 138 percent of poverty) will be:

- 123,586 additional adults would enroll in Medicaid
- Medicaid service and administration costs will increase by \$3.2 billion (due to federal matching money, the state share of this increase would be \$260 million)
- State public assistance programs would save \$156 million
- County public assistance programs would save \$39 million
- Generate an additional \$113 million in state tax revenues
- Generate an additional \$90 million in county tax revenues
- Hospitals would save \$814 million in uncompensated care
- Generate \$2.9 billion statewide in economic impact, create 4,160 new jobs

The Governor will announce his decision about Medicaid expansion in the fall of 2013. The mindset of the state legislators usually is for less government, less state dollars going toward federal programs, etc. So, it will be interesting to see how the potential expansion will play out in Utah.//2014//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Title V in Utah maintains a strong presence in the public health arena, at national, state and local levels. Title V programs have been held in high regard for many years. With the Department reorganization in 2009, we are positioned to better integrate and collaborate more internally as well as externally.

Programs in three bureaus serve mothers and children, but previously have worked independently of each other. The reorganization affords an opportunity to revisit the MCH programs, improve efficiency, move towards stronger leaders over programs and better understand what we all do to improve the health of mothers and children. The reorganization has provided a fresh look at clinical programs in terms of services we provide, how we provide them. We have had an effective working relationship with local health departments. As always there is room for improvement at the state level, and we anticipate that over the next year, we will be able

to bring together state program staff from three Bureaus that serve mothers and children to discuss ways that we can better communicate, understand what each program does and its impact.

Budget shortfalls have impacted both MCH and CSHCN programs. The Governor 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. /2013/Utah's economy has improved creating a budget surplus, however, we did not receive any replacement funds for those cut in CSHCN clinics.//2013// /2014/Hiring has proceeded, however, we are currently holding off filling vacant positions until we know what cuts will need to be made. Positions funded with short term federal funds are now classified as a temporary position. For long term funding, such as Title V, positions can be filled through the career service system.//2014// **/2015/Given that the state budget cuts have not been restored, our capacity to serve children and youth with special health care needs has been greatly reduced. The Division Director, Dr. Marc Babitz, has initiated negotiations with the University of Utah Department of Pediatrics for options to serve more CSHCN, especially in rural areas of the state. At present the arrangement will be a cooperative effort, with the University putting some of its funding into the clinics, better supporting clinics with personnel to increase numbers served, and to increase utilization of the clinic space. //2015//**

Title V staff continually identifies needs of underserved mothers and children to prioritize allocation of resources. Staff 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 as authors.

/2013/The Utah Department of Health signed the challenge agreement with ASTHO and the March of Dimes to reduce prematurity rates in the state. As part of UDOH's strategic plan, healthy babies is a priority, a tremendous opportunity to promote preconception health and life course for healthier mothers and babies. The work focuses on preconception up to a child's 5th birthday so we can promote health during a time of critical development. The Department's inclusion of MCH is a first and gives us a wonderful opportunity to get support for what we already are doing and for expansion of our work in this area. The action plan includes the following areas: 1) prevention of prematurity, 2) promotion of breastfeeding as a means to reduce maternal and childhood obesity, 3) preconception through media and print materials, and 4) promotion of universal developmental screening with evidence based tools. //2013//

/2014/In November 2012, the Utah Chapter of March of Dimes with its partners, including UDOH, sponsored a Prematurity Symposium to discuss the impact of prematurity and develop an action plan to address the problem. Four main prevention areas were identified: 1) Optimization of inter-pregnancy interval, 2) Early identification and treatment of high-risk pregnant women, 3) Increasing the use of progesterone supplementation during high risk for preterm birth pregnancies to reduce recurrent preterm births, and 4) Increasing single embryo transfers for in vitro fertilization to reduce selective multiple gestations and resultant preterm births. At this meeting, Dr. Jay Iams presented on the quality collaborative work being done in Ohio and a formal proposal was made to begin work on establishing an ongoing, statewide Perinatal Quality Collaborative in Utah. It has also been proposed that the NICU collaborative group be incorporated into the larger quality collaborative. A collaborative leadership committee was formed and work has begun to convene an inaugural meeting in July 2013. The name of the collaborative will be the Utah Women's and Newborn's Quality Collaborative (UWNQC).//2014// **/2015/ The March of Dimes awarded the Virginia Apgar Award to the Department for achieving a 8% reduction in preterm birth. //2015//**

Data capacity

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 UNSchIE 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 birth and death certificates, BabyWatch/Early Intervention 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. //2013/CHARM will enable authenticated and approved providers to look up a child's records to determine immunization status, newborn screening results, etc. Within the next year, CHARM data will be available through the cHIE system and other access points to link multiple data sets and provide the most current and accurate information available. //2013// /2014/ Information from the Birth Defects Network and from the Neonatal Follow-up Program will also be linked within the next few months.//2014//

The Division has built extensive 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.

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.

The Division oversees the Birth Defects Registry and the Autism Registry. Both are collaborative efforts between the Utah Department of Health and the University of Utah, School of Medicine. 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. /2014/The WIC information system, VISION, was rolled out fall of 2012 and is operating very well. Significant staff time and efforts went into the development, design, testing and rollout of the system. Local WIC clinic staff appreciates the new system's functionality and reliability. We hope to be able to obtain data from the new system in the next year or so.//2014//

Title V programs

The Department has many programs that address needs of women, mothers, children and adolescents 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. The 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.

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/norw 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 annual staff retreats 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.

Bureau of Child Development

The Bureau of Child Development is a newly formed Bureau and brings together programs for young children: child care licensing, early childhood systems, Baby Watch Early Intervention and the Office of Home Visiting. The Bureau's vision is to support parents in their efforts to ensure their child's healthy development. /2014/The state match required for the Head Start State Collaboration Office grant was eliminated in 2012 so we no longer administer the grant.//2014//

The Baby Watch/Early Intervention Program provides early identification and developmental services for families of infants and toddlers aged birth to three. These services are provided through the coordinated effort of parents, community agencies, and a variety of professionals. Services are delivered in the child's natural environment, which can include the child's home, child care settings, and other community locations, including local early intervention centers. Baby Watch serves children birth to three years of age who meet or exceed the definition of a moderate developmental delay in one or more of the following areas: physical development; vision and hearing; feeding and dressing skills; social and emotional development; communication and language, and learning, problem solving, and play skills.

Services offered include: a full assessment of a child's current health and development status; service coordination among providers, programs and agencies; strategies to build on family concerns, priorities, & resources (CPR), and developmental services: occupational therapy, physical therapy, speech/ language therapy, etc. The Child Care Licensing Program's vision is to support working parents by protecting the health and safety of children in regulated child care programs. This is accomplished by:

- Establishing and enforcing health and safety standards for child care programs.
- Training and supporting providers in meeting the established health and safety standards.
- Providing the public with accurate information about regulated child care.

The program is responsible for implementing and enforcing the administrative rules that govern child care facilities. There are several different types of center-based and home-based child care facilities, each with its own requirements. Licensors travel throughout the state inspecting child care facilities to ensure children are safe and healthy care. All providers, including owners and members of the governing body, directors, employees, providers of care, volunteers, anyone age 12 or older who lives in a home where care is provided, and anyone who has unsupervised contact with a child in a care center is required to have a background screening before licensure, and an annual background screening when the license is renewed. Complaints against providers are investigated and any rule violations found must be corrected in order for the facility to remain open. Staff provides trainings in licensing rules for the providers.

Early Childhood Utah

//2014//In September 2011, Governor Herbert designated the existing ECCS State Team in the Utah Department of Health (UDOH), Bureau of Child Development (BCD), to also function as the State Advisory Council on Early Care and Education. This combined team is known as Early Childhood Utah (ECU). ECU is comprised of four standing committees: Access to Health Care and Medical Homes, Early Care and Education, Mental Health Services, and Parenting Education and Family Support.

ECU is striving to ensure that all Utah children enter school healthy and ready to learn by improving the healthy physical, social, and emotional development during infancy and early childhood, eliminating disparities; and increasing access to needed early childhood services by coordination and collaboration at both the state and local level. ECU is working to ensure that all Utah children enter school healthy and ready to learn by:

- working with public and private partners to foster the development of cross sector service systems;
- identifying opportunities for, and barriers to, collaboration and coordination among early childhood programs and services;
- assessing and developing recommendations for improving quantity, quality, and participation in early childhood programs and services;
- assessing and developing recommendations for improving the capacity and effectiveness of professional development training and education for early childhood service providers;
- assessing and making recommendations for improved early childhood data collection and usage; and
- engaging in mutually agreed upon cross sector work projects designed to accomplish these purposes.

A major focus of ECU is the development of a multi-agency data sharing project which will facilitate data sharing and coordination among early childhood programs in Utah. The data system will allow for study of longitudinal outcomes so that we can examine which programs or combination of programs lead to the best long-term outcomes not only in early childhood but also as children transition to school and to employment. Currently, assessment of health and development is fragmented and siloed, making it difficult to completely understand families' needs in order to collaborate and coordinate needed services. Key data from multiple early childhood databases will be integrated into the state's longitudinal data system, resulting in a usable data source from early childhood through elementary, secondary, and post-secondary education and into the workforce. This system will enable agencies and programs to track long-term outcomes due to early childhood investments, and make better informed policy, program, and resource decisions.//2014//

The statewide developmental screening initiative works to promote developmental screening of children age birth through five years using the Ages & Stages Questionnaire (ASQ). Child Care Resource & Referral agency staff train early care and education providers to use the ASQ with children in their care and share screening results with parents. The program aims to help early care and education providers connect children and families to community resources for child

development.

/2014/Help Me Grow (HMG) is a resource and referral program that maintains an integrated child and family referral service. The Program uses the ASQ developmental screening tools with families by distributing ASQs to parents of all young children who enroll in HMG. HMG helps parents score the questionnaire and shares the results with the child's health care provider. HMG currently operates in Utah County and is in the process of expanding into Salt Lake County. In the coming year it will also pilot its first rural expansion into Carbon, Vernal and Duchesne Counties.

/2015/ The pilot has started so the expansion in rural areas is on its way. //2015// The Bureau believes that HMG has the potential to be an umbrella service that could link multiple early childhood programs/services and integrate them with ongoing developmental screening with other services. UDOH is collaborating with Help Me Grow Utah (HMG) to provide universal screening for young children. The HMG program helps to find services for children birth through 8 years of age that are at risk for developmental or behavioral concerns. Using a comprehensive database of current community based services and resources, Care Coordinators are able to refer families to appropriate services. The Care Coordinators talk to families about options and help them maneuver through the maze of services and programs. Follow-up is done to ensure the families have been linked to services and to see if additional referrals are needed. The Care Coordinators also mail general information on child development or specific developmental issues to families. Families have the option to sign up to participate in a child developmental monitoring program using the ASQ.

HMG has the capability of reaching all children in a community through their health care provider and community outreach efforts. HMG enrolls families, assists parents in completing ASQ developmental screenings, and sends screening results to parents and (with parental permission) to the child's health care provider. For children whose screen indicates possible developmental concerns, a referral for a more comprehensive assessment is made. A benefit of having HMG as the conduit for developmental screening is the linkage it provides to health care providers. With parental consent, all screening and referral information is communicated to the provider, allowing a collaborated, comprehensive approach to treating the whole child.

Currently, three UDOH programs in the BCD contract with Help Me Grow. These programs are: Baby Watch Early Intervention (BWEI) and Parent Support Programs (PSP) which include ECU and the Office of Home Visiting (OHV).//2014//

The early childhood data integration project to facilitate data sharing and coordination among early childhood programs in Utah, in order to:

- Evaluate long term outcomes for children who participate in early childhood programs,
- Improve child outcomes and the quality of early childhood programs by promoting data-driven decision making,
- Answer key policy questions regarding early childhood programs and services,
- Evaluate data that is timely, relevant, accessible, and easy to use to answer policy questions and
- Facilitate the State's ability to participate in funding opportunities by collecting basic information on children, early childhood professionals, and early childhood programs

Using a combination of ECCS and SAC funding, key data from multiple early childhood databases will be integrated into the state's longitudinal data system being developed by the Utah Data Alliance, resulting in a usable source of data from early childhood through elementary, secondary, and post-secondary education and into the workforce. This will enable agencies and programs to track long-term outcomes from early childhood investments and make better informed policy and resource decisions,

Office of Home Visiting

The mission of the Office is to promote a coordinated service continuum of research-informed home visiting that supports healthy child development and ensures the safety of young children

and family members by: developing state infrastructure to support home visiting; supporting a local continuum of services; providing training and technical assistance to local programs; securing sustainable funding; and, evaluating outcomes and quality of services. The Office of Home Visiting (OHV) acts as a support and resource center for entities interested in implementing an evidence-based or research-informed home visitation program. The OHV provides:

- Support for home visiting programs with training and technical assistance
- Support for starting new evidence-based home visiting programs
- Augmentation and/or development of knowledge and linkages between home visiting programs and the related

services systems at the state and community level identified as but not limited to:

- oOther home visiting programs
 - oHealth care providers
 - oSubstance abuse providers
 - oMental health providers
 - oChild care, and
 - oParenting programs
- Identification of existing and new sources of funding for local home visiting programs
 - Promotion of evidence-based home visiting as an effective way to prevent child abuse
 - Evaluation of EBHV programs currently operating in Utah

OHV funds several home visiting programs in the state based on three evidenced-based models: Nurse Family Partnership, Parents as Teachers, and Healthy Families America.

CSHCN Bureau

The CSHCN Bureau oversees seven programs 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 Title V, Medicaid, CHIP, state, and collections from private insurance. Newborn blood screening kit fees fully fund the Newborn Blood Screening program and partially fund newborn hearing screening.

The Bureau oversees Department 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 (UNSCHIE) will expand the Child Health Advanced Records Management (CHARM) project which allows sharing of health data among different data systems. CSHCN continues other major initiatives including the Utah Collaborative Medical Home; Transition for Youth and Young Adults programs; SSI outreach information and referral.

Utah Birth Defect Network (UBDN) is a population-based statewide program that provides surveillance, research, and prevention of birth defects. 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 each phenotype, trends over time, and to serve as the case group for research. /2013/BDN successfully applied with the University of Utah (UofU) for a newborn critical congenital heart disease grant.//2013// **/2015/This grant is now in its second year. The staff involved in the grant will be responsible for statewide education and training to prepare for the implementation of the mandated CCHD screening in all hospitals.//2015//**

Clinical Services include three programs

/2015/Three clinical programs are included in the discussions with the University of Utah to provide services to more children with special health care needs.//2015// Developmental

Consultative Services Program provides developmental evaluation, diagnosis, and referral to community resources for children up to age 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. Neonatal Follow-up Program tracks very low birth weight babies less than 1250 grams 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 of the clinical findings is shared with the Medical Home or primary care provider and respective newborn ICU and research. Specialty Services Program includes the Hearing Screening Program 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. ***/2015/This program is also included in discussions with the University of Utah to expand services to more children statewide.//2015//***

Family Involvement

The program for family involvement, leadership and support provides information and support to families of children and youth with special health care needs and the professionals who serve them. The program in collaboration with Utah's Family to Family Health Information Center and Parent Training and Information Center provide individual consultations, workshops, publications and web-based educational materials. The program partners with various disability, advocacy and family organizations in the State in organizing events throughout the state in a conference format. Parent participation and perspective is added into all the programs and services delivered to children and their families. The MCH programs continue to be fortunate to have excellent family advocates who are known nationally as well as in the state promoting the needs of children and families. The Family Involvement Program collaborated with the University of Utah in the Children's' Healthcare Improvement Collaboration (CHIC) that is funded by a CHIPRA grant for a Medical Home Demonstration Project. Through this project the Utah Family Voices Director contract to coordinate Family Partner activities and training, provide information and resources to the Medical Home Coordinators and visit each of the sites to provide technical assistance and training on community based resources. There are 12 clinics involved in the project with three of them being a specialty practice. Through this project and Medical Home initiatives the UFV Director was able to spread statewide building capacity for comprehensive, family-centered, coordinated, culturally competent health care for children with special health care needs. The CHIC project has Medical Home teams that include a parent partner, a primary care provider, a medical home coordinator and office staff. The University of Utah's Department of Pediatrics also host a website, the Medical Home Portal www.medicalhomeportal.org, developed through collaboration with additional partners that contains information on diagnosis, special education, transition, family issues, coding, and resources for providers and families. The website is being adapted to include local services from other states and includes guest authors from other states.

Additional CSHCN staff submits a quarterly article in the newsletter for the Utah Chapter of the American Academy of Pediatrics referred to as the Medical Home Corner, and provides on-going expansion of content and services to the Medical Home Portal. 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 Specialist, SSI Specialist, and Medical Home Care Coordinator addressed 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 Medical Home Portal website noted below. Additionally, several dental homes were provided training in dealing with the unique needs of children with autism spectrum disorders. The training was provided through a partnership with CSHCN staff and staff at the University of Utah's Utah Pediatric Partnership to

Improve Healthcare Quality (UPIQ) with funding through a federal grant.
www.medicalhomeportal.org.

The Hearing and Speech Program 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. 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.

The program has reached out to lay midwives to ensure that infants born outside of hospitals are screened for hearing loss. /2013/CSHCN collaborated with partners to establish the electronic exchange of Department newborn hearing and blood screening results with Medical Homes. This effort is in its last year of HRSA funding.//2013//

/2014/Additional access to immunization information, blood screening and hearing screening has been made available through secure access points to authorized users through this project. New legislation takes effect July, 2013 that mandates CMV testing after a 2nd failed hearing screen (HB 81). A Pilot Project will also provide funding for hearing aids for children diagnosed with hearing loss from birth to 3 years (HB 157).//2014//

The Maternal and Child Health Bureau oversees five programs, four of which are primarily funded with Title V funding: Data Resources, Maternal and Infant Health, Oral Health and Pregnancy Risk Line. In addition, the Bureau has a Quality Improvement Director. The MCH Bureau oversees local health department contracts for services to mothers, children and youth, and P-5 home visiting. The fifth program in the Bureau is WIC, funded solely with USDA dollars. The Bureau oversees the MCH Block grant application and needs assessment processes with input from CSHCN, Child Development and other Department programs.

The Data Resources Program 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. The Program assists staff with survey development, database development, and report writing. The program has the lead responsibility for coordination of MCH Block Grant processes each year. In 2012, the program developed the UBID (Utah Block grant Information Data system) system which allows writers to submit materials online. UBID allows staff easier understanding of the block grant requirements for which they are responsible and allows more efficient transfer of information to TVIS.

The Maternal and Infant Health Program (MIHP) is comprised of several components. Preconceptional/Reproductive health focuses on promotion of the importance of good health before pregnancy, reducing unintended or closely spaced pregnancies. The Perinatal Mortality Review program convenes a group of health care providers to reviews infant deaths and pregnancy related maternal deaths to determine if there are factors that might have prevented the deaths. The reviews also provide information on trends in causes of death, such as related to obesity, substance abuse.

The adolescent health component works closely with stakeholders to analyze, prioritize and address critical adolescent issues. This component also includes oversight and management of the federal abstinence only and PREP grants to local communities.

PRAMS (Pregnancy Risk Assessment Monitoring System), funded with CDC and state funds, provides a wealth of information on experiences before, during and after pregnancy that is used to identify issues, develop strategies, and improve the health care systems. The PRAMS staff issue reports on specific topics that arise in the analysis of the data, such as the use of infertility treatments, pregnancy weight gain, gestational diabetes follow up, preconception health

measures, and breastfeeding. /2014/ Utah PRAMS was one of five initial pilot states to go live with the new PRAMS data collection system, known as "PIDS".//2014//

/2014/The Maternal and Infant Health Program is working on initiatives geared towards improving maternal mortality case identification and reviews, improving postpartum follow up testing of women with gestational diabetes, validation of birth certificate data, preterm birth classification, and issues related to non-regulation of single room birthing suites staffed by Lay Direct Entry Midwives (LDEM) and lay midwives.//2014// ***/2015/The program and other stakeholders are reviewing out of hospital births to include home and birthing center births. Utah has no licensed birthing center due to a gap in the regulations that allows one room birth centers to deliver babies without regulation or certification. The lay midwives involved in home and birth center births are engaged in the process with the program and others. //2015//***

Oral Health Program promotes prevention of dental decay and other oral diseases and increased access to services. The program provides technical assistance to local health departments and others in the community. The State Dental Director heads the program and works collaboratively with the Utah Dental Association, Medicaid, community providers and advocates to identify key issues related to the dental health of children and adults. The program works through a coalition of stakeholders to promote the importance of oral health and availability of health insurance covering dental health. The program promotes good oral health, dental sealants, fluoride varnish application and regular dental care. The Oral Health Program supports fluoride rinse and sealant activities in schools. ***/2015/The Oral Health Program Dental Hygienist has started traveling with the CSHCN itinerant clinic staff to examine children's teeth, applying fluoride varnish as appropriate. She has been instrumental in engaging local dental hygienists in volunteer work so that the children can be screened and fluoride varnish applied. Referrals are made to local dentists if the child doesn't have dental insurance. In addition, the dental hygienist has offered fluoride varnish services in our local CSHCN clinics. //2015//***

Every five years the program conducts a dental health survey of 6-8 year olds in the schools to assess oral health status. Information from this report is helpful in identifying the needs of children to policy makers. 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 data to measure the impact of water fluoridation. ***/2015/The next Oral Health Survey is being planned for the Fall of 2015.//2015//***

Pregnancy Risk Line /2014/MotherToBaby//2014// 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. Pregnancy Risk Line handles more than over 9,000 calls in a fiscal year. The Program works closely with University of Utah Department of Pediatrics, Genetics and Pharmacy to review current literature to update information on possible harmful effects of medications, infections and other agents, such as chemicals, on the developing fetus or breastfed infant. In the past year Pregnancy Risk Line has addressed antidepressant use in pregnancy.

/2014/ Pregnancy Risk Line has worked with the International Organization of Teratology Information Specialists (OTIS) in developing and implementing the MotherToBaby initiative with the purpose of creating a more consumer-friendly name. Pregnancy Risk Line anticipates effectively reaching more women and health care professionals that benefit from our services, as well as the ability to better engage with key stake-holders and supporting partners.//2014// Pregnancy Risk Line provides training and mentoring for pharmacy, nursing and genetic counseling graduate students. Pregnancy Risk Line collaborates with other agencies to educate about the dangers of alcohol, tobacco and other drugs and resources for treatment.

/2014/Pregnancy Risk Line continues to participate in numerous research projects aimed at better understanding of the use of medications during pregnancy and breastfeeding and their possible effects on a fetus or breastfed baby. //2014// ***/2015/Pregnancy Risk Line, now MotherToBaby,***

celebrated its 30th Anniversary in May 2014.//2015//

WIC serves more than 67,000 pregnant and postpartum women and young children each year. The program has earned a national reputation of leadership in several areas including the online system for vendors to submit food prices electronically, early implementation of the new food rules, and so on. The WIC Program works closely with other programs on nutrition and obesity. Having WIC in the MCH Bureau has greatly enhanced our ability to work together on common issues and solutions. MCH programs and other programs in the department often consult with WIC nutritionists on breastfeeding and nutritional issues. The Utah WIC Program has been recognized nationally as a leader in innovation and early adopter of new practices.

Quality Improvement Initiative identifies issues related to quality of care for mothers and children. Currently, the Director is working with NICUs on establishing guidelines for appropriate designation of level of care. The workgroup was recently expanded to add perinatal quality of care in order to bring the life course perspective into the quality improvement realm.

In the Child Development Bureau is the Part C Baby Watch Early Intervention Program, Child Care Licensing, Office of Home Visiting and Early Childhood Utah. The Part C Early Intervention Program serves infants and toddlers with disabilities or developmental delays, and is funded with a combination of state general funds and Federal OSEP funds. The Child Care Licensing Program is funded with a combination of state general funds and Federal CCDF funds through an interagency agreement with the Utah Department of Workforce Services. Early Childhood Utah is funded with a combination of Federal ECCS and SAC funds.

The Office of Home Visiting (OHV), created by a 5 year cooperative agreement with ACF, 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 programs.

Other Programs Funded with Title V Funding:

School Health

Many health promotion programs in the Department work with school-age children and youth, but we did not have a dedicated staff member to promote the overall health of school-aged children. The former school nurse provides consultation to the State Office of Education, schools, school nurses and others on the health needs of children and youth. She divides her time between the Utah Department of Health and the State Office of Education. ***/2015/The School Health Consultant has received grant funding for a School Nurse Institute that will bring school nurses together from all over the state to provide training on the nurse practice act and state laws that impact school health, such as requiring schools to have epi-pens available in the event of an anaphylactic reaction. //2015//***

Violence and Injury Prevention Program, in another Division, works to reduce injury with specific focus on youth injury prevention. The program includes: school injury prevention, youth suicide prevention, 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. The program is very active in injury prevention activities and participates with other stakeholders with the state's suicide prevention efforts. The program utilizes Title V funding as well as Prevention Block grant funding and other sources to support its activities. Two youth are treated for suicide attempts every day in Utah. Utah's suicide rate has been consistently higher than the U.S. rate for the last decade.

/2014/Recent legislation funded two positions to address youth suicide, one in the Office of Education and the other in the Division of Substance Abuse and Mental Health in the Department of Human Services.//2014//

Programs that serve mothers and children in Utah with other sources of funding

In CSHCN Fostering Healthy Children Program (FHCP), through contract with Division of Child and Family Services (DCFS), is responsible for oversight and coordination of health, dental and mental health needs for children in DCFS custody. CSHCN nurses work with DCFS caseworkers to ensure that all children in state custody 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. Oversight of health care requirements for children in foster care were mandated by federal court settlement agreement.

In CSHCN Newborn Screening Program oversees the state newborn blood screening of 37 congenital conditions and follow-up for infants with positive screens. The program works closely with birthing hospitals to improve compliance for timely accurate bloodspot samples. CSHCN issues "report cards" for each hospital and providers to improve the quality and timeliness of blood samples. /2014/SCID testing will be added in 2014.//2014// **/2015/ There are now 38 disorders which are screened by this program. //2015//**

/2015/In October 2014, the state mandate that all newborns receive CCHD screening within 48 hours after birth. Currently, the Department is working with the University of Utah and Intermountain Medical Center on a pilot project to determine appropriate levels of oxygenation at high altitude for screening //2015//

In CSHCN 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 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. This program is entirely funded by Medicaid and state match funding. /2014/Ten additional slots have been added to the waiver this year.//2014//

In the Bureau of Child Development, the Office of Home Visiting (OHV), created by a 5-year cooperative agreement with the ACF 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 programs.

Also, in the same Bureau is the Part C Early Intervention Program, Child Care Licensing, Early Childhood Systems Development and the State Advisory Committee.

An Attachment is included for 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 became Governor when former Governor Jon M. Huntsman, Jr. was appointed by President Obama as Ambassador to China. Governor Herbert had retained the 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 the Executive Director in January 2011. Deputy Director, David Patton, PhD, was appointed 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// /2014/ Gov Herbert retained Dr. Patton upon his election to his first full-term as Governor. //2014//

Due to discussions among Utah legislators during the 2009 Legislative Session to dismantle the Department of Health /2012/nw former Executive Director//2012// Dr. Sundwall initiated a Department reorganization. The reorganization 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.

/2013/The Utah Department of Health is Utah's Title V agency and is responsible for all aspects of Title V administration. The programs funded by Title V are mainly in two Bureaus in the Division of Family Health and Preparedness: Maternal and Child Health and Children with Special Health Care Needs. A small amount of Title V funding is allocated for oversight of our early childhood efforts in the Bureau of Child Development, another bureau within the Division. The Division of Disease Control and Prevention's Bureau of Health Promotion uses Title V funds for violence and injury prevention and school health. Some Title V funds are contracted to health care providers for specialty services for consultation or direct services.

In addition, local health departments receive Title V funds for maternal and child health services and violence and injury prevention activities. The legislatively mandated Governance Committee which oversees all grants that the Department applies for has reviewed the Title V Block Grant, but is not convinced that we are allocating the funding to support a statewide public health system. A new pilot process is being implemented for all grants that requires co-chairs, one local and the other state, to oversee the grant planning processes. The MCH Grant is going to pilot the process first. //2013//

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 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 (BCD). In addition, Harper Randall, MD was appointed the CD/CSHCN/MCH Medical Director.

/2013/The reorganization of the three Bureaus under one Deputy Director has facilitated improved collaboration, improved oversight of certain programs needing leadership, growth in staff capacity and performance. Programs are working much better, collaborating more and seeing the "big picture" of how MCH, CSHCN and Child Development are all related with each other. We have had discussions of how to apply "life course" in our work and approaches to our programs. In discussions with program managers, it is evident that they are, by and large, applying Life Course, but hadn't perceived it as "Life Course" in particular.//2013//

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 mothers, infants, children and youth, including those with special health care needs and their families. CVs for senior management are attached. The Bureau of Child Development is headed by Teresa Whiting. Teresa has background and experience in child development, child care, Head Start, the State Office of Child Care and child care licensing. She has headed the Department's Bureau of Child Care Licensing, and now her responsibility has been expanded to include other programs related to young children. /2013/The state Part C program, Baby Watch/Early Intervention, was moved from the CSHCN Bureau to the Bureau of Child Development to align with other early childhood programs.//2013//

The CSHCN Bureau includes eight programs /2013/ With Holly Williams' retirement on July 1, 2012, the new CSHCN Bureau Director is Richard Harward, Au.D. who had been the Program Manager over the Speech and Hearing Program for a number of years. Dr. Harward has extensive experience in management and public health programs. The new Bureau Director is committed to work to better integrate programs with each other and with other Bureaus' programs, strengthen partnerships and establish new ones and ensure that available data are used to evaluate programs and services.//2013// ***/2015/Richard Harward retired November of last year. The new CSHCN Bureau Director is Noel Taxin who started in the spring. Noel comes to this position with experience in a number of areas that relate to health, such as Early Intervention, children with special health care needs and a variety of experience in pediatric clinical work.//2015//***

The MCH Bureau includes 5 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 forty years of experience to this position.

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 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 individual 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// /2013/The Governor designated the Department of Workforce Services Office of Child Care to administer this grant.//2013//

The statewide developmental screening initiative promotes developmental screening of all children birth through five years using the Ages & Stages Questionnaire (ASQ). Staff at local Child Care Resource & Referral agencies train early care and education providers to use the ASQ and share results with parents. The program aims to help early care and education providers connect children and families to community resources for child development.

Surveys to assess the knowledge and use of standardized developmental tools by health care providers were distributed to members of the Utah Chapter of the American Academy of Pediatrics (UCAAP). /2014/The preliminary results indicate that the majority of providers who responded use a developmental screening tool.//2014//

Children and Youth with Special Health Care Needs Programs

The seven 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 five MCH programs include: Data Resources, Maternal and Infant Health, Oral Health, Pregnancy Risk Line, and WIC. The Maternal and Infant Health Program includes PRAMS.

Other programs that reach mothers and children:

Violence and Injury Prevention Program (VIPP) 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. /2014/The WIC program currently serves approximately 67,000 mothers and children annually.//2014//

As part of the Department's Strategic Plan, we are working on HUB-Healthy Utah Babies, which is focused on the health of the mother before, during and after pregnancy and the health of her child up to age 5. We are trying to communicate that in order to have a healthy baby, the mother has to be healthy before getting pregnant. HUB is currently working on several areas to accomplish improved health of mothers and their infants: 1) promotion of breastfeeding by

promoting WHO's 10 steps for hospitals to support breastfeeding; 2) promotion of preconception health and care through our Power Your Life campaign; 3) reduction in premature births through several avenues: a) promotion of 17P among women who have had a preterm birth; b) promoting long term effective contraceptive methods for women at high risk for preterm births; c) convening a collaborative effort with the 10 tertiary hospitals to promote prematurity reduction and appropriate level of care in NICUs; 4) promotion of universal developmental screening as a means to ensure all young children are screened using an evidence-based screening tool, such as Ages and Stages, and to identify developmental delays early when early intervention is most effective.

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 Utah Department of Health building, the Martha Hughes Cannon Building, and some are housed at the clinical services building, the Center for Children with Special Health Care Needs. MCH programs are located at the main Department building. In addition to Children with Special Health Care Needs staff at the clinical services building, the Bureau of Child Development staff is also housed there. The Bureau of Child Development houses the Department's early childhood program, child care licensing, Early Childhood Systems grant, Office of Home Visiting and BabyWatch/Early Intervention.

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 out-stationed 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 out-stationed staff in Ogden and in St. George, a growing community in southern Utah, and contract staff in 7 rural 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 Follow up 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.

Division program managers are all well experienced skilled health professionals with significant experience in their field and in program administration, planning and evaluation. //2013//The MCH Bureau created a part-time Quality Improvement position to evaluate health care and develop strategies to improve outcomes. One of the QI projects is examining capacity of NICUs and self designation of NICUs as Level III NICUs. This focus is a very sensitive issue to hospitals, especially the smaller hospitals with fewer deliveries, yet designating themselves as Level III NICUs.

We have garnered support for our efforts to improve outcomes for babies needing Level III care from the University of Utah as well as from Intermountain Healthcare, the largest health system in Utah. Representatives from the smaller NICUs are concerned about the state examining outcomes since their outcomes follow studies on NICUs with small numbers, that is, poorer outcomes.//2013//

The Office of Public Health Assessment (OPHA) includes Department health survey functions. BRFSS phone follow-up is 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 leadership coordinator. 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 CSHCN Bureau hired the Director for the Utah Chapter of Family Voices (UFV) as the Bureau family involvement coordinator. She is a parent of five children, three of which have special health care needs children with over 25 years of experience in parent advocacy and navigation of the health care and disability system of care. She has been involved with the Utah Parent Center (UPC) which is Utah's Parent Training and Information Center federally funded by the Office of Special Education and Rehabilitation Services. 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 more than 50 parent and family partners in the individual Medical Home practices across the state.

The Family to Family grant was awarded to Utah Family Voices (UFV) in 2008 and will continue through May 2014. There are many efforts going on at the Federal level to have additional funding for long-term sustainability for the Centers across the country. CSHCN has provided some funding to the Utah Parent Center to support their Autism Hotline and update the on-line Autism resource fact sheet available on their website at <http://www.utahparentcenter.org/disabilities/autism/>. CSHCN continue to dedicate has dedicated

MCH resources available to enhance family-to-family activities and support to families. The F2F maintains a database of family contacts, demographics and issues. With the collaboration of the CSHCN Family Voices director, data are shared with CSHCN to understand what the ongoing needs of families are. Families are compensated for their consultation and expertise when partnering with any of the projects and programs the CSHCN Family Voices director involves them in such as the URLEND program, Medical Home activities, development of materials written for families by families and working with medical residents to provide a parent's perspective.

The F2F staff is available as needed to the CSHCN clinics and programs to provide support and resource navigation to families served. 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. /2013/CSHCN will contract with the Family to Family project to provide consultation and family support to CSHCN clinics and programs.//2013//

The CSHCN Family Voices director and the F2F staff have provided a series of trainings to families of children with ASD as well as professionals working with them. The training came out of a curriculum developed in collaboration with the URLEND program, CSHCN, Center for Persons with Disabilities and an Integrated Services grant for children with ASD. The F2F trained 20 separate communities throughout the state of Utah over the last year and continues to enhance and adapt the curriculum to the specific needs of the audience. The topics cover everything from adapting to a new diagnosis, to learning about the specific diagnosis, education and community resources, health insurance and financing options as well as emergency preparedness and communication skills. The curriculum also is continuing to evolve into a curriculum for all disabilities that the F2F will provide for all families throughout the state as well as including via a web based mechanism. The F2F under the Utah Parent Center and its Board of Directors is actively seeking additional opportunities and funding to sustain the valuable services provided.

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. /2013/Since its inception, BYB Presumptive Eligibility has been overseen by the MCH Bureau. A state audit recommended that the Department should move away from the current three Division arrangement (Divisions of Family Health and Preparedness, Medicaid, and Disease Control and Prevention) for better oversight. Enrollment, social media/hotline, and reimbursement for services have been overseen by the three Divisions for many years. MCH Bureau is working with Medicaid to transfer the responsibilities of oversight of the enrollment process and the Qualified Provider orientation and training. This change will be of great benefit to the program so that the agency responsible for the program oversees all the providers that determine eligibility and that oversight remains with one Division, Medicaid.//2013// /2014/ The oversight of Presumptive Eligibility was successfully transferred from the MCH Bureau to Medicaid. Quarterly coordination meetings are held with all divisions involved to ensure the program is running as intended.//2014//

The Department of Health employs about 174 /2012/norw 210 FTEs due to 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. /2013/ We have experienced a number of retirements in key staff who have worked for the Department 20+ years, such as our Newborn Blood Screening Program Manager, Division Financial Manager and recently the CSHCN Bureau Director. We are in the process of recruiting to fill those positions, but as with any long term employee, a lot of institutional memory goes with those retiring. Since we know that we will see additional retirements, we are working to shift some responsibilities around and to enhance the skills of some of the younger staff with potential to assume managerial and administrative responsibilities.//2013//

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. **/2015/One "Nursing Director" is actually a PA.//2015//** WIC Directors have various backgrounds with many being Registered Dietitians.

E. State Agency Coordination

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 Risk Line to promote messages about the impact of alcohol consumption during pregnancy.

/2015/Fortunately, the Violence and Injury Prevention Program (VIPP) has developed a close working relationship with DSAMH. Program staff co-chair the Utah Suicide Prevention Coalition with DSAMH and works together on all suicide prevention efforts following the jointly developed activities of the Utah Suicide Prevention Plan. DSAMH staff serve on the Utah Child Fatality Review Committee and Domestic Violence Fatality Review Committee. VIPP also works with them on all prescription drug overdoses activities, such as coordinating the Use Only As Directed campaign. VIPP provides extensive data to DSAMH for use in their program planning and advises on legislative issues concerning suicide and prescription drug, etc. As part of the federal traumatic brain injury grant, VIPP staff also work with DSAMH on the Coordinating Council for Persons with Disabilities.//2015//

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 has a School Health Consultant to address health issues in schools and works 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. ***/2015/This effort has not continued due to retirement of staff and elimination of the position.//2015//***

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. /2014/ The MCH Bureau applied, and was accepted, for an AMCHP Action Learning Collaborative on Improving Birth Outcomes through health care reform. Through this process, the MCH Bureau will work with Medicaid and community partners to leverage the Affordable Care Act to improve birth outcomes.//2014/

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 ***/2015/weekly//2015//*** to determine authorization for non-covered services for Medicaid recipients. The Medical Director serves 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. ***/2015/ CSHCN's physical therapist and speech therapist actively participate in discussion when cases require their expertise. The state Dental Director is no longer an active member due to his part-time status.//2015//***

The CSHCN Family Voices Director was a member of the Medical Care Advisory Committee for Medicaid for over nine years and as the term ended, the UFV Director identified another parent of a child with special health care needs to represent the family and consumer voices. The new member of the committee also works with the Family to Family Health Information Center.

*/2012/ 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 University of Utah Health Sciences Center Genetics Director to improve the coordination of EPSDT coverage of genetic testing for children. ***/2015/These meetings are no longer needed as submission for payment for genetic testing has been established and coverage has improved.//2015//****

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//*

/2013/The relationship between the Department of Health and the local health departments is slowly improving and becoming more positive. Through the efforts of the Department's leadership and the local health department leadership, we are making strides in building a more collaborative partnership. The Department has initiated a number of different efforts to address the need for better collaboration, such as working to develop a Statewide Public Health Improvement Plan and so forth.//2013//

/2014/The relationship between the Department and most local health departments has greatly improved over the past several years. The Department leadership along with strong LHD leadership have made a number of concerted efforts to enhance the relationship, improve communications, increase awareness of the challenges that public health faces at a state and at local levels.//2014//

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.

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 **/2015/now eight/2015/**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// /2013/MCH staff worked with the University of Utah Department of Obstetrics and Gynecology on a Strong Start grant that the UofU submitted to CMS. The grant will be a collaborative effort among the UofU, CHCs, Intermountain Healthcare, Medicaid ACOs, Medicaid and MCH to identify women at high risk for preterm birth.//2013// /2014/Unfortunately Utah was not funded to implement this grant.//2014// /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 Voices Director works closely with the Family Advisory Council at PCMC and has the staff at the F2F also involved with the committee. One of the staff members was selected to be on the PCMC Board of Trustee, which is the first "Parent" member. The CSHCN Family Voices Director sits on the committees of the URLEND program, the Medical Home Portal, and UPIQ which provides education and information through professionals to outreach and support families of children and youth with special health care needs throughout the state.

CSHCN continues to support medical homes through the UFV Director's direct consultation and site visits as requested to the clinics in the CHIPRA grant and other UPIQ Medical Home projects. CSHCN also continues the collaboration with University of Utah, Department of Pediatrics and Utah State University, Center for Persons with Disabilities in providing interdisciplinary leadership training to trainees in the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND).

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. The programs focus on more traditional public health and have no specific focus on maternal and children health, but rather a more traditional public health focus. /2013/ The Department is often asked to "mentor" students or to assist them with a project required for completion of a degree. We promote the importance of state-level work in public health as it seems there is more focus on

local public health. For example, we will get requests from the UofU, BYU and Weber State to provide internships to students from nursing, health education, pharmacy, genetics and so on. We believe that it is our responsibility to train and mentor students in the work we do at the state level.//2013//

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. ***/2015/This program no longer exists./2015//***

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 Risk Line.

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. ***/2015/The Medical Home Advisory Committee and the Genetic Advisory Committee have been dissolved. UofU Pediatric faculty, in addition to the other committees listed above, now sit on the CCHD Advisory Committee, Newborn Screening Advisory Committee, ATA Advisory Committee, and URADD Oversight Committee. //2015//***

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. URLEND 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 URLEND supplemental grants, in its fifth /2012/tenth//2012// year for audiology and ASD. /2012/A new URLEND 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 Education, CDC, USDA, HRSA, etc., including Early Intervention (Part C), SSDI, WIC, PRAMS, Autism, EDHI, Lost to Follow up,

Home Visiting, IT, Critical Congenital Heart Disease, Abstinence Education and the Personal Responsibility Education Program (PREP) 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 funds 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 lead the Family Involvement, Leadership and Support programs which provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. Family Voices has successfully applied for and awarded funding to continue the Family to Family Health Information Center (F2F) through fiscal year 2013. The F2F is housed in the Utah Parent Center a federally funded Parent Training and Information Center. The F2F provide direct consultation with information, resources and peer to peer support to families through various mechanisms. Families connect with the CSHCN Family Voices Director and F2F staff in person, by phone which includes a toll-free line, electronically through email and social media and trainings throughout the state. Both the Utah Parent Center and Utah Family Voices provide the services above as well as provide leadership training and mentoring for families. The model of collaboration between the UPC and F2F effectively provides comprehensive services of each of the Centers expertise. The UPC provides top quality services related to Special Education, the F2F provides valuable services related to the healthcare and financing system and both partner to provide services related to home and community based resources and systems of care. Staff at both Centers are parents of children with special health care needs and disabilities. All staff participates on local, state and national level committees to provide a parent's voice and perspective to systems change efforts and policy-making. The F2F and the UPC are engaging in projects and collaboration with the state's Federation of Families project (Allies with Families) and the Division of Human Services to partner in providing supports to families who have children with emotional, behavioral and neurobiological disorders. The integration of children's mental health within Medical Homes has been a focus for the CSHCN Family Voices Director and the F2F and the training of Family Resource Facilitators in the Mental Health centers is the focus of the UPC and Allies with Families. Efforts to continually enhance integration between parent-run initiative only helps to provide as many family voices into the system as possible for better outcomes for all children, youth and their families. The state has greatly benefited from family involvement in programs and hopes to expand efforts so that more programs have family support to better address the needs of families with CSHCN.

F. Health Systems Capacity Indicators

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 - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 17.2 | 14.3 | 17.5 | 18.3 | 18.3 |
| Numerator | 461 | 389 | 460 | 473 | 473 |
| Denominator | 268059 | 272653 | 262121 | 257848 | 257848 |
| 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 - 2013

N: Utah Inpatient Hospital Discharge Data, Office of Health Care Statistics, Utah Department of Health.

D: Utah Population Estimates Committee (UPEC) and the Governor's Office of Planning and Budget (GOPB) for years 1980-1999. For years 2000 and later the population estimates are provided by the National Center for Health Statistics (NCHS) through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2012.

Notes - 2012

Numerator: Hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2011

Data reported are the most recent data available.

Numerator: Hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9, 2011
Denominator: IBIS Population Estimates 2011

Narrative:

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

The Asthma Program, through CDC funding, has conducted several activities to help children under five manage asthma. During the past five years, child care providers have been trained to encourage asthma-friendly child care environments and to teach care givers to recognize and manage asthma symptoms. In 2012, a Telehealth session was held addressing ways to improve provider-patient communication and self-management among pediatric asthma patients. 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 developed asthma educational materials based on the results. Materials were distributed through various partners including the Baby Your Baby Program and are available on the Utah Asthma Program website. The Asthma Program funded 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 train staff parents at monthly meetings.

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

The Asthma Program develops strategies according to its Utah Asthma Plan, which was updated for 2012-2016. The State Plan is written to address several aspects of Utah's communities

including schools, health systems, environment, and others. The Asthma Program added numerous resources for health care providers and the public to its website. These include a health care provider manual addressing guidelines to manage pediatric and adult asthma as well as a guide to asthma medications. The Asthma Program has held over ten quarterly Telehealth sessions to educate health care providers across the state on various asthma-related health issues. The Green and Healthy Homes Initiative was established in Salt Lake City in 2012. This program will help reduce asthma triggers in homes and provide education on how to manage and prevent asthma symptoms. 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.

c. Interpretation of what the data indicate:

In 2012, the asthma hospitalization rate for children less than five years of age was 18.3 hospitalizations per 10,000 population which is beneath the Healthy People 2020 Goal of 18.1 per 10,000, and well below the baseline of 41.4 in 2007. These data indicate that interventions and asthma education around the state may have had a positive impact. However, the rate of change over the last 5 years in Utah has not been statistically different. This suggests a need for a stronger focus on educating care-takers about asthma symptoms and management in children under 5.

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 02 - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 83.0 | 83.9 | 89.0 | 88.4 | 88.6 |
| Numerator | 18803 | 18803 | 15475 | 14719 | 14637 |
| Denominator | 22647 | 22404 | 17393 | 16644 | 16515 |
| 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 - 2013

Numerator: CMS 416 for FFY 2013: total eligibles receiving at least one initial or periodic screen (line 9)

Denominator: CMS 416 for FFY 2013: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.88 (line 10)

Notes - 2012

The calculation for this measure has been revised since 2010. Data are not comparable with previous years.

Numerator: CMS 416 for FFY 2012: total eligibles receiving at least one initial or periodic screen (line 9)

Denominator: CMS 416 for FFY 2012: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.88 (line 10)

Notes - 2011

The calculation for this measure has been revised since 2010. Data are not comparable with previous years.

Numerator: CMS 416 for FFY 2011: total eligibles receiving at least one initial or periodic screen (line 9)

Denominator: CMS 416 for FFY 2011: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.89 (line 10)

Narrative:

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

This indicator has improved which is a positive move in getting more infants care than in previous years. Because the SCHIP program is open continuously and applicants apply for SCHIP and Medicaid at the same time, more children are likely to be enrolled in Medicaid than in the past. However, the indicator really doesn't measure the extent to which Medicaid children are getting regular periodic screenings during the first year of life. A better indicator would be children's screen visits versus the recommended number of visits for the first year.

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

Medicaid contracts with each local health department for CHEC (Utah's EPSDT) outreach to assist families in accessing insurance coverage and health care services.

The local health departments also provide targeted case management services for Medicaid children under age 5, which include education about the importance of the well child visits, especially for children under one year, and referrals to needed health care services when appropriate. A barrier to access to care is the fact that the Medicaid reimbursement rate for health care providers is low and thus, fewer providers are willing to accept low reimbursement rates. 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 remained steady from 88.9% in 2011 to 88.6% in 2013. The steady rate may be indicative of efforts to improve access to care for infants on Medicaid through outreach workers assisting families as well as targeted case management services which assist families in accessing needed health care.

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 03 - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 97.6 | 97.1 | 97.8 | 97.8 | 97.5 |
| Numerator | 283 | 299 | 175 | 175 | 195 |
| Denominator | 290 | 308 | 179 | 179 | 200 |

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------|-------|
| 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 - 2013

Numerator: HEDIS measure "Well Child Visits in First 15 Months" HCS 2013
Denominator: HEDIS number of children under one in CHIP, HCS 2013

Notes - 2012

Numerator: HEDIS measure "Well Child Visits in First 15 Months" HCS 2012
Denominator: HEDIS number of children under one in CHIP, HCS 2012

Notes - 2011

Data reported are the most recent data available.
Numerator: HEDIS measure "Well Child Visits in First 15 Months" 2011
Denominator: HEDIS number of children under one in CHIP, 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCI?
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 HSCI?
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 its 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 2013, 97.5% received a service. The increases may be due to better reporting of information.

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 04 - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 82.8 | 84.5 | 84.9 | 84.7 | 84.7 |
| Numerator | 41794 | 41430 | 41269 | 41740 | 41740 |
| Denominator | 50475 | 49010 | 48596 | 49263 | 49263 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2012

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2011

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCI?
Eligibility for Utah Prenatal Medicaid is at the lowest allowable income level. Utah women's income must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. In addition, Utah is one of only six states that require an asset test to qualify for Medicaid. Because of these policies, many working poor women who may be eligible in other states across the country are not eligible in Utah and have 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 this small amount of funding is inadequate to cover the need.

With changes required by the Affordable Care Act in 2014, the income level to qualify for prenatal Medicaid was raised to 138% and the asset test for pregnant women was eliminated. In addition, prenatal care should now be offered without cost sharing for women with private insurance. We hope that these changes will have a positive impact on prenatal care rates in the future.

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

We continue to promote safety net providers that cover uninsured women. The UtahClicks online enrollment application system provides easy access for pregnant women to begin their Presumptive Eligibility process to enroll in prenatal Medicaid. MCH staff holds quarterly coordination meetings with the Medicaid staff involved in oversight of the Baby Your Baby enrollment. The Baby Your Baby media campaign was resumed after a hiatus for contract reasons. Ads educating women on financial help for prenatal care through Baby Your Baby aired on radio and television.

c. Interpretation of what the data indicate:

In 2012, 84.7% of Utah women ages 15-44 delivering a live infant received adequate prenatal care based on the Kotelchuck Index. Among Hispanic women, 75.6% received adequate prenatal care compared to 86.5% 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 immigration status or other criteria. 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 lower rate 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 are younger, less educated, and unmarried.

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 07A - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 86.6 | 84.6 | 69.1 | 56.9 | 56.3 |
| Numerator | 142476 | 166381 | 94830 | 93354 | 93894 |
| Denominator | 164602 | 196665 | 137236 | 163947 | 166639 |
| 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 - 2013

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2013 data (ages 0 - 20) (line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2013 data (ages 0 - 20) (line 8)

Participation ratio .56 (line 10)

Notes - 2012

The calculation for this measure has been revised since 2010. The data are not comparable with previous years.

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2012 data (ages 0 - 20) (line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2012 data (ages 0 - 20) (line 8)

Participation ratio .57 (line 10)

* The rate now includes data for infants and 19 - 20 year olds.

Notes - 2011

The calculation for this measure has been revised since 2010. The data are not comparable with previous years.

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2011 data (ages 0 - 20) (line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2011 data (ages 0 - 20) (line 8)

Participation ratio .69 (line 10)

* The rate now includes data for infants and 19 - 20 year olds.

Narrative:

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

This indicator has shown a decline from 69.1% in 2011 to 56.3% in 2013. We need to increase our efforts to ensure that Utah children enrolled in Medicaid are receiving needed health care services.

[Data note: Since 2010 the calculation for this measure has been revised for more accurate reporting. The rate now includes children from birth to 20 years. Utah in the past has reported for ages 1-18.]

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

This is an area for Medicaid and the Department of Workforce Services (they do Medicaid enrollment) to address with our support. We will meet with Medicaid to illustrate the decline in accessing services and work with them to develop better strategies to improve in this area.

c. Interpretation of what the data indicate:

It appears from the data that fewer children enrolled in Medicaid are receiving services. Perhaps efforts in targeted case management are not as effective, although those services are only available up to age 5. We will look at the age groups that are not receiving services to identify particular ages when children aren't receiving services.

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 07B - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 52.6 | 54.3 | 54.8 | 57.0 | 58.1 |
| Numerator | 18550 | 21772 | 24516 | 26694 | 28056 |
| Denominator | 35280 | 40125 | 44736 | 46861 | 48316 |
| 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 - 2013

Numerator: Medicaid CMS 416, FFY2013
Denominator: Medicaid CMS 416, FFY2013

Notes - 2012

Numerator: Medicaid CMS 416, FFY2012
Denominator: Medicaid CMS 416, FFY2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Medicaid CMS 416, FFY2011

Denominator: Medicaid CMS 416, FFY2011

Narrative:

a.

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 (UOHC) in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits for children.

b.

The OHP collaborated with staff in the Utah Department of Health (UDOH) Division of Medicaid and Health Financing to expand the Child Health Evaluation and Care program (CHEC), Utah's EPSDT outreach program. 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, Medicaid 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 (UDA) to encourage dentists to see Medicaid eligible children to improve the percent receiving early and regular dental care. The Dental Director meets when possible with members of local UDA dental districts around the state to promote increased access for children to dental services.

The OHP has worked with the UOHC and Dental Select in the refinement and expansion of the Sealant for Smiles program. Elementary School students from Salt Lake, Davis and Tooele counties free and reduced lunch rate schools are provided dental education, screened for dental disease and have fluoride varnish and dental sealants placed. Care is coordinated for those students who have dental needs. Children from Utah County Title I School programs also receive fluoride varnish.

The OHP has collaborated with the UOHC and the Salt Lake County 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.

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 08 - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 18.7 | 15.8 | 8.8 | 9.6 | 9.6 |
| Numerator | 846 | 743 | 427 | 482 | 482 |
| Denominator | 4522 | 4709 | 4845 | 5019 | 5019 |
| 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 - 2013

Numerator: CSHCN DDS Log and MegaWest data, 2012

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2012

Data reported are the most recent data available

Notes - 2012

Numerator: CSHCN DDS Log and MegaWest data, 2012

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2012

Notes - 2011

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, 2011

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2011

Reason for the decrease in percent (15.8% to 8.8%) is due to seeing fewer and fewer children due to budget cuts.

Narrative:

a.

Sufficient information about possible SSI eligibility may be lacking since it is a case by case non-mandatory sending of information thus limiting application for eligibility and receipt of services. Data from Disability Determination Services (DDS) to CSHCN is processed by two people for completeness and will process the information faster. Client information is now sent to Electronic Records Express which holds, and notifies us when new data is available. We have been able to access the Social Security information that DDS sends to us much quicker than in the past, through a secure web system.

b.

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 DDS. As a member of the DDS Advisory Council, the Specialist offers consultation on 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, CSHCN services, 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 English/Spanish speaking families. These families are referred to resources like The Utah Parent Center, Utah Legal Services, Disability Law Center or other consulting staff or agencies when needed.

CSHCN also employs transition specialists who provide information, consultation, and support to 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 our clinic about their SSI eligibility. It is then recorded in electronic charting system. Our SSI specialists keep the DDS log updated from the information DDS sends electronically. An informational letter is sent in a timely manner to inform families they may be eligible for Disability Medicaid and they need to apply, being that, it is not an automatic process. Families call due to the letter and seek more information/counsel with SSI and Medicaid.

c. CSHCN has changed to an electronic charting system/database. We are in the process of training staff to gather statistical information every time a family is checked-in. We may be able to receive all of our data from this CaduRx system in the future.

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) | 2012 | matching data files | 8.3 | 6.2 | 6.9 |

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCI?
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 babies. These risk factors include lower levels of education, low socio-economic status, being unmarried, using tobacco before and during pregnancy, and being of a racial or ethnic minority group. 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 HSCI?
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 the 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 elective inductions, previous preterm birth, substance use, etc. 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 worse than their non-Medicaid counterparts. The percentage of low birth weight births among Medicaid women was 8.3% in 2012 compared to 6.2% in women not enrolled in Medicaid. These numbers reflect little change from previous years. 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, unmarried, have less than a high school education, be of a racial or ethnic minority group, 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 | 2011 | matching data files | 5.8 | 5.1 | 5.3 |

Narrative:

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

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 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 discussions being implemented, as possible, to prevent future infant deaths.

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

The MCH Bureau continues work with a consortium of ten facilities in the state that self-designate as Level III NICUs. The purpose of this consortium is to build consensus on how facilities designate themselves for level of neonatal care with the goal of improving outcomes for VLBW. The consortium is also working towards the goal of sharing clinical data on these vulnerable infants.

In October 2013, the UDOH partnered with the March of Dimes to hold the second Utah Prematurity Symposium. The 2013 symposium focused on the importance of preconception health to prevent preterm birth.

The Utah Chapter of the March of Dimes, the Utah Department of Health, the University of Utah Health Sciences Center, and Intermountain Healthcare has collaborated to form the Utah Women and Newborns Quality Collaborative (UWNQC) to improve perinatal and neonatal service quality in Utah. The UWNQC is a statewide, multi-stakeholder network dedicated to improving perinatal outcomes in Utah. The first three projects will include; increasing appropriate use of 17P to reduce preterm birth, appropriate evidence based treatment of neonatal abstinence syndrome, and improving the safety of out of hospital births.

c. Interpretation of what the data indicate:

The rate of infant mortality for the nation as a whole was 6.0 infant deaths per 1,000 live births (2011). Utah compares favorably with a rate of 4.6 infant deaths per 1,000 live births (2012), one of the lowest infant mortality rates in the country. Utah's infant mortality rate fluctuates yearly, but remains within a range of 4.8-5.3/1,000. Women enrolled in Medicaid have a higher rate of infant mortality (5.4/1000 live births, 2012) than women who were not enrolled in Medicaid (4.1/1000). 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, unmarried, have less than a high school education, or be of a racial or ethnic minority group. They are also more likely to deliver a premature infant, which is one of the leading causes of infant mortality in Utah.

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 | 2012 | matching data files | 65.9 | 80.4 | 75.5 |

Narrative:

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

Eligibility for Utah Prenatal Medicaid is at the lowest allowable income level. Utah women's income must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Utah is one of only six states that require an asset test to qualify for Medicaid. Because of these policies, many working poor women who may be eligible in other states across the country are reduced to self-pay for prenatal care affecting entry into prenatal care. We note a growing population of women who are not eligible for Prenatal Medicaid due to lack of eligibility or issues with citizenship status, which interferes with early prenatal care. Utah's Baby Your Baby program provides presumptive eligibility for up to 60 days while women apply for Medicaid.

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

The Maternal and Infant Health Program maintains a web-based application system for presumptive eligibility for prenatal Medicaid, called UtahClicks. We continue to work with Medicaid to improve processes for pregnant women to enroll in the program and begin prenatal care before the end of the first trimester.

With implementation of the Affordable Care Act in 2014, the qualifying poverty level for Medicaid will be slightly higher and the asset test will no longer be required for eligibility. Not having the asset test will hopefully increase application processing time. In addition, pregnancy tests will no longer be required to apply for Baby Your Baby. The Maternal and Infant Health Program will work with Medicaid to educate pregnant women on changes occurring to eligibility requirements.

c. Interpretation of what the data indicate:

The overall entry into first trimester prenatal care for Utah pregnant women was 75.5%. There is a large disparity between rates for women on Medicaid (65.9%) and women not enrolled in Medicaid (80.4%). Utah falls short of the Healthy People 2020 goal for 77.9% 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 program, 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]) | 2012 | matching data files | 77 | 88.6 | 84.7 |

Narrative:

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

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. Utah is one of only six states that require an asset test to qualify for 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 HSCI?

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 engage safety net providers who will cover uninsured women and encourage them to receive early and adequate prenatal care services. The Utah Clicks online enrollment application system provides easy access for pregnant women to begin their presumptive eligibility process to enroll in prenatal Medicaid. In FY13, the Maternal and Infant Health Program returned oversight of presumptive eligibility to Medicaid. MCH staff work with Medicaid to improve processes for presumptive eligibility. The Baby Your Baby media campaign educates women about the availability of presumptive eligibility.

c. Interpretation of what the data indicate:

Women enrolled in prenatal Medicaid (77.0%) are significantly less likely than non-Medicaid (88.6%) 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 entry into prenatal care accounts for the majority of inadequate prenatal care.

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) | 2013 | 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) | 2013 | 200 |

Narrative:

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

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.

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

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 reaching 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 19) (Age range to) | 2013 | 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) | 2013 | 200 |

Narrative:

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

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.

Few years ago, the 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 HSCI?

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 reaching 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 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 | 2013 | 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 - 2015

Pregnant women usually are not covered under UT CHIP unless they are <18 years old

Narrative:

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

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. In 2014, the asset test was eliminated due to requirements of the Affordable Care Act. These requirements also raised the qualifying poverty level for prenatal Medicaid from 133% to 138%.

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

The Department works with its partners, community-based organizations and advocates reaching out to individuals who may be eligible for prenatal Medicaid. The Division of Health Care Financing assumed administration of the Baby Your Baby Presumptive Eligibility (PE) Program. With this, Medicaid staff are able to work on system improvements to enrollment in the program and works to ensure access for potentially eligible women to apply for PE while waiting for determination of their Medicaid eligibility. The MCH Bureau continues to support the UtahClicks online application system; making access to PE easier and more convenient.

c. Interpretation of what the data indicate:

This HSCI has been constant since the Medicaid prenatal program was first implemented. Throughout 2013, Medicaid had 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.

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 | 2 | Yes |
| 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 |
| | 3 | Yes |

| | | |
|----------------------------------------------------------------|--|--|
| Survey of recent mothers at least every two years (like PRAMS) | | |
|----------------------------------------------------------------|--|--|

Notes - 2015

Narrative:

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

We are very fortunate to have strong data linkages with vital records, PRAMS, and Medicaid. Birth and Medicaid eligibility data have been linked every year to report birth outcomes for women on Medicaid. In the last two years, we have been successfully merging infant birth certificate and death certificate data with Neonatal Follow-Up Program (NFP) data to conduct the "Preemie Facts Survey" as well as to analyze the data. We plan to link WIC data with birth data now that we have a new WIC information system.

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

Linkages in general have improved in the past few years, as well as surveillance efforts. The Department conducts an annual Health Status Survey/BRFSS 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 on a regular basis.

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 |
| SAMHSA Prevention Needs Assessment (SHARP/PNA) | 3 | Yes |

Notes - 2015

Narrative:

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

Utah uses the Youth Risk Behavior Survey (YRBS) to monitor trends in youth tobacco use. In 2003, the YRBS was integrated into Utah's SHARP project, a larger biennial school survey that includes Utah's substance abuse survey overseen by the Division of Substance Abuse and Mental Health in Human Services. The Department of Health received a CDC grant to conduct the 2009, 2011, and 2013 YRBS because the funding requirements were changed to allow health departments to apply. Weighted Utah YRBS results (1999-2013, odd years) 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 HSCI?

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 Utah 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, minimize the survey burden on schools, and to achieve adequate participation rates despite Utah's active parental consent requirement.

c. Interpretation of what the data indicate:

Utah continues to have low rates of tobacco use among high school students. The rate of current tobacco use was 5.6% in 2013. The cigarette smoking rate reached its lowest recorded level at 4.4%. Any tobacco uses as well as cigarette smoking have declined significantly since 1999 when the rates were 14.5% and 11.9% respectively.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The initial planning process for the FY2011 - 2015 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.

/2013/ For the 2011 reporting year, we accomplished 14 of the 18 National Performance Measures, and 4 of the 10 State Performance Measures. The National Performance Measures

that we did not meet include: NPM 3, 4, 5 which relate to coordinated care for CSHCN in a medical home, adequate insurance and community-based services. The fourth measure we did not meet was related to adequate immunizations for young children. The CSHCN Performance Measures that we did not accomplish may be related to, in part, to our ability to provide as many services as we have in the past due to significant budget cuts. The Immunization Performance Measure has been an ongoing challenge to meet.

The State Performance Measures that we did not meet include: multivitamin use prior to pregnancy, reduction in proportion of primary C/Sections among low risk women, depression in youth, dental service utilization for children ages 1 - 5, routine developmental screenings, and proportion of CSHCN in rural areas receiving direct clinical services. Obviously we need to continue our efforts to promote the importance of multivitamin use, routine developmental screenings and dental care for young children, as well as a reduction in C/Sections, addressing depression among our youth. The decrease in the proportion of CSHCN in rural areas receiving services from our programs is directly related to funding cuts that occurred due to a cut in clinics and clinical services to the rural areas. Unless we are able to regain the state general funds lost in the previous years, our ability to address the great needs in the rural areas for CSHCN will continue to be a challenge.

We will continue to address the measures that we have been successful in achieving, but will put forth more efforts for the measures that are not progressing as we would like. //2013//

/2014/ For the 2012 reporting year, we accomplished 15 of 18 National Performance Measures and 8 of the 10 State Performance Measures. The National Performance Measures that we did not meet include: deaths of children <14 due to MVC, children without insurance, and pregnant women smoking in the last trimester of pregnancy. MVC deaths for children under 14 years of age increased this past year which will be addressed by the Violence and Injury Prevention Program through its strategies to reduce these deaths. Children without insurance as reported in this application is reported based on Department data sources which is much lower than the percentage reported in national surveys. The explanation for this may be due to different ways of evaluating the measure, such as no insurance in the past 30 days, no insurance at any time this past year, etc. Of concern is the increasing proportion of children without insurance. Factors influencing insurance access are discussed in the State Overview section under Medicaid and CHIP. MCH staff have discussed the rising uninsured children rate with Medicaid and they are in the process of developing strategies to better facilitate children's access to Medicaid and CHIP. The eligibility process is the responsibility of another state agency which makes it difficult to impact agency practices. rising and Utah has established policies that restrict eligibility more than in other states. Smoking during the last trimester of pregnancy did not decline as projected by 0.1% of objective. We will continue to work with colleagues in the Tobacco program to address this issue.

The State Performance Measure that we did not meet include: developmental screening and CSHCN in rural communities receiving CSHCN services. The developmental screening measure was categorized as not met because we were only able to establish a baseline for this measure for this year's application. The disappointing reach to CSHCN in rural communities is due to the large cuts in state funding for these clinics. The Department submitted a request for additional ongoing funding to the Legislature, but it was not approved. We plan to resubmit the request for the 2014 Governor's budget. //2014//

/2015/ For the 2013 reporting year, we accomplished 12 National Performance Measures. The Measures that we did not accomplish include: breastfeeding, hearing screening, children without insurance, children with BMI >85th percentile, smoking during pregnancy and youth suicide. We achieved 8 of the State Performance Measures. The two that we did not achieve include reduction in primary C/Sections and increasing the proportion of

CSHCN eligible for SSI and Medicaid Disability coverage. Given that the Governor and State Legislature are still negotiating the state Medicaid expansion, we do not expect to see improvement in the proportion of uninsured children. We will continue to work on the Performance Measures that we did not accomplish to improve these this next year. //2015//

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.

/2013/ The Utah Department of Health has identified "Healthy Utah Babies" as a priority to include in its strategic plan. The staff working on "Healthy Births" plans to initiate an effort to be called "Healthy Utah Babies" (HUB) that will cover preconception through pregnancy, postpartum and interconception for women and cover infancy to young childhood to age 5 years. We viewed this priority of the Department as an opportunity to enhance work already being done in MCH/CSHCN programs and to provide the impetus to expand our efforts to promote the importance of key periods of life course for women of child bearing ages and key periods of life course for infants through early childhood.

The Department signed on to the ASTHO/MOD commitment to reduce prematurity by 8% by 2014, another effort that will contribute to the work on HUB. We are working with the March of Dimes on their efforts to reduce prematurity. We see this as an opportunity to address areas of great concern with multiple partners at the table working towards the same goal. The March of Dimes is sponsoring a Prematurity Summit in November 2012 in which the Department will play a key role. From this Summit will come an action plan in which public health will have a key role.

These efforts address the three priorities for mothers and infants and several of the priorities for children. The Department's Strategic Plan for healthy births affords us the opportunity to work with staff from all areas within the Department, especially the chronic disease programs. Through this work, we will bring forth the importance of a life course perspective as it relates to an number of different areas that really need to be addressed through a life course perspective if we are to have an impact on the health outcomes.

Other areas that we are working on include: 1) promoting awareness of risk of recurrent preterm birth and promotion of possible interventions to reduce risk; 2) addressing factors that may contribute to poor pregnancy outcomes, such as weight before pregnancy and after, healthy weight gain during pregnancy, 3) developing criteria for NICU Levels of Care and developing a rule for hospital reporting; and 4) developing a report on prematurity in Utah.

For future work, we plan to address the following issues related to healthy births: Chronic Disease in Women, Obesity, Smoking and Substance Abuse, Mental Health, Family Violence, Infertility, Multiple Births, Hearing Loss, Metabolic Disorders, Oral Health, Health Disparities, Health Insurance, Preconception Health and Medical Home in no particular order. //2013//

/2014/ We currently are working on a number of strategies to address Healthy Utah Babies (HUB) as part of the Department's strategic plan. The workgroup has divided into several sub-committees: Preconception with a focus on health before pregnancy and between pregnancies, Infants with a focus on promotion of breast feeding and young children with a focus on early childhood developmental screening.

The Breastfeeding workgroup has developed a survey of all birthing facilities to gather information on the status of efforts to move toward meeting the 10 steps that are recommended to be classified as a Baby Friendly Hospital. Almost all birthing hospitals responded. The responses were encouraging in that 4 hospitals indicated that they are in the process of becoming Baby Friendly. Many responders indicated they would like to be involved in a collaborative effort with UDOH to help more facilities move in this direction.

Early Childhood Developmental Screening has entailed a survey of pediatricians and other providers on their practice of developmental screening, including tools used, is it done routinely, etc. Preliminary review of responses indicates that most pediatricians use a formal tool to screen for developmental delays and most also were aware of the AAP recommendations on developmental screening. //2014//

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 423 | 417 | 322 | 302 | 302 |
| Denominator | 423 | 417 | 322 | 302 | 302 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes - 2013

Utah Newborn Screening Program Database 2012 Data

Notes - 2012

Utah Newborn Screening Program Database 2012 Data

Notes - 2011

Data reported are the most recent data available.

Utah Newborn Screening Program Database 2011 Data

a. Last Year's Accomplishments

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

The Utah Newborn Screening Program (NSP) continued surveillance and identification of children with 37 different disorders including: congenital hypothyroidism, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders, fatty acid disorders, hemoglobinopathies and cystic fibrosis. NSP collaborated with the University of Utah (U of U) Metabolic Clinic, ARUP Laboratories, Ambry Genetics and the Utah Department of Health State Laboratory (UDOH Lab) to provide testing for disorders and follow up.

All newborns requiring 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 was adopted by a family out of state, every attempt was made to locate the family and medical home as well as to notify 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.

Newborn screening education was provided to hospitals, medical homes, other medical

providers, families and the general public. Additionally, the Bureau of Children with Special Health Care Needs (CSHCN) continued to provide financial assistance for medical food for individuals with PKU.

The Genetic Advisory Committee Newborn Screening subcommittee met on a quarterly basis to provide input on the addition of Severe Combined Immunodeficiency (SCID) to Utah's newborn screening panel and Critical Congenital Heart Disease (CCHD) screening. NSP and the Utah Birth Defects Network (UBDN) were awarded a grant to evaluate Critical Congenital Heart Disease (CCHD) pulse oximetry screening at high altitude and develop a statewide implementation plan as part of newborn screening.

NSP is working with the UDOH State Laboratory with a Laboratory Information Management Software upgrade. In addition to institutions of birth, newborn screening kits are sold to direct entry midwives.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Abnormal screening results, if appropriate, were reported to the newborn's medical home. | X | | | |
| 2. All newborns referred for confirmatory testing were referred to a sub-specialist, as needed, and tracked to final outcome (normal or disorder identified). | X | | | |
| 3. The addition of Severe Combined Immunodeficiency disorders to Utah's newborn screening panel was recommended. | | | X | |
| 4. Grant application was funded to evaluate pulse oximetry screening for Critical Congenital Heart Disease at elevation. | | | | X |
| 5. Education was provided to hospitals, medical homes, other health care providers, families and the general public. | | | | X |
| 6. Financial assistance for medical food was provided to families and individuals with PKU. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Newborn Screening Program (NSP) continues surveillance and identification of children with congenital hypothyroidism, galactosemia, hemoglobinopathy, biotinidase deficiency, congenital adrenal hyperplasia, cystic fibrosis, amino acid disorders and acylcarnitine disorders. As of July 1, 2013 NSP initiated identification and surveillance of children with SCID. Care coordination and data tracking are ongoing. Collaboration continues with the U of U Metabolic Clinic, U of U Pediatric Immunology Clinic, ARUP Laboratories, Ambry Genetics and the UDOH State Lab to provide testing for disorders and follow up.

The Newborn Screening Advisory subcommittee continues to meet on a quarterly basis and has recommended that the Genetics Advisory Committee be dissolved and the subcommittee moves to the primary advisory committee.

NSP and the Birth Defects Network (BDN) pilot project to evaluate the efficacy of Critical Congenital Heart disease pulse oximetry screening as part of newborn screening is ongoing. NSP is working with BDN and the U of U Pediatric Cardiology group to implement statewide CCHD screening.

Monthly quality assurance report cards are sent to hospitals. NSP continues involvement with the cHIE data integration project. NSP is working with the BDN on its National Birth Defects Prevention Study project. Newborn hearing and NSP are collaborating to provide education and assistance with other UDOH programs such as the Fostering Healthy Children and Neonatal Follow-up programs.

c. Plan for the Coming Year

Newborn Screening Program (NSP) will continue surveillance and identification of children with congenital hypothyroidism, galactosemia, hemoglobinopathy, biotinidase deficiency, congenital adrenal hyperplasia, cystic fibrosis, amino acid disorders, acylcarnitine disorders and SCID. Care coordination and data tracking will be ongoing. Collaboration will continue with the U of U Metabolic Clinic, U of U Pediatric Immunology Clinic, U of U Pediatric Cardiology Clinic, ARUP Laboratories and the UDOH State Laboratory to provide testing for disorders and follow-up.

The NSP will coordinate and participate in Newborn Screening Advisory Committee quarterly meetings. The NSP will request a kit fee increase to offset costs of implementing the CCHD screening.

NSP plans to utilize CSHCN's updated telehealth capacity to increase access to heelstick training for birth hospital staff and medical homes throughout Utah with an emphasis on rural areas. NSP will continue to work with the UDOH State Laboratory with a Laboratory Information Management Software upgrade.

The QA Report Card for hospitals will continue with an emphasis on decreasing unsatisfactory specimens, completing data on cards and improving timeliness of specimen receipt at the laboratory.

The NSP will assist with educating providers on accessing newborn screening results through the cHIE/CHARM website.

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 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 U of U 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 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: | 52727 | | | |
| Reporting Year: | 2012 | | | |
| Type of Screening | (A) | (B) | (C) | (D) |

| Tests: | Receiving at least one Screen (1) | | No. of Presumptive Positive Screens | No. Confirmed Cases (2) | Needing Treatment that Received Treatment (3) | |
|----------------------------------------------|-----------------------------------|------|-------------------------------------|-------------------------|-----------------------------------------------|-------|
| | No. | % | | | No. | No. |
| Phenylketonuria (Classical) | 50873 | 96.5 | 4 | 2 | 2 | 100.0 |
| Congenital Hypothyroidism (Classical) | 50873 | 96.5 | 23 | 14 | 14 | 100.0 |
| Galactosemia (Classical) | 50873 | 96.5 | 2 | 0 | 0 | |
| Sickle Cell Disease | 50873 | 96.5 | 256 | 0 | 0 | |
| Congenital Adrenal Hyperplasia | 50873 | 96.5 | 8 | 7 | 7 | 100.0 |
| Cystic Fibrosis | 50873 | 96.5 | 24 | 15 | 15 | 100.0 |
| Biotinidase | 50873 | 96.5 | 1 | 1 | 1 | 100.0 |
| Amino Acid Disorders** | 50873 | 96.5 | 19 | 5 | 5 | 100.0 |
| Galactosemia (non-classical) | 50873 | 96.5 | 2 | 0 | 0 | |
| Hemoglobinopathies (non-sickle cell disease) | 50873 | 96.5 | 256 | 225 | 225 | 100.0 |
| Hearing Screening*** | 51880 | 98.4 | 696 | 100 | 70 | 70.0 |
| Acylcarnitine Disorder* | 50873 | 96.5 | 39 | 13 | 13 | 100.0 |
| Diet Monitoring, 0-18y (Ref 1) | 672 | | 82 | 82 | 82 | 100.0 |
| Diet Monitoring Pregnant Women (Ref 2) | 46 | | 3 | 3 | 3 | 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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 55.1 | 55.1 | 55.1 | 71.5 | 71.5 |
| Annual Indicator | 55.1 | 55.1 | 71.5 | 71.5 | 71.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 71.5 | 71.5 | 71.5 | 71.5 | 72 |

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 71.5% and the indicator was 71.5%.

Due to the number of families that contact the Family to Family Health Information Center, the Utah Parent Center and other disability and advocacy organizations about information on navigating the system and how to find all the information that would be beneficial to their children and families. A caregiver educational series was implemented for families of children with special health care needs that had been adapted from a curriculum developed for families of children

diagnosed with an Autism Spectrum Disorder (ASD). The ABCs of Special Needs covers: Resiliency, Being a Wise Consumer, Funding Special Needs, Sensory, Communication, Behavior, and Finding Community Resources.

The Utah Parent Center (UPC) provided autism information through a toll-free phone line and up-to-date resources and a fact sheet for families of children with an ASD. The CSHCN Bureau provides a small contract to help the UPC respond to families especially as Utah has been shown to have the highest prevalence of ASD in the nation. Parents and family members contacted the UPC with many concerns and fears to get additional information. The UPC provided credible resources, information and referral to both families and professionals.

As the Affordable Care Act (ACA) was being anticipated and rolled out, the UFV staff was trained through the same modules as the Navigators and the Certified Application Assistors to help families that contacted the Bureau of CSHCN, the UPC or Utah Family Voices (UFV) with information that pertained to those with special health care needs and disabilities. Information about the provisions of the ACA and helpful resources were added to the workshops and presentations provided throughout the state.

Early childhood and intervention programs are vital to the community and especially to families of children with special health care needs. Parents of special health care needs children serve on the Early Childhood (ECU,) Utah State Advisory Committee and the Part C Early Intervention Interagency Coordination Council (ICC). Collaboration with Help Me Grow and the Medical Home Portal staff and resources helps to get families connected earlier and in a timely manner to assist in early intervening for better outcomes of children at risk or diagnosed with any delay.

The CSHCN Bureau continued to employ the UFV Director as a program manager for Family Involvement and Leadership, providing a model for family professionals at the state level. The program manager works with all of the other programs within the Bureau of CSHCN but also with programs in the Bureau of Child Development in providing technical assistance regarding family-centered programs and initiatives. She also works with other agencies, organizations and groups to facilitate community partnerships and shared goals for children and youth with special health care needs and their families.

Collaborative initiatives continued to include the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND), the Utah Pediatric Partnership to Improve Children's Healthcare Quality (UPIQ) and the Children's Health Improvement Collaborative (CHIC). This effort encompassed medical home demonstration activities as well as expansion of the Medical Home Portal, a comprehensive website that provides information for families and professionals on services, resources, referral and diagnosis information from credible sources that have been vetted by parents, consumers and healthcare providers. Parent Partners continued to be a vital part of all the projects to provide the expertise and experience of the key stakeholders. Compensation for family involvement continued to be a top priority.

The UFV Director was selected for the Woman of Distinction Award from the local chapter of the National Assistance League. The award was in honor of the passion, work and volunteerism shown for families of children with special health care needs. A luncheon was held to help kickoff a philanthropic fundraiser that supported two specific projects, Baby Bundles to help indigent new moms and Assault Survivor Kits for woman who have endured domestic abuse. Additional partnerships and resources for vulnerable populations were a positive outcome of the activity and event.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------|--|---|--|---|
| 1. ABCs of Special Needs trainings were developed and presented in the state. | | | | X |
| 2. The Autism hotline was maintained and resource lists were continually updated. | | X | | |
| 3. Training on the Affordable Care Act as it may apply to families of children with special health care needs was completed. | | X | | |
| 4. Partnerships with families and professionals continued to get families connected to early childhood programs in a timely manner. | | X | | |
| 5. Family involvement was enhanced and maintained through various projects. | | X | | |
| 6. New partnerships were developed to assist at-risk mothers and children. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The CSHCN UFV Director is participating in the MCH Public Health Leadership Institute through May 2014. The leadership project is in collaboration with URLEND trainees. The project is developing a data and informational tool kit related to the TEFRA option or related program. The tool kit will assist both families and policy-makers in making informed decisions that may potentially result in enhanced family satisfaction and ultimately better outcomes for children and youth with special health care needs.

The UFV staff continues to work with families of children with special health care needs to explain the changes in health care financing and insurance due to the Affordable Care Act (ACA). Families will be given information through various workshops and webinars as well as referred to the official Navigators in the state.

Funding from the CSHCN Bureau was secured for the F2F staff in providing peer support and resource navigation for families. An office space was secured and remodeled to provide a private setting for the Parent Consultants to work with individual families as they are seen in the CSHCN clinics. This accommodation has provided an opportunity for families to immediately access to peer-to-peer emotional support and resource navigation.

c. Plan for the Coming Year

Having the UFV staff, also known as Parent Consultants, on site three days a week during clinics has proved successful. The interaction with families and the referrals from health care providers has more than doubled since the office space was completed. Plans to extend the number of hours and days that Parent Consultants could be on site will be looked at, including increasing staff if funding allows. Collaborating with the University of Utah, Utah Medicaid and Intermountain Healthcare including Primary Children's Hospital will be explored for sustainability.

Further development of trainings for families of children and youth with special health care needs will be evaluated and implemented based on needs assessments gathered in various ways including the MCH 5 year needs assessment planning. The ACA and health care financing will continue to be the top priority and adapted as needed.

Additional avenues of family involvement will be explored including compensation for families that volunteer their time and expertise to Title V programs to offset any cost associated with

volunteering that they incur such as transportation and childcare. Due to limits within the current structure , grants and other funding mechanisms will be identified to sustain and enhance current efforts.

The CSHCN UFV Director will provide input on an ongoing basis to the Coordinating Council for Persons with Disabilities (CCPD). The Council is made up of the directors of agencies that serve children, youth, and adults with disabilities and their families. Additional partnerships will be revisited to help coordinate services with families in the lead. The family involvement and leadership program will work with the Title V agency and other agencies in creating a matrix mapping document to visualize some of the gaps in the system and work with partners in multiple organizations and different funding streams to maximize the limited resources and assist in resolving issues.

Data will be gathered from past and current projects that involved parents as partners in Medical Home initiatives to evaluate the lessons learned best practice models, barriers, and sustainability methods. A presentation will be developed to share with families, health care providers and policy-makers highlighting examples of family professional partnerships and the benefits to policies and programs in all areas of Maternal and Child Health and other health care settings.

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 Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 52.2 | 52.2 | 52.2 | 46.2 | 46.2 |
| Annual Indicator | 52.2 | 52.2 | 46.2 | 46.2 | 46.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 46.2 | 46.2 | 46.2 | 46.2 | 46.2 |

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The Performance Measure was achieved. The performance objective was 46.2% and the Annual Indicator was 46.2%.

The 2009/10 National Survey of Children with Special Health Care Needs indicated a 6% decrease in the percentage of children with special health care needs who receive care within a medical home from the previous survey in 2005/6. The Survey also indicated a 2% increase in children with special health care needs without insurance, 4% increase in children with special health care needs with inadequate insurance, and 7% increase in children with special health care needs without a usual source of care when sick (or who rely on the emergency room). It is possible that the economic downturn affecting Utah and the nation impacted the number of children with insurance thereby impacting access to a medical home. It is possible that NPM-3 will not see a significant increase until Utah has seen a significant, sustained economic recovery and access to insurance coverage improves.

The Medical Home Program and the Bureau of Children with Special Health Care Needs (CSHCN) utilized the CSHCN Executive Group (CEG) and its consultant group to gather feedback from stakeholders. The CEG included CSHCN administration and program managers and key consultants. The CEG consultants included representatives of selected community partners including the University of Utah Department of Pediatrics, Utah State University Center for Persons with Disabilities, Utah Family Voices, State Office of Education, Utah School Nurse Association, Utah Parent Center, and other partners.

In an effort to promote a coordinated services system, CSHCN partnered with various groups. CSHCN partnered with the Medical Home Portal staff at the University of Utah to provide quarterly Medical Home Corner articles for the Growing Times, the newsletter of the Utah Chapter of the American Academy of Pediatrics. The two groups also collaborated to provide quarterly "Your Medical Home" articles for the Medical Home Portal newsletter. The Medical Home Portal team continued to develop new content and add new resources to the website. They also continued negotiations to include other states' lists of community services.

In other efforts to improve the system of services, the Medical Home Program staff served on a variety of interagency committees including the Steering Committee of the Interagency Outreach Training Initiative (IOTI). The IOTI provided state-funded grants for training to increase capacity of organizations to serve people with disabilities and their families. Staff also participated on the Utah Oral Health Coalition, Utah Fetal Alcohol Coalition, Employment Partnership, and others.

Collaboration continued among 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. Medical students met with Utah Family Voices Staff to gain a perspective from families with CSHCN. URLEND trainees provided consultation to the medical practices involved in the CSHCN medical home trainings along with families of CSHCN.

The University of Utah's Pediatric Partnership to Improve Healthcare Quality (UPIQ) is involved with the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant to help improve medical homes and the quality of health care for children in Utah and Idaho. Efforts include supporting care coordinators, improving content and resources for families and providers on the Medical Home Portal website, and a variety of other activities. The Medical Home Program staff provides consultation to the Medical Home Portal team regarding potential and planned improvements to better serve CSHCN, their families, and their providers.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. CSHCN provided quarterly articles for the Utah Chapter of the American Academy of Pediatrics newsletter. | | | | X |
| 2. Medical Home Program staff developed Work Sheet newsletters for the Employment Partnership workgroup to support youth transitioning to adulthood. | | X | | |
| 3. Medical Home Program staff participated as a member of the Interagency Outreach Training Initiative to provide training grants to improve services for people with disabilities. | | | | X |
| 4. Families and professionals helped improve content on the Medical Home Portal website: www.medicalhomeportal.org | | X | | |
| 5. Medical Home Program staff partnered with Early Childhood Utah and the Mountain States Genetic Regional Collaborative to improve the system of services for children and youth with special needs. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Medical Home Program is involved with efforts to increase developmental screening and improve the system of services for young children. The Medical Home Program is collaborating with the Family Involvement and Leadership Program, Bureau of Child Development and staff from other programs to help providers expand the use of standardized screening tools and to help parents and providers understand the need for developmental screening.

The Medical Home Program is represented on committees and boards to improve the coordination of services and the provision of family-centered care. Staff serves on the Interagency Outreach Training Initiative Committee, Oral Health Coalition, and other interagency committees. The Medical Home Program staff serves on the Employment Partnership workgroup to develop the Work Sheet newsletters with highlights from the meetings for members and interested community organizations.

Outreach efforts include dissemination of medical home topic-oriented articles to pediatricians through the Utah Chapter of the American Academy of Pediatrics 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 Medical Home Portal staff is working with New Mexico to import services from their 211 Information Resource and Referral agency at the University of New Mexico to enable New Mexico families and providers access to their community resources.

c. Plan for the Coming Year

The Medical Home Program will provide in-office trainings 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 articles.

The Medical Home Program will partner with the Medical Home Portal team to develop quarterly articles for the Utah Chapter of the American Academy of Pediatrics newsletter. The Medical Home Portal team will develop content related to genetic and 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.

The Medical Home Program will provide "Learn the Signs. Act Early." campaign materials and support the website, Facebook and Twitter pages to help parents learn about healthy developmental milestones and areas of possible concern.

The Medical Home Program will participate on committees and boards to improve the coordination of services and family-centered care. Staff will serve on the Interagency Outreach Training Initiative Committee, the Employment Partnership workgroup, the Utah Fetal Alcohol Coalition, the Utah Oral Health Coalition, the Early Childhood Utah committee, the Mountain States Genetics Regional Collaborative Medical Home Workgroup, and other interagency committees. Collaborative efforts to support improved transition services in Medical Homes and to provide resources for young adults as they transition to adulthood will continue with the Medical Home Program and the Bureau of Children with Special Health Care Needs (CSHCN) Transition Specialist.

CSHCN will continue to seek input on activities and strategic plans from community partners. Key community partners include Utah State University, the University of Utah, Utah Family Voices, the Utah School Nurse Association, and other organizations serving families with CSHCN. The Medical Home Program will work with the new CSHCN Bureau Director regarding the importance of Medical Home, current activities, and future opportunities.

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.

CSHCN will continue its support of the University of Utah's Pediatric Partnership to Improve Healthcare Quality (UPIQ) on the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant to help improve medical homes and the quality of health care for children in Utah and Idaho. Efforts will include supporting care coordinators, improving content and resources for families and providers on the Medical Home Portal website, and a variety of other activities. The Medical Home Program staff will provide consultation to the Medical Home Portal team regarding potential and planned improvements to better serve CSHCN, their families, and their providers.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 59.5 | 59.5 | 59.5 | 55.9 | 55.9 |
| Annual Indicator | 59.5 | 59.5 | 55.9 | 55.9 | 55.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 55.9 | 55.9 | 55.9 | 56 | 56 |

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 55.9% and the Annual Indicator was 55.9%.

Financing health care services for children and youth with special health care needs continued to be dynamic with the implementation of the Affordable Care Act and the Health Insurance Exchange. Medicaid outreach efforts were conducted through CSHCN urban and rural clinics, health education activities and department and program web sites to identify children and families who may be eligible for funding of health services. Providing information to families was a major component of the outreach process and included providing eligibility and application information on Medicaid, SSI, the health insurance exchange, home and community based waiver programs, charitable organizations and other state and federal programs.

Care coordinators, family partners and clinical staff assisted families in working with their private insurances, Medicaid and Medicaid contracted Accountable Care Organizations to access needed health-related services. Other resources such as charitable organizations and foundations were contacted to assist families with needed items and services not available under traditional insurance or Medicaid. Utah's Family-to-Family Health Information Center worked one-on-one with families giving them the information and tools needed to tap into a variety of resources and programs to help meet their needs. CSHCN identified SSI-eligible children who were not yet enrolled in Medicaid and provided their families with information on how to apply. Primary Children's Medical Center continued its agreement to write-off service charges for children who qualify for CSHCN (up to 133% of poverty) services and do not have any other payer source.

CSHCN conducted 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 services. Case managers performed the day-to-day administrative activities for Medicaid's Technology Dependent Waiver Program and for the coordination of health services for children in the Fostering Healthy Children Program. The Division's medical director and physical therapist continued their participation on the EPSDT Expanded Services and Prior Authorization Committee for Medicaid reviewing documentation and providing recommendations on authorization of requested Medicaid services.

Three autism pilots programs, the Medicaid Autism Waiver, the Autism Treatment Account and the PEHP Autism Treatment Pilot, were implemented during FY13 and served a combined total of 375 children ages 2-6. The projects provided assessment and treatment services and an evaluation of outcomes. In each of the pilots, outcome results were positive and showed increases in positive behaviors and adaptive skills.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Outreach efforts were conducted statewide to identify children with autism spectrum disorders and their families that may be eligible for public funding of health services through one of the three pilot programs. | | X | | |
| 2. Information was provided to families including eligibility and application information on Medicaid, Social Security Income, the Health Insurance Exchange, charitable organizations and other state and federal programs. | | X | | |
| 3. Direct assistance was provided to families in working with their private insurances, Medicaid and Medicaid-contracted Accountable Care Organizations to access needed health-related services. | | X | | |
| 4. Medicaid administrative case management activities were provided to ensure children covered under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program received timely and appropriate access to needed health services. | | X | | |
| 5. The Medicaid Autism Waiver, Autism Treatment Account and the PEHP (Public Employee Health Plan) Autism Treatment Pilots were implemented and served 375 children ages 2-6. | X | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Outreach is conducted statewide to identify children who may qualify for funding of health care. Strategies to reach potentially eligible children include evaluating eligibility during itinerant rural clinics, providing information and application support, identifying SSI eligible children not yet enrolled in Medicaid, outreach to minority and under-served populations and utilizing parent consultants in CSHCN clinics and medical homes.

Utah's Family-to-Family Health Information Center is responding to the financing needs of families with information on public and private health insurance including changes as a result of the Affordable Care Act and access to the Health Insurance Exchange.

The autism pilot projects are covering assessment and behavioral therapy for approximately 375 children, ages of 2-6, financed with public funds. Although the three pronged Autism Treatment pilot will end in June 2014, the Medicaid waiver and PEHP autism services will continue as funded programs after June 2014.

The Hearing and Speech Services Program is currently administering the Children's Hearing Aid Pilot Program funded for two years during the 2013 Legislative Session. The pilot program is providing hearing aids to qualifying children under three years of age who have a hearing loss.

The Technology Dependent Waiver program added 10 new recipient slots during FY14 and the Bureau continues to assist Medicaid with utilization review for their Expanded Service and Authorization Committee.

c. Plan for the Coming Year

Conducting outreach activities to identify children and families who need assistance with financing health services will continue to be a priority. Outreach efforts will be a component of each CSHCN program and focus on minority and underserved populations who may be eligible for programs that pay for health care. Education will also be a major component and will provide families with culturally relevant and linguistically appropriate information on available programs, eligibility requirements and application processes. Outreach activities will occur during statewide clinics, through case managers, family partners and medical homes, web sites, and Utah Family Voices' parent consultants. A database will be updated and maintained 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 and how to apply.

CSHCN case managers and clinical staff will perform 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. Assistance will be provided to help families work with their private health insurances, Medicaid and Medicaid Accountable Care Organizations to access needed health-related services.

Utah's Family-to-Family Health Information Center will respond to the needs of families through direct family-to-family support and information on public and private health insurance. Applications for grant funding will be sought and used to educate families on the impact of the Accountable Care Act and navigating the health care system. CSHCN will continue to educate families on the options for private insurance coverage through the Health Insurance Exchange and possible expansion of Medicaid under the Accountable Care Act.

CSHCN will work with Medicaid and state partners on the continuation and expansion of the Medicaid Waiver for children with autism and monitor the new legislation passed during the 2014 Utah session for an insurance mandate to cover autism treatment. The new mandate will apply to large employers and individual health plans sold or renewed starting Jan. 1, 2016.

The Children's Hearing Aid Pilot Program administered by CSHCN's Hearing and Speech Services Program will continue through FY15 with funding appropriated during the 2013 Legislative Session. The pilot program is providing hearing aids to qualifying children under three years of age who have hearing loss.

The Technology Dependent Waiver Program will add 10 new recipient slots during FY15 and the Bureau will continue to assist Medicaid with utilization review for their EPSDT Expanded Services and Prior Authorization Committee.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 86.2 | 86.2 | 86.2 | 62.2 | 62.2 |
| Annual Indicator | 86.2 | 86.2 | 62.2 | 62.2 | 62.2 |
| Numerator | | | | | |
| Denominator | | | | | |

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 62.2 | 62.2 | 62.2 | 62.2 | 62.2 |

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 62.2% and the Annual Indicator was 62.2%.

Children with Special Health Care Needs (CSHCN) Bureau faced major funding challenges due to increased specialty provider contract fees and flat State and Federal funding. Even so, CSHCN staff worked closely with Utah Medical Home Program, University of Utah health care providers, community agencies and Utah Family Voices on efforts to enhance access, collaboration, and efficient and effective clinical services and care coordination between community agencies, health care providers and families. CSHCN and U of U Pediatrics continued a comprehensive collaboration during this reporting period to increase the availability of their specialty consultations. Efforts and collaboration were initiated with the Department's Oral Health Program to provide dental hygiene education to families and fluoride varnish application for the children at CSHCN rural clinics statewide. Working with local dental hygienists, these services were provided to all interested families of CSHCN children in rural areas, making sure dental homes were identified and in place for ongoing care.

CSHCN continued to provide access to community-based specialty care through statewide satellite case management and traveling clinics. Specialists travel to the 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 and transition services.

CSHCN provided case management to high-risk populations including children dependent on technology in Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). FHC assisted foster families to coordinate community care and collected and documented medical information for approximately 4200 children in the foster care system. FHC worked with Utah Medicaid to improve health status outcome measures 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 2000 children from NICUs that meet program eligibility criteria. CSHCN worked with the Department's Office of Health Disparities Reduction and the 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.

Continued 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. The Bureau enhanced the use of its electronic health records (EHR) system, CaduRx, increasing efficiency in scheduling, care coordination, billing, and was successful in meeting Federal Meaningful Use mandates during its first reporting phase.

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. Use of referral forms and processes initiated statewide facilitated access to and coordination of services, along with a complete update of the Bureau website for ease of use. | | X | | |
| 3. Utah's Family Voices and the Family-to-Family Health | | X | | |

| | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|--|---|
| Information and Education Center provided parent-to-parent support and information on community resources and services. | | | | |
| 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 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. Neonatal Follow-up Program continued provision of clinical diagnostic, assessment and follow-up for NICU graduates meeting program eligibility criteria. | X | | | |
| 7. CSHCN continued the use of the EHR system, CaduRx and successfully attested for Meaningful Use requirements for the initial reporting period. | | | | X |
| 8. State Oral Health Program initiated access to dental hygiene education and fluoride varnish application for special needs children seen in rural clinics. | X | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In the face of flat State and Federal funding and increased contract fees, Children with Special Health Care Needs continues to reassess the allocation of resources 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 to high-risk populations, including children 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). Bureau programs continue to evaluate the service delivery system to increase efficiency, and assess for needs in case management and clinical services. CSHCN continues collaboration with EMS-C to facilitate access to their registry. In addition, the Bureau continues to work with the Oral Health Program to provide access to dental hygiene and education for special needs children seen in our rural clinics. CSHCN initiated on-site availability of parent-parent advocacy in the Salt Lake clinics.

The Bureau has entered into discussions with U of U, Pediatrics and Primary Children's Hospital, to look at avenues to enhance collaboration and private funding opportunities in order to increase accessibility and availability of specialty services for CSHCN children statewide.

c. Plan for the Coming Year

The Bureau will continue to review and evaluate the clinic service delivery system to increase efficiency and serve more children. Additionally, we will continue the newly initiated negotiations and collaboration with the University of Utah, Department of Pediatrics in looking at avenues to increase availability and accessibility to specialty services in urban and rural areas of the State. The Bureau's current contracted affiliations with University of Utah providers will be maintained in order to facilitate ongoing provision of multidisciplinary specialty clinics in Salt Lake City and rural areas.

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 to access health-related and community care and to collect and document medical information for children in the foster care system.

CSHCN will continue to strengthen the community-based infrastructure for CSHCN. Bureau programs such as Family Leadership and the clinics will augment community clinical services, case management and capacity building efforts to enhance a coordinated, community system of care. Utah's Family-to-Family Health Information and Education Center will provide increased on-site 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 have a seat on the EMS-C advisory board, assisting that program in enhancing access to their registry, in addition to improving overall emergency medical services for CYSCHN throughout the State. The Oral Health Program will continue its collaboration to foster access to dental hygiene and education for families seen in clinics with the plan to have these services available at all clinic sites statewide.

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.

Continued collaboration among CSHCN clinical entities and CHARM, UHIN and CHIE will focus on implementing and expanding data sharing via CaduRx, our electronic health records system. CSHCN will continue efforts to meet Federal Stage 1 and Stage 2 Meaningful Use requirements.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 42.5 | 42.5 | 42.5 | 49.3 | 49.3 |
| Annual Indicator | 42.5 | 42.5 | 49.3 | 49.3 | 49.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 49.3 | 49.3 | 49.3 | 49.3 | 49.3 |

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 49.3% and the Annual Indicator was 49.3%.

In FY2013, the Bureau of Children with Special Health Care Needs (CSHCN) promoted and supported transition services for young adults, their families and medical providers. In September of 2012 the transition duties shifted to other staff due to staff vacancies. The change included re-prioritization of duties and continued partnership with Medical Home Program (MHP) representative to promote transition to adulthood. Children with Special Health Care Needs (CSHCN) transition duties expanded to include clinic social workers who provided on-site services to young adults with disabilities and their families both in the rural locations and urban-based CSHCN programs. Transition brochures were available at CSHCN clinic sites statewide.

The transition team included a SSI specialist, a Spanish-speaking social worker, who supported Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services, provided transition information and collaborated with the Office of Health Disparities Reduction in providing transition information and support to Latino young adults. Each transition brochure was translated to Spanish, posted on the CSHCN website transition page and is available in hard copy. The transition team reviewed and updated transition information as needed in the CSHCN website and partner websites and promoted CSHCN transition collaborative efforts to continue to improve the health of the state's special needs population by working with various state/federal agencies and community programs.

The transition specialist and Medical Home Program (MHP) representative were available for telephone transition consultation and provided written documents supporting parents and young adults within the agency, the greater community and the state. The transition specialist provided telephone transition consultation across the transition continuum. The transition specialist and/or MHP representative attended transition fairs to disseminate resources and information in the community.

The implementation of the Brief Transition Survey with parents and young adults at CSHCN clinic sites was delayed due to staff vacancies.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Transition duties shifted and were re-prioritized to expand to Children with Special Health Care Needs (CSHCN) clinic social workers, who provided onsite services in transition consultation in rural locations and urban-based CSHCN programs. | | X | | |
| 2. Transition brochures were provided to families and were available at CSHCN clinic sites statewide. | | X | | |
| 3. The transition specialist along with the Medical Home Program (MHP) provided telephone transition consultation to parents and young adults and written material as needed for parents within the agency and greater community. | | X | | |
| 4. The transition specialist and Medical Home Program (MHP) representative promoted Children with Special Health Care Needs (CSHCN) transition collaborative efforts by working with various state/federal agencies and community programs. | | X | | X |
| 5. The transition specialist provided telephone consultation across the transition continuum and brochures were provided to families and were available at CSHCN clinic sites statewide. | | X | | |
| 6. The SSI specialist, a social worker, continued to support Latino and non-Latino young adults and their families in accessing community services and transition information and to collaborate with Office of Health Disparities Reduction. | | X | | |
| 7. The specialist prepared the first draft of proposed Brief Transition Survey questions to be reviewed by Utah Family Voices and administration in preparation for presentation to parents and possible young adults at all 2014 CSHCN clinic sites. | | X | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Children with Special Health Care Needs (CSHCN) clinic social workers continue to provide on-site transition services for young adults and their families both at rural clinic sites and the CSHCN clinics based in Salt Lake City. The Spanish speaking SSI/Medicaid specialist continues to support Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services and collaborates with the Office of Health Disparities Reduction in providing transition information and support to Latino young adults. The transition specialist and the Medical Home Program Representative (MPR) continue to provide transition consultation to parents and young adults along the spectrum of transition. The staff continues to attend transition fairs to disseminate resources and information in the community and to consult with families and providers. The staff continues to update information and resources for the transition section of the CSHCN and partner website encompassing the spectrum of transition to adult services and programs. The transition specialist and MPH representative continue to develop new relationships and work collaboratively with federal state and local agencies and organizations to provide transition services and information. Draft of Brief Transition Survey is in revision in preparation for review by Utah Family Voices and administration.

c. Plan for the Coming Year

As a part of the transition team, CSHCN clinic social workers will continue to provide onsite transition services for young adults and their families both at rural clinic sites and the CSHCN programs based in Salt Lake City. The vital partnership with the Medical Home Program (MHP) representative will be continued.

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 collaborate with the Department's Office of Health Disparities Reduction in providing transition information and support to Latino young adults.

The transition team (transition specialist and the MHP representative) will continue to provide telephone transition consultation to parents and young adults and the transition specialist will continue to provide consultation along the spectrum of transition.

The transition team will continue to update information and resources for the transition section of the CSHCN and partner website encompassing the spectrum of transition to adult services and programs. The transition team will continue to attend transition fairs to disseminate resources and information in the community and to consult with families and providers.

The transition team, along with clinic social workers 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. This effort will include writing articles and columns as requested. After administration approval, the Brief Transition Survey will be distributed to parents and young adults in fall 2014 and results will be provided in 2015.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 82.5 | 80 | 75.8 | 70.6 | 71.1 |

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Indicator | 75.8 | 70.6 | 70.6 | 71.1 | 74.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 74.9 | 74.9 | 75 | 75.1 | 75.1 |

Notes - 2013

This measure does not have a numerator or denominator because it is taken from CDC's 2012 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

Notes - 2012

This measure does not have a numerator or denominator because it is taken from CDC's 2011 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

Notes - 2011

Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2010 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

a. Last Year's Accomplishments

The performance measure was achieved. The performance objective was 71.1% and annual indicator was 74.9%.

The Utah Immunization Program (UIP) Provider Relations Staff continued to implement the quality improvement program, AFIX. They worked through 2013 with a goal of 70% of providers receiving face-to-face feedback on their 4:3:1:3:3:1 immunization rates. AFIX was promoted to providers through VFC site visits, brochures, and participating in local conferences with a new AFIX display. Provider relations staff continued to assist VFC providers with understanding immunization best practices and conducted CASA/AFIX assessments at 100% of VFC provider clinics in order to determine coverage levels in 2013.

The UIP worked closely with providers to help improve pre-teen and teen immunization coverage levels in Utah. The program promoted several quality improvement strategies including: participation in the Utah Statewide Immunization Information System (USIIS); promotion of HPV, Meningococcal Conjugate, and Tdap vaccines; and encouragement to incorporate school requirements for children K-12, not just for kindergarten entry. The 2013 immunization coverage report was disseminated to UIP partners/stakeholders and made available to the public on the UIP website.

The UIP continued collaboration and financial support to regional immunization coalitions to support early childhood and adolescent immunization efforts. The UIP was able to provide educational support to the Northern Utah Coalition Conference, Greater Salt Lake Coalition, and the Tri-County Coalition. The UIP continued to provide support to local health departments, community health centers and Indian Health centers for NIIW, National Immunization Awareness Month, Back to School, and Adult Immunization months.

The UIP reviewed all materials and provided age/culturally appropriate educational and informational immunization materials to consumers, including program materials in English and Spanish. The UIP promoted the VFC Program with articles in minority magazines and newspapers. Collaborations with state and local Indian Health Services provided a focus on CASA/AFIX immunization information with Tribal VFC providers in the Southeast corner of the state.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Immunizations Provider Relations staff achieved their goal of conducting AFIX quality improvement site visits regarding 4:3:1:3:3:1 immunization rates for 70% of VFC providers. | | X | X | X |
| 2. Adolescent immunization was promoted during the statewide coalition workshop/conference and all adolescent promotional materials were updated to reflect the new changes to the adolescent schedule. | | | X | |
| 3. The UIP collaborated with Select Health (Medicaid ACO) on their adolescent immunization recall project and relationships were established with Molina Health Care (Medicaid ACO) to discuss development of a recall project within their system. | | X | | |
| 4. USIIS data were utilized to determine coverage levels based on race/ethnicity, Medicaid status and local health department areas. | | | X | |
| 5. The Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) Project recruited providers to participate in quality improvement activities, including the current HPV grant project. | | | | X |
| 6. The UIP was awarded a CDC grant to increase adolescent HPV immunization rates in Utah through the provision of education for providers and parents. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The AFIX Program feedback sessions are being implemented by the Provider Relations staff to meet the new VFC requirements for 2014 and will provide a more intensive quality improvement program to 90 providers (meeting the VFC goal of 25%). The UIP has elected that the 90 providers will be those with larger adolescent populations and the QI will focus on improving adolescent immunization, especially HPV.

USIIS enrollment increased in 2013 due to meaningful use and changes to the Pharmacy Act. In response, the UIP has dedicated staff to this project with responsibilities for VFC/USIIS and non-VFC USIIS outreach, enrollment, and education/training to better address provider needs. Using Televox, USIIS did two recall reminder efforts in August and October of 2013 and will continue

with two more scheduled in February and April 2014.

The UIP received a HPV grant to increase HPV immunization rates in Utah by educating providers and parents. In the last quarter of 2013, an advisory committee was identified, a media partner was obtained, contracts were developed with local health departments and community health centers, and baseline data were requested from USIIS. In January 2014, education efforts were completed by partners focusing on Cervical Cancer Prevention month. The media campaign is being developed with parent focus groups and is scheduled to begin in April 2014. In collaboration with UAAP, UIP will provide three regional HPV provider conferences in March and April 2014.

c. Plan for the Coming Year

Provider relations staff will continue to assist VFC providers with understanding immunization best practices and conduct 90 CASA/AFIX assessments and determine coverage levels focusing on adolescents. These activities will meet the new VFC requirements for 2014 and will provide a more intensive quality improvement program to 90 providers (meeting the VFC goal of 25%). Furthermore, Provider Relations staff will continue to conduct VFC Compliance Site Visits to all participating VFC Providers and Storage & Handling visits with the goal to improve provider staff education regarding Vaccine Management, including accountability, storage, and handling.

The Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) is currently working on the HPV grant project to recruit providers for focus groups and surveys to determine attitudes and practices related to providing HPV and other adolescent vaccinations. The group is also working on recruitment of providers to focus quality improvement activities targeting HPV vaccination. In the coming months, the group will continue recruiting providers to participate in quality improvement activities.

As in previous years, USIIS data will be queried to determine coverage levels based on race/ethnicity, Medicaid status and local health department areas. The annual immunization coverage report will be disseminated to UIP partners/stakeholders and available on the UIP website.

The UIP will continue collaboration with the regional immunization coalitions to support early childhood, back to school, adolescent, and adult immunization efforts. The UIP will continue to provide support to local health departments, community health centers and Indian Health centers for National Immunization Awareness Month, Pre-Teen/Adolescent Month, Back to School/College, and Adult Immunization Month.

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. The UIP will continue work with Utah Indian Health Advisory Board to create culturally and linguistically appropriate posters, educational materials, and identify Tribal medical clinics to participate in the HPV projects.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 18.5 | 18.5 | 16.5 | 14.3 | 11.1 |

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Indicator | 16.5 | 14.3 | 11.2 | 10.3 | 10.3 |
| Numerator | 995 | 876 | 706 | 668 | 668 |
| Denominator | 60127 | 61154 | 63253 | 64625 | 64625 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 10.2 | 10.1 | 10 | 9.9 | 9.8 |

Notes - 2013

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: IBIS Population estimates for 2012

Notes - 2012

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: IBIS Population estimates for 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Denominator: IBIS Population estimates for 2011

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 11.1 and the Annual Indicator was 10.3.

The Utah Department of Health (UDOH), Maternal and Child Health Bureau, Maternal and Infant Health Program (MIHP) continued to receive funding from the U.S. Department of Health and Human Services (HHS), Administration for Child and Families to implement Personal Responsibility Education Programs (PREP) and Abstinence Education Programs to reduce teen pregnancy in Utah.

Funds for PREP were used to implement community programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS, and to provide other adulthood preparation subjects. MIHP sub-contracted most of the PREP funds out to local organizations through a competitive grant process. Those organizations that received funding were: Bear River Health Department, Boys and Girls Clubs of Greater Salt Lake, Club Red: Moab Teen Center, Centro Hispano, Teen Mother and Child Program, and the Weber-Morgan Health Department. However, funding was cut to one site in June 2013 due to sequestration cuts and an inability to sufficiently recruit adolescents to the program in this area. Among the six funded agencies, the following populations were served:

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, teen mothers, and youth residing in areas with teen birth rates higher than Utah's state rate.

MIHP also continued to sub-contract Abstinence Education funds to local organizations through a competitive grant process. The organizations that received funding were: National Tongan American Society, Midvale Community Building Community Initiative, Planned Parenthood Association of Utah, Pregnancy Resource Center of Salt Lake, Tooele County Health Department, Utah County Health Department and the Weber-Morgan Health Department. Among the seven funded agencies, the following populations were served: 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 teen birth rates higher than Utah's state rate.

A part-time PREP assistant coordinator was hired in February 2013 to assist with management, reporting, and technical assistance tasks for this grant. The Adolescent Health Coordinator left her position in March 2013 and the position remained vacant for the remainder of the grant year. Before leaving the UDOH, the coordinator organized and held one February 2013 meeting of the Utah Adolescent Health Network, a group of diverse stakeholders of adolescent health from government, academic, non-profit, and community organizations. The presentation for this event was entitled: "Best Practice Recommendations for Transitioning Adolescent Foster Girls".

Prior to leaving the UDOH, the Adolescent Health Coordinator also monitored, analyzed, and released Utah teen pregnancy, birth, and STD data. These data were distributed among the Adolescent Health Network, various media and legislative entities, and maintained on the Department of Health, Indicator-Based Information System for Public Health (IBIS-PH).

MIHP continued to work on reaching the UDOH Teen Pregnancy goal. The goal was set to decrease the rate of teen pregnancies to 31.7 per 1,000 Utah females ages 15-19 by 2015. In 2011, this goal was far surpassed with a rate of 27.0 per 1,000 Utah females ages 15-19, a 29% decrease since 2006. MIHP issued a press release regarding this notable achievement during May 2013 and received substantial media attention, including several newspaper, television, and radio interviews. A reporter from the Associated Press in New York also contacted MIHP for comment regarding a CDC report showing that Utah had experienced the sharpest decline in teen pregnancies of all 50 states.

MIHP continued to distribute the teen life plan, Plan Your Health, Live Your Life, among Utah adolescents and community groups. Efforts were made to collaborate with the new Health Education Specialist at the Utah State Office of Education to distribute and promote the use of this resource.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. MIHP continued to sub-contract the majority of PREP and Abstinence Education funds to 12 local agencies through a competitive grant process. | | | X | |
| 2. A February 2013 meeting of the Utah Adolescent Health Network was held. The presentation for this event was entitled: "Best Practice Recommendations for Transitioning Adolescent Foster Girls". | | | | X |
| 3. The Adolescent Health Coordinator monitored, analyzed, and distributed Utah teen pregnancy, birth, and STD data. | | | | X |
| 4. The 2015 UDOH teen pregnancy goal of 31.7 per 1,000 Utah females ages 15-19 was surpassed with a rate of 27.0 per 1,000 | | | X | |

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---|--|
| Utah females ages 15-19 in 2011, a 29% decrease since 2006. | | | | |
| 5. MIHP issued a press release regarding the achievement of the UDOH teen pregnancy goal during May 2013 and received substantial media attention, including several newspaper, television, and radio interviews. | | | X | |
| 6. A reporter from the Associate Press in New York also contacted MIHP for comment regarding a CDC report showing that Utah had experienced the sharpest decline in teen pregnancies of all 50 states. | | | X | |
| 7. MIHP continued to distribute the teen life plan, Plan Your Health, Live Your Life, among Utah adolescents and community groups. | | | X | |
| 8. Efforts were made to collaborate with the new Health Education Specialist at the Utah State Office of Education to better distribute and promote the use of this resource. | | | X | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Maternal and Child Health Bureau, Maternal and Infant Health Program (MIHP) continue to oversee the Title V State Abstinence Education Program and Personal Responsibility Education Program (PREP). The Adolescent Health Coordinator position was restructured to focus more on teen pregnancy prevention programs and related activities. The vacancy was filled in the summer of 2013 and continues to provide project oversight and technical assistance to 12 funded community-based projects. An RFP was released to provide Utah PREP funding for an additional sub-awardee in February 2014 and the application review process is currently underway. An additional PREP site will be selected and funded in April 2014.

The Utah Adolescent Health Network has been suspended as it is no longer the most effective way to coordinate adolescent health activities. MIHP is currently exploring more effective ways to connect and promote collaboration among various adolescent health programs, activities, and stakeholders. Training was conducted at four school districts to promote the teen life plan.

MIHP continues to work on the UDOH teen pregnancy goal. Although the 2015 goal of 31.7 per 1,000 females aged 15-19 was surpassed with in2011 with a rate of 27.0 per 1,000 females aged 15-19, work continues to sustain this decline. The current rate f or 2012 births is 22.3 per 1,000 females aged 15-19. MIHP monitors and shares state birth and pregnancy data pertaining to this goal.

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 oversee and provide technical assistance to funded community-based projects. A specific focus will include ensuring program sustainability as continued funding for these programs is uncertain. For example, each site will work with the Adolescent Health Coordinator to create a sustainability plan and training funds will be used to build state training capacity for the currently implemented curricula.

The abstinence education programs will continue to 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 teen birth rates higher than Utah's state rate. All funded abstinence programs will ensure that abstinence from sexual activity is the expected outcome as outlined in the federal requirements.

PREP will continue to focus on programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS, and adulthood preparation topics. The programs 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. An additional PREP sub-awardee will begin program implementation during August 2014.

The Utah Adolescent Health Network will be replaced with a more effective strategy to connect and promote collaboration among various adolescent health programs, activities, and stakeholders. MIHP will continue to explore best practices and strategies for meeting this goal. One way this objective will be met is through collaboration with the Health Education Specialist at the Utah State Office of Education to distribute and promote the teen life plan, specifically through school district training with health and sexual education teachers.

Although the state 2015 teen pregnancy goal of 31.7 per 1,000 females aged 15-19 has already been achieved with the 2012 rate of 22.3 per 1,000, work will continue to sustain the downward trend. The Adolescent Health Coordinator will monitor and share state birth and pregnancy data pertaining to this goal and work towards continued reduction through education and programs. Additionally, a formal report will be produced to analyze and discuss the recent declines in the teen pregnancy rate. To produce this report, MIHP will draw upon a variety of data sources, including vital statistics birth data, PRAMS, program data, and data obtained from collaboration with the University of Utah's Teen Mom clinic.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 45.1 | 45.1 | 41.9 | 41.9 | 41.9 |
| Annual Indicator | 45.1 | 41.9 | 41.9 | 41.9 | 41.9 |
| Numerator | 155 | 392 | 392 | 392 | 392 |
| Denominator | 344 | 935 | 935 | 935 | 935 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 41.9 | 41.9 | 45 | 45 | 45 |

Notes - 2013

Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH

Notes - 2012

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

Notes - 2011

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

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 41.9% and the Annual Indicator was 41.9%.

A statewide survey of first through third grade children was performed during 2010 and the final report was released in 2012. The Division of Family Health and Preparedness (DFHP) Oral Health Program (OHP) promoted sealants through screening and referral activities. The OHP 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 collaborating with Sealant for Smiles in training staff and in providing screening and referring procedures for children attending high-risk elementary schools in Salt Lake, Davis and Tooele counties .

The OHP supported and provided technical assistance in collaboration with Dental Select's sponsored Sealants for Smiles school-based preventive dental program. The Sealant for Smiles program provided education and direct services to schools in Davis, Tooele and Salt Lake Counties. More than 9200 (9,265) children were screened and 10,521 sealants were placed on 3,402 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 districts included local 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 promoted oral health prevention including sealant utilization 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. During 2013 More than 9250 children were screened and more than 10,500 sealants were placed on the teeth of 3400 low-income uninsured and Medicaid/CHIP insured children by the Sealants for Smiles program. | X | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

| | | | | |
|-----|--|--|--|--|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

During FY14, DFHP Oral Health Program (OHP) is promoting dental screening, sealant and referral. A statewide survey of 6-9 year old children was performed in 2010 with results indicating improvement in oral health among Utah children since 2005. However, sealants remain underused in Utah with only 36.1% of 8 year olds having sealants compared to 45.1% in 2005. The OHP is supporting direct delivery of sealants at the local health district 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. It is anticipated that about 10,000 sealants be placed on low-income uninsured and Medicaid/CHIP insured children through this program.

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 and health care providers who have opportunities to promote sealants.

The OHP is also promoting fluoride varnish application in children as another mechanism to reduce tooth decay. The program is actively participating in rural CSHCN clinics and applying fluoride varnish for children and their siblings in the clinics.

c. Plan for the Coming Year

During FY15, DFHP Oral Health Program (OHP) will promote sealants through screening and referral activities. Results from the 2015 statewide survey of 6-9 year old children will help direct OHP activities in the future years. 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 referral 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, Davis and Salt Lake counties. It is anticipated that more than 9,000 children will be screened and about 10,500 sealants placed on low-income uninsured and Medicaid/CHIP insured children.

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, Fortis College, Salt Lake Community College, and Dixie College. Sealant Projects in the Salt Lake County, Weber-Morgan, Utah County and Southwest Utah health departments will include 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. OHP will work with programs in CSHCN to promote good oral health among the most vulnerable children, those with special health care needs. The dental hygienist will travel to rural clinic sites to screen and apply fluoride varnish on the teeth of children seen in rural CSHCN clinics.

The OHP will continue to work with Head Start Programs, pediatricians and other non-dental health care providers in promoting early caries prevention programs including oral health risk assessment and fluoride varnish application. The OHP will work with the Department's Office of Home Visiting to offer fluoride varnish application training to home visiting nurses and provide oral health education resources.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 3.4 | 4.3 | 2.2 | 2 | 2.8 |
| Annual Indicator | 2.2 | 2.0 | 2.8 | 1.6 | 1.6 |
| Numerator | 16 | 15 | 21 | 12 | 12 |
| Denominator | 736615 | 749214 | 749774 | 754356 | 754356 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 1.6 | 1.6 | 1.6 | 1.6 | 1.6 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2012
Denominator: IBIS Population estimates for 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2012
Denominator: IBIS Population estimates for 2012

Notes - 2011

Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2010
Denominator: IBIS Population estimates for 2010

a. Last Year's Accomplishments

The Performance Measure was achieved. The Annual Performance Objective was 2.8 and the Annual Indicator was 1.6.

The Violence and Injury Prevention Program (VIPP) provided funding to each of Utah's 12 local health departments (LHDs) to conduct local injury prevention programs. Approximately 979 injury-related activities were conducted in FY2013 by the LHDs, reaching about 89,000 individuals. These activities included classes, bike rodeos, assemblies, safety fairs, car seat installation classes, high school assemblies, evidence-based injury prevention programs, etc. In addition LHDs and VIPP engaged in media and social networking outreach through PSAs, press conferences, media interviews, news releases, and use of Twitter and Facebook.

The LHDs and VIPP lost substantial funding from the Utah Highway Safety Office for child passenger safety during the FY2013 year, as a result of changes to the federal MAP-21 guidance. These cuts may ultimately impact the rate of unintentional injuries due to motor vehicle crashes in future years if LHDs are unable to sustain current levels of infrastructure and intervention/education in this area. MCH Block Grant funding is vital to this process, as it provides the bulk of funding for motor vehicle crash prevention activities at the LHDs.

VIPP continued to provide data and surveillance expertise to a variety of partners including LHDs, state agencies, and legislators. VIPP developed fact sheets on child abuse/neglect, firearm injuries, motor vehicle injuries, poisoning, spinal cord injuries, traumatic brain injuries, and suicides during FY2013 which were disseminated to partners, state agencies, department leadership, and the media.

VIPP, the lead agency for Safe Kids Utah, worked with LHDs to promote use of child safety seats through Safe Kids Utah. LHDs are required to participate in their local coalitions/affiliates. There are 13 active Safe Kids coalitions/affiliates in addition to the statewide Safe Kids Utah Coalition, which provide education, awareness, and prevention activities targeting children ages 1-19. LHDs conducted car seat checkpoints, correctly inspected and installed car seats and booster seats, and distributed low-cost car seats and booster seats to families in need. LHDs also distributed bicycle helmets. VIPP coordinated 20 media events and requests on motor vehicle safety. Staff from the LHDs attended several traffic safety conferences to increase staff expertise including the Zero Fatalities Safety Summit, Four Corners Conference, National Safe Kids Conference, Lifesavers Conference, and Safe States Alliance Annual Meeting. Seat belt use still varied widely among LHDs, with rural LHDs reporting lower seat belt use than urban LHDs.

The VIPP continued to co-chair the Utah Teen Driving Task Force to coordinate efforts of state, local, and private agencies working together on the issue of reducing teen motor vehicle crashes. The task force developed its first ever strategic plan. VIPP contracted with the Utah Department of Transportation and Zero Fatalities program to develop a media campaign targeting parents of teens ages 15-17 to encourage parental involvement and increased knowledge of Utah's Graduated Driver Licensing (GDL) laws. A YouTube video, Facebook and Twitter ads/posts, web banner ads, and a radio ad were developed.

A Parent Night Program was developed by Zero Fatalities and VIPP. The program educates parents on Utah's GDL laws and how to keep their teen safe on the road. A parent guide was developed to accompany the class and is available online (www.health.utah.gov/vipp/motorvehiclesafety/teendriving.htm). Utah's largest school district mandated the program for all driver education students.

VIPP released the fifth teen memoriam book in FY2013. The teen memoriam book is a collection of stories told by grieving families who have lost a teen in a motor vehicle crash. VIPP has published a memoriam book since 2008. When surveyed by VIPP, high school students reported they were more likely to follow driving laws and understand the risk associated with driving after reading the book. Additionally, 95% of the students said it should be required reading for all driver education students.

Education efforts by VIPP, LHDs, and the Utah Teen Driving Task Force have led to an

astounding 61% decrease in the rate of teens killed in motor vehicle crashes since 1999, when the Utah Graduated Driver Licensing laws were enacted.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. VIPP provided funding to the LHDs to conduct car seat checkpoints, correctly check and install child safety seats, and distribute low cost car seat or booster seats to families in need. | | | X | |
| 2. VIPP provided funding to the LHDs to conduct activities such as classes, presentations, bike rodeos, assemblies, safety fairs, high school assemblies to encourage safe driving and seat belt use, etc. reaching more than 89,000 individuals. | | | X | |
| 3. VIPP remained the lead agency for Safe Kids Utah and required each of Utah's 12 LHDs to be an active participant or sponsor of their local Safe Kids coalition/affiliate as part of their injury prevention contract with VIPP. | | | | X |
| 4. VIPP developed a media campaign in conjunction with Zero Fatalities targeting parents of teens. The goals were to encourage parental involvement in driver education training and increase knowledge of Utah's Graduated Driver Licensing laws. | | | X | |
| 5. LHDs conducted seat belt use observation studies in targeted high schools in their communities. | | | X | |
| 6. VIPP and the Zero Fatalities Program developed the 5th teen memoriam booklet which shares stories of teens killed in motor vehicle crashes. The books are distributed to driver education classes around the state. | | | X | |
| 7. VIPP and Zero Fatalities developed the Parent Night Program to educate parents of teen drivers about Utah's Graduated Driver Licensing laws and how to keep their teen safe on the road. | | | X | |
| 8. VIPP's parent guide was developed to accompany the Parent Night Program and is available online. | | | X | |
| 9. VIPP continued to provide data and surveillance expertise and support to a variety of partners including LHDs, state agencies, and legislators. | | | | X |
| 10. | | | | |

b. Current Activities

VIPP collaborates with partners to implement strategies to reduce motor vehicle crash deaths among children. This coordination is vital to statewide implementation and success. Funding and technical assistance are provided to each of Utah's 12 local health departments (LHDs) to address traffic safety issues. LHDs primarily focus on child passenger safety and teen driving, and Safe Kids issues. Teen driving activities are done in partnership with the Zero Fatalities program (funded by the Utah Department of Transportation). VIPP is coordinating a statewide campaign with LHDs and other partners to reduce teen motor vehicle deaths. Each year, the VIPP contacts families of teens who died in a motor vehicle crash to participate in a Teen Memoriam Book. FY14 will mark the 6th year a memoriam book has been created. VIPP promoted use of media campaign materials developed with Zero Fatalities to educate and engage parents in their child's driving experience. VIPP also provides statistical support to its many partners and legislators. A new Small Area Report, which includes motor vehicle traffic crash indicators, was published in FY2014. VIPP provides weekly legislation updates to partners during the legislative session and developed a fact sheet on teen cellphone use while driving.

VIPP will remain the lead agency for Safe Kids Utah. LHDS will promote proper use of child safety seats, conduct inspections, and distribute low cost seats.

c. Plan for the Coming Year

VIPP will continue collaboration work with its many partners to implement strategies for reducing motor vehicle crash deaths (MVCs) among children in Utah. The Child Fatality Review Committee will continue to review all child deaths and give recommendations for system and policy changes, education, and interventions to prevent future deaths.

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.

VIPP will remain the lead agency for Safe Kids Utah and oversee coalitions statewide. Car seat efforts will include: partnering with Safe Kids Utah and LHDs to promote proper use of car/booster seats; conduct car seat inspections; assist with technician training; distribute low-cost car seats; educate children ages 0-19 and their parents; work with media; and provide information on the VIPP and Safe Kids Utah websites.

VIPP will continue to coordinate and co-chair the Utah Teen Driving Task Force with the Utah Highway Safety Office and ensure implementation of the teen driving strategic plan. VIPP will also coordinate a campaign with all LHDs aimed at reducing deaths to teens, 15-19 years of age, from motor vehicle crashes. Multifaceted interventions will include: education, mobilizing partnerships to solve traffic safety problems, partnering with law enforcement, partnering with Zero Fatalities and drivers education classes to teach the Parent Night Program, media campaigns, and creation of a 7th Teen Memoriam book. Younger children will also be taught about safe driving as passengers and to prepare them for the responsibility of driving in a few years through the "Click it Club", and "Countdown To Drive" programs. The 2013 Teen Memoriam Book will be produced and distributed statewide through driver education classes.

VIPP will continue to work with the Utah Brain Injury Council to produce reports and training on motor vehicle crashes as a major cause of traumatic brain injuries. Pedestrian and bicycle safety efforts conducted by the LHDs will be overseen by VIPP and Safe Kids Utah. Efforts will include distribution of helmets, pedestrian safety events, and coordination with enforcement agencies. LHDs will scale back these efforts in FY15 because of funding cuts from the Utah Highway Safety Office and due to data showing the need to address other injury areas. Pedestrian and bicycle safety activities are often used by the LHDs to garner support from community partners which lead to more effective interventions in child passenger safety and teen driving.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 60.5 | 69.6 | 58.5 | 61.5 | 65 |
| Annual Indicator | 69.5 | 61.5 | 61.5 | 64.4 | 64.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 64.2 | 64.5 | 65 | 65.2 | 65.4 |

Notes - 2013

The data reported are from the National Immunization Survey, 2010 (Prelim data). These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2012

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2009. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2011

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2008. 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 65% and the Annual Indicator was 64.2%.

The U.S. national average for breastfeeding at 6 months was 49%. Utah is one of eight states that have surpassed the Healthy People (HP) 2020 goal of 60.6%. The National Immunization Survey data (2010-preliminary) indicated that Utah's breastfeeding rates were above the HP 2020 objectives but Utah fell short with exclusive breastfeeding. Utah's rates of exclusive breastfeeding at three and six months were 43% and 22.5% and the HP objectives are 46.2% and 25.5%.

The Pregnancy Risk Line program counseled more than 3,000 women who had questions about exposures to medicines, chemicals and other exposures and whether they should continue to breastfeed. During the calls with the women, the benefits of breastfeeding were emphasized and women were counseled as to the exposures effect or not on the breastfed infant.

The program wrote articles for the WIC newsletter on the importance for all family members, especially mothers, to get a flu vaccine and the importance for mothers to continue breastfeeding even if they did get influenza. Another published article in the WIC newsletter discussed the use of alcohol and binge drinking while breastfeeding and the concern for a baby if receiving alcohol through the breast milk. The article stresses the proper time period to "pump and dump" after consuming alcohol and the concern for dehydration and loss of milk supply if the mother binges.

In other efforts to continue outreach to low-income risk groups, the Pregnancy Risk Line/MotherToBaby program attended several health fairs such as Junior League Care Fair, Davis School District Transition Fair, Adoption Conference, All About Baby Expo, Troubled Youth Conference, Family and Spanish Links Conferences, Utah American Academy of Pediatrics Conference and the Good Shepard Child Care Provider Training, resulting in distribution of materials to more than 1,500 families and more than 500 health care providers.

Healthy Utah Babies is one of the goals of the Utah Department of Health's current strategic plan. The Utah Department of Health's (UDOH) Maternal Child Health Bureau, in collaboration with our partners in the Bureau of Health Promotion, is working to improve breastfeeding support practices in all Utah birthing hospitals. A Breastfeeding Workgroup was established and through data review and discussions decided that since only one of Utah's 43 delivery hospitals has been designated as "Breast Feeding Friendly", our focus should be increasing the number of hospitals that support breastfeeding following the WHO guidelines.

The Workgroup carried out an Assessment of Breastfeeding Supportive Maternity Care Practices in Utah Hospitals Survey with 43 delivering hospitals throughout the state; all but 3 hospitals responded. Survey responses indicated that Utah hospitals are performing very well in some areas; however there are weaknesses in a few areas of supporting breastfeeding. While being designated as "Breast Feeding Friendly" is the gold standard for hospitals, numerous Utah hospitals have cited cost and processes as major barriers to pursuing the designation; it currently costs over \$10,000 for a facility to become designated "Breastfeeding Friendly" by the U.S. Baby Friendly Hospitals Initiative and the designation process is lengthy and somewhat cumbersome.

Our survey results found that only four facilities had applied to become "Baby Friendly". An overwhelming majority, 75% of responding facilities, indicated that it would be easier for their facility to adopt "baby friendly" practices if the Utah Department of Health supported a state specific designation. Department Executive leadership approved implementation of a program similar to several other states that have established state level criteria for a program.

The Utah Breastfeeding Coalition (UBC) hosted "The Breastfeeding Cafe" in Salt Lake City and other key counties from August 1-14 in conjunction with World Breastfeeding Week. WIC and UBC, in conjunction with the Perinatal Professional Consortium, sponsored a two-day perinatal and breastfeeding annual conference in April.

WIC has been leading the development of a Utah Donor Human Milk Bank. The Utah Donor Human Milk Bank project moved forward by starting a HMBNA (Human Milk Banking Association of North America) application and business plan.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. More than 3,000 women were counseled on the importance of continuing to breastfeed as appropriate if taking certain medications or exposed to certain chemicals, drugs of abuse, alcohol and some viruses. | | X | | |
| 2. Pregnancy Risk Line/MotherToBaby wrote articles for the WIC newsletter on flu vaccine, alcohol. | | | X | |
| 3. More than 1,500 families and 500 health care providers were educated at health fairs and conferences on the importance of breastfeeding. | | | X | |
| 4. An Assessment of Breastfeeding Supportive Maternity Care Practices in Utah Hospitals Survey was carried out with a response rate of 94%. | | | | X |
| 5. Department Executive Leadership approval was gained to implement a program similar to several other states who have established state level criteria for being designated as breastfeeding friendly. | | | | X |
| 6. | | | | |
| 7. | | | | |

| | | | | |
|-----|--|--|--|--|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Pregnancy Risk Line/MotherToBaby is implementing a marketing and education campaign regarding its new name, MotherToBaby Utah. The campaign is directed at hospital lactation specialists and WIC educators. The program continues to submit articles for the WIC newsletters.

The Healthy Utah Babies Workgroup continues to meet regularly to develop a Utah designation for hospitals to certify as Breastfeeding Friendly. The Utah program is currently under development. Permission was obtained from the Texas State Health Department to borrow materials they have developed for a similar program in their state. The Texas Ten Step Toolkit is currently being modified to use in Utah. The Workgroup has planned to implement regional dinner kick off meetings with facilities interested in participating in the Utah Collaborative for Achieving the Ten Steps (UCATS). Facilities participating in UCATS will be recognized by the Utah Department of Health for taking steps to promote, protect, educate and encourage breastfeeding in their organizations.

The Program allows hospitals to implement two (2) steps at a time with a goal of completing all ten (10) steps. Upon completion requirements for each two UCATS steps, the Utah Department of Health will recognize successful hospitals with local celebrations and public recognition through press releases and other acknowledgements through UDOH and hospital networks.

c. Plan for the Coming Year

The MotherToBaby program plans to attend more health fairs and conferences for under-served families and for social service providers and health care professionals who serve low-income populations. The program will develop news articles, television stories and social media messages to keep mothers breastfeeding. MotherToBaby will include in the conversation with callers about plans to continue breastfeeding based on the information that they received on the call.

The Maternal and Child Health Bureau will continue to support the "Healthy Utah Babies" Workgroup to implement the UCATS program. UCATS will support delivery hospitals throughout the state that are interested in working toward adopting the ten steps to becoming "Breastfeeding Friendly". Participating hospitals will be publicly recognized by the Utah Department of Health for every two steps they achieve.

WIC will continue to implement the food rules that adjusted formula issuance (more limited) and increase breastfeeding assessment and counseling. WIC will collaborate with local community, state, and national organizations to better promote, support and protect breastfeeding. WIC will celebrate World Breastfeeding Week statewide during the month of August by participating in Breastfeeding Cafe and other educational and promotional events.

The WIC state office will continue to mentor University dietetic interns from across the nation to expose them and utilized them for breastfeeding projects.

WIC will continue to provide a variety of manual and electric breast pumps, prenatal and postpartum breastfeeding classes, and offer breastfeeding assessment and counseling.

Continued work on the Mountain West Mother's Milk Bank in developing milk collection sites and the opening on a Milk Bank in Utah in 2016 .

Will implement an improved and updated UDOH Worksite Breastfeeding Policy based on the

federal law of Flexible Work-time for Nursing Mothers - to maximize the success of employee breastfeeding and to fully meet the intent of the ACA Fair Labor Act law. Technical assistance services will be offered for all state buildings.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 97.9 | 98.1 | 98.3 | 98.6 | 98.8 |
| Annual Indicator | 98.3 | 98.6 | 98.8 | 97.8 | 97.8 |
| Numerator | 54225 | 52624 | 51661 | 51541 | 51541 |
| Denominator | 55143 | 53395 | 52288 | 52727 | 52727 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 97.8 | 97.9 | 97.9 | 98 | 98.1 |

Notes - 2013

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2012

Notes - 2012

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2011

a. Last Year's Accomplishments

Performance measure not achieved; Performance Objective was 98.80%; Annual Indicator was 97.75%.

Newborn hearing screening (NBHS) is done at all 42 birthing hospitals, the pediatric specialty

(Primary Children's) hospital, and 7 birth centers. Utah had 52,446 births reported in Hi*Track (Utah newborn hearing screening database) in 2011 with over ninety-eight percent (98.3%) being screened for hearing loss. The pass rate for those screened was 95.2%, with 50,524 (97.02%) passing before one month of age. Home birth screening rates were 69% for 2012 births, similar to the previous year. A total of 435 newborns born in 2012 were referred for diagnostic evaluation. Of the 435 infants, 111 infants were identified with a hearing loss.

Approximately 0.3% of Utah's 2012 newborns did not return for outpatient/diagnostic testing, had no screening results reported, or missed newborn hearing screening. Targeted efforts continued for meeting national 1-3-6 EHDI, Early Hearing Detection and Intervention, aka newborn hearing screening (NBHS), goals.

Utah EHDI continued to focus on decreasing the number of infants lost to follow-up or documentation to improve program success. Four lay midwife practices were added to the Home Birth Hearing Project (HBHP) to bring the total to 29 participating lay midwife practices, resulting in improved rural and non-hospital screening rates. Popularity of our HBHP has necessitated a waiting list for other interested lay midwives, and a lay midwife consultant has been added to the Utah Newborn Hearing Screening Advisory Committee (NBHSAC). Utah EHDI's partnership with Davis County Early Head Start has been successful during its first year of collaboration, finding 4 children who missed or had unresolved NBHS results.

In September, 2012, Utah EHDI hosted an annual conference for NBHS audiologists, coordinators, and screeners. Guest speakers presented "A Parent Perspective on Hearing Loss", "The Role of the Pediatric Otolaryngologist/An Approach to Newborn Hearing Loss" and "Communicating with the Medical Home about EHDI". An intense 2-day conference on infant physiologic audiology testing was hosted in May 2013, which included both didactic and practical "hands-on" audiometric brainstem response testing. Trainings that increase the competency of pediatric audiology testing such as this are critical components in our state's plan of reduction in numbers in EHDI Loss to Follow-Up (LTF-U).

Another effort at increasing the availability of pediatric audiology diagnostic services in rural/frontier areas of our state has been through tele-intervention. Utah EHDI is piloting a "proof of concept" tele-audiology project. Our strategy used remotely controlled Auditory Brainstem Response (ABR) equipment, video-conferencing, and the assistance of a lay midwife in central Utah. This lay midwife serves as a local attendant for the "remote" site. An EHDI Audiologist at the "home" site in Salt Lake City conducts, via telehealth, a diagnostic ABR on an infant. Utah is one of only a few states in the nation to be utilizing tele-audiology. Our EHDI Director presented on our efforts at two national conferences: the Association of Maternal & Child Health Programs (AMCHP) in February 2013 and at the National EHDI Conference in April 2013.

Twenty-two hospital NBHS program site visits have been completed. A hospital Self-Assessment Tool was developed and approved by the NBHSAC. The tool was distributed to hospital coordinators for completion prior to site visits; evaluation focused on programmatic data and training areas. Strengths and challenges were discussed and goals set for the next year with each hospital program. A written report of the site visit was provided to each coordinator, managing audiologist, and hospital administrator.

The first hospital upgraded to Hi*Track Web in July 2012 with over half of hospitals web-enabled by June 2013, allowing more accessible and efficient data reporting. Utah EHDI implemented weekly Hi*Track reporting for all hospital programs (vs. monthly) which has positively impacted the availability of NBHS results to Medical Homes. In collaboration with the American Academy of Pediatrics (AAP) EHDI Chapter Champion, the NBHS and Hearing Loss modules for the Medical Home Portal were updated and are available at www.medicalhomeportal.org.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Utah EHDI improved the percentage of infants meeting the 3 month and 6 month national EHDI milestones (for diagnosis and intervention, respectively). | | X | | |
| 2. The Program increased collaboration with partners, including Davis County Early Head Start, Utah Hands & Voices, Maternal-Fetal Medicine Centers, Fostering Healthy Children, UofU clinics, and other organizations serving at-risk populations. | | | | X |
| 3. Utah EHDI developed and instituted the Hospital NBHS Self-Assessment Tool. | | | | X |
| 4. The Program planned and hosted regional NBHS workshops, a statewide EHDI Conference, and an intense two-day conference on infant electrophysiologic audiology testing. | | | | X |
| 5. The Program updated the NBHS and Hearing Loss modules of the Medical Home Portal. | | | | X |
| 6. The Program successfully transitioned 50% of hospital NBHS programs to Hi*Track Web, enabling more efficient and complete data entry. | | | X | |
| 7. The Program upgraded all NBHS hospitals to the latest version of Hi*Track, improving functionality and more accurate reporting capabilities. | | | | X |
| 8. Utah EHDI piloted a tele-audiology project to provide more timely NBHS diagnostic follow-up services in rural/frontier Utah and provided a presentation on this project at two national conferences. | X | | | |
| 9. Through a collaboration with CHARM, a client match between Utah's Vital Records and Hi*Track was increased to run on a weekly vs monthly basis, allowing more immediate access to all the required information necessary for tracking and reporting. | | | | X |
| 10. The Birth Certificate Alert Project was successfully re-deployed at the vital records office at the UDOH, enabling an alert letter to be generated to the family with an incomplete hearing screening at the time of their birth certificate application. | | X | | |

b. Current Activities

The Birth Certificate Alert Project is being replicated at local health departments across the state. A "Birth Certificate Alert" report is generated so that Utah EHDI's Follow-Up Coordinator can contact affected families. The Home Birth Hearing Project is continuing its expansion; three more otoacoustic emission (OAE) hearing screening units have been placed with additional lay midwives across Utah. There are currently twenty-one OAE units serving home birth lay midwives and free-standing birth centers, with some units being shared among lay midwives. A lay midwife newborn hearing screening consortium is being formed to assist with unit sharing to improve NBHS access across Utah for out-of-hospital births.

Utah EHDI is responsible for the new UCA 26-10-10 Cytomegalovirus (CMV) Public Education and Testing law. Utah NBHS protocols are continuing to be refined and improved to accommodate the needed changes that UCA 26-10-10's requires for all infants who fail two newborn hearing screenings be tested for congenital CMV infection before 21 days of age. Utah EHDI's prenatal education brochure, "Newborn Hearing Screening: What You Need to Know Before You Have Your Baby" is being distributed to maternal-fetal medicine practices across Utah. The Utah EHDI Director will be conducting three seminars at the National EHDI Conference on Utah's CMV law and its changes to NBHS, the development of a CMV data tracking module, and the partnerships required to implement such a law.

c. Plan for the Coming Year

During FY15, we will continue to focus on decreasing loss to follow-up/documentation (LTF-U/D) after failed newborn hearing screening. We will further focus these efforts by utilizing specific interventions such as quality improvement (QI) methodology to achieve measurable improvement in the number of infants who receive appropriate and timely follow-up. Utah EHDl goals will align with those of the national goal of decreasing the number of infants who is LTF-U/D following a failed hearing screening by 5% during the next year. We will work to improve the achievement of newborn hearing screening goals for families who have limited access or resources and increase the tracking and reporting capabilities for these infants. We will do this by conducting on-going analysis of programs, projects and data systems to determine barriers to follow-up and disparities to receiving care (needs and gaps) which will lead our QI efforts. The Home Birth Hearing Project will be expanded and additional referral strategies will be determined. EHDl staff will attend the National EHDl Conference to identify program improvement activities and to share LTF-U/D strategies. The capacity of both the database and web servers will be increased to better serve all users. Technical support and training will be provided. Regional NBHS program meetings will be conducted.

Continued data integration projects with CHARM will increase avenues to link health information systems and decrease infants LTF-U/D. Links with additional programs, such as USIIS (Utah Statewide Immunization Information System) will allow Utah EHDl access to the most current demographic and Medical Home information to facilitate timelier hearing follow-up, and CMV testing if necessary. Mandatory reporting fields will be added to facilitate a higher matching rate between births recorded in Hi*Track and those of Vital Records. Utah EHDl will assist families in obtaining parent to parent support and provide a Parent Notebook to all families of children diagnosed with hearing loss. The Prenatal Project will include the development of an online survey to target an expectant mother's knowledge of NBHS before and after receiving the educational brochure. The same will be done re: knowledge of CMV. Collaborations with Mother2Baby Utah and the University of Utah Maternal-Fetal Medicine department will be utilized for the dissemination of these brochures/surveys.

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 Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 9.1 | 8.3 | 5.9 | 5.9 | 7.9 |
| Annual Indicator | 6.9 | 5.9 | 7.9 | 9.0 | 9.0 |
| Numerator | 59700 | 51367 | 69600 | 80500 | 80500 |
| Denominator | 860368 | 870623 | 886110 | 892307 | 892307 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 9 | 9 | 8.5 | 8.5 | 8 |

Notes - 2013

Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2012

Denominator: IBIS Population estimates 2012

Notes - 2012

Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2012

Denominator: IBIS Population estimates 2012

Notes - 2011

Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2011

Denominator: IBIS Population estimates 2011

a. Last Year's Accomplishments

The percent of children without health insurance performance measure was not achieved. The Performance Objective was 7.6% uninsured and the Annual Indicator was 9%.

The method for collecting information on Utah's uninsured children is through the Utah Behavioral Risk Factor Surveillance System 2012 (BRFSS), a cell and landline telephone survey that measures key public health indicators.

Findings included:

- 937,784 Utah children, age's birth-18. A population increase of 5,312 in one year.
- 88,600 or 9.4% of Utah children, age birth-18 were identified as having no health insurance coverage.
- 369,500 Utah children, age's birth-18 years live below 200 percent of the poverty level making them eligible for Children's Health Insurance Program (CHIP).
- 48,200 or 13.1% of Utah's children living below 200 percent of the federal poverty level were uninsured.

Despite Efforts to improve children's health coverage through open enrollment for the CHIP program included specific targeting to promote awareness and application process to the Children's Health Insurance Program during home visits, referral by the Women's Infants and Children's program (WIC), and schools providing CHIP application information. However, Utah's proportion of uninsured children rose to 9.4% from the 7.9% reported in 2011.

A 2012 report from Georgetown University Center for Children and Families, using data from the U.S. Census Bureau, reported Utah as having one of the highest uninsured rates in the country, ranking 44th among states. Of Utah's total population, 13.2% are uninsured, with many uninsured children live in these households.

The debate of drawing on federal funds for Medicaid expansion to include families at 138% of the federal poverty level continues in Utah, creating a significant coverage gap for thousands of Utah families. With forward movement of accountable care, the way we pay providers, focusing on outcomes that make patients well and keeping them healthy, rather than payment based, which at times encourages unnecessary testing and procedures, Utahns will see improved health care coverage, access and quality. The Affordable Care Act (ACA) requires everyone to have health insurance. With Medicaid expansion, almost 200,000 Utahans would be eligible for Medicaid, significantly closing the coverage gap. As more families receive health coverage the rate of uninsured children should improve.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. With 937,784 Utah children, ages birth-18, 88,600 or 9.4 percent of Utah children, age birth -18 were identified as having no health insurance coverage | | | X | |
| 2. 48,200 or 13.1 percent of Utah's children living below 200 percent poverty level went uninsured. | | | X | |
| 3. 369,500 Utah children, age's birth-18 years live below 200% of the federal poverty level making them eligible for the Children's Health Insurance Program (CHIP). | | | X | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In 2012 the number of children insured by Medicaid increased by 3,604 with a total enrollment in February 2014 of 175,201 compared to the February 2013 enrollment of 171,597. Enrollment in CHIP decreased by 10,070. Current February 2014 enrollment of CHIP was at 25,678 compared to February 2013 CHIP enrollment of 35,748. Part of the Affordable Care Act changed how states determine eligibility for CHIP. By removing the asset test from the Medicaid program for children, many current CHIP recipients moved to Medicaid effective in January 1, 2014. Although there is a decline in CHIP recipients from the previous year, many of the children are now eligible and receiving benefits through Medicaid.

Effort was made to improve outreach measures: Increased effort was made by WIC and Home Visiting programs to expand promotion of CHIP and Medicaid. During a WIC or home visit, staff was prepared to introduce families to the application process for Medicaid or the CHIP program via language interpretation assistance.

School nurses were encouraged through emails, newsletters, telehealth webinars and conference presentations to seek out students and families that may need access to care and to provide enrollment information on the CHIP program. Schools were encouraged to have CHIP brochures in sight in their front offices for easy parent access. The responsibility for production and distribution of CHIP brochures fell to Molina Health Care who managed effective wide spread campaigns.

c. Plan for the Coming Year

Senior Health Policy Analyst, Lincoln Nehring, from Voices for Utah Children sums up the gap of Utah's uninsured children by stating, "Utah can do better. There is a lot more we can and should do to get all of Utah's children and families covered." Nehring and others involved in children's insurance coverage offer the following suggestions to improve Utah's Medicaid and CHIP coverage:

- Improve continuous coverage through use of an annual renewal process for Medicaid and CHIP coverage.
- Work to eliminate waiting periods for CHIP enrollment.

- Work to remove five-year waiting period that keeps legally-residing non-citizen children from enrolling in CHIP and Medicaid.
- Promote Medicaid Expansion or the Governor's flexible block grant plan "Healthy Utah". Without Medicaid expansion, thousands families will not have access to the ACA premium subsidies. Providing subsidies to families at the 138% of the federal poverty rate would improve the rate of insured children.
- Work towards closing the coverage gap of uninsured parents which will have a direct impact the rate of uninsured children.

The school nurse consultant will continue to promote the distribution of CHIP materials in the school setting. Help educate and encourage school nurses to their role of coordinating linkages between the medical home, family and school, to provide families with referral information and community resources and to assist families in obtaining health insurance as needed. Planning for a 2-3 day School Nurse Summer Institute (orientation) that will provide Utah school nurses an opportunity for professional development that focuses on current school nursing practice and enforces the scope and standards of school nurse practice. Particular emphasis will be given on their role in identifying students with unmet health needs and assessing the need to access a primary care provider and/or health insurance. Continue with school nurse telehealth educational opportunities and promoting awareness of the CHIP and Medicaid programs for children.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 21.8 | 21.8 | 20.7 | 20.7 | 19.1 |
| Annual Indicator | 21.8 | 20.7 | 20.7 | 19.3 | 24.7 |
| Numerator | 6558 | 7083 | 7083 | 9967 | 11753 |
| Denominator | 30083 | 34217 | 34217 | 51735 | 47644 |
| Data Source | See footnote for source | See footnote | See footnote | See Footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 24.6 | 24 | 24 | 23.6 | 23.6 |

Notes - 2013

WIC SharePoint Ad Hoc Report Child Participation Count, 2013 Data
(Includes infants and 1 year olds at risk in the measure with 2 - 5 year olds)

* CDC no longer provides the data on this measure.

Notes - 2012

WIC SharePoint Ad Hoc Report Child Participation Count, 2012 Data
(Includes infants and 1 year olds at risk in the measure with 2 - 5 year olds)

* CDC no longer provides the data on this measure.

Notes - 2011

The data are from the 2010 CDC Pediatric Nutrition Surveillance, Table 6F (combining the 85th- <95th and greater than or equal to 95th BMI categories).

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 19.1% and the Annual Indicator was 24.7%.

The Utah WIC Program continued to collaborate with the Utah State University "Food \$ense Program" also called SNAP-Ed and the Expanded Food and Nutrition Education Program (EFNEP). WIC children who were at risk of overweight or overweight were referred to these nutrition programs for Healthy Lifestyle classes. During FY 2013, more than 6,000 WIC participants received the Healthy Lifestyle classes either in the Utah WIC clinics or at a Food \$ense (SNAP-Ed) location. These classes included information about healthy eating, budgeting food dollars, becoming more physically active and choosing healthy recipes and food preparation. The class approach was interactive centering on family mealtime which allowed participants to experience cooking and setting goals to achieve healthy lifestyle changes. All of the topics were well received by the WIC participants.

The results of the 2012 Utah WIC Program Participant Satisfaction Survey were compiled and analyzed. These results indicated that 96.4% of participants rated the certification/nutrition education assessment process as excellent or good. In addition, 71.0% reported that their family now eats more fruits and vegetables since they started the WIC program. Almost 53% reported that they eat more whole grains, while 41.1% said they and their family drink fewer sodas and sweetened powder drinks. These 2012 survey results were used to update the Utah WIC Program Authorized WIC Foods booklet, effective October 2013. In this up-to-date 2013 booklet, reduced fat and natural peanut butter were allowed for the first time due to more reasonable prices. Over 3,000 lessons about WIC foods and other nutrition education topics were completed by WIC participants using the wichealth.org computer application. The most popular nutrition lessons completed were "Understanding Your Baby's Cues", "Starting Your Infant on Solid Foods and Fruits" and "Veggies Grow Healthy Kids". When WIC participants were using wichealth.org, the average amount of time spent on the site was 15.59 minutes and the average number of links visited was 3.09.

USDA Fit WIC articles were published in the monthly newsletter, WIC Wire. Fit WIC was designed to reduce the prevalence of overweight/obesity in childhood and has demonstrated positive results. The WIC Wire articles covered topics such as, Family Activities and Fitness, Starting Your Day Off Right: Breakfast Consumption, Fit WIC Kits to Increase Physically Active Playtime, Feeding Guides for Infants/Toddlers/Pre-School Children, and Eating Out and Portion Control. To accompany the Fit WIC information, Utah WIC staff revised more than 90 nutrition education resources including brochures, lesson plans, bulletin board topics and self-paced modules.

Additional training was offered to local WIC staff and included WIC 101, Communicating with Parents, Counseling Skills, Reaching Participants Through WIC, Feeding Infants, Value Enhanced Nutrition Assessment, USDA Core Nutrition Messages, MCH Life Course Webinar, Improving the Health of Communities Webinar Series, and Eat Healthy, Be Active Community Workshops. These additional trainings provided information to enhance nutrition assessments and target nutrition education, especially for the revised USDA nutrition risks for underweight, overweight, obese, short stature and low head circumference which were implemented between

October 2012 and April 2013.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Healthy Lifestyle classes were completed by more than 6,000 WIC participants. | | X | | |
| 2. Over 3,000 wichealth.org nutrition lessons were completed by WIC participants. | | X | | |
| 3. More than 90 nutrition education resources were revised. | | | | X |
| 4. The Utah WIC Program Authorized Foods List was revised. | | | | X |
| 5. Training on assessment, counseling and nutrition messages was offered. | | X | | |
| 6. Revised nutrition risks for underweight, overweight and obese were implemented. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

All WIC children at risk of overweight/overweight and obese are being referred to the Healthy Lifestyle classes offered by SNAP-Ed and EFNEP. Over 50 nutrition and breastfeeding computer enhancements are being used since July 2013. Articles on the USDA Fit WIC Program continue to be published in the Utah WIC Program newsletter entitled, WIC Wire. The World Health Organization (WHO) growth charts are currently being used and indicate how children should grow in optimal conditions with breastfeeding as the norm.

Additional training on communicating, counseling and providing healthy nutrition messages is being offered to all local WIC staff on the Utah WIC SharePoint which is a computer communication tool. Local WIC Directors are being surveyed for the "MyPlate" resources they need, as well as other nutrition education materials related to maintaining a healthy weight. Their recommendations on the USDA Final Food Rule regulations which include more fruits and vegetables for children are being implemented.

The current "Loving Support - A Journey Together Peer Counselor" training is being provided for Peer Counselors. In addition, the Utah WIC Program, in collaboration with the developers of wichealth.org, is piloting an Online Peer Counselor (OPC) application. The wichealth.org developers are conducting one-on-one conference calls with each local WIC Director to obtain their suggestions for finalizing the OPC application to meet specific local agency needs.

c. Plan for the Coming Year

The Utah WIC Program will continue to collaborate with the Utah State University Food Sense (SNAP-Ed) Program and the Expanded Food and Nutrition Education Program (EFNEP). Parents and caretakers of WIC children who are at risk of overweight/overweight or obese will be referred to these nutrition programs for Healthy Lifestyle classes. The Utah WIC Program will continue to provide MyPlate resources. Articles on the USDA Fit WIC Program which are designed to promote maintenance of a healthy weight will continue to be published in the WIC Wire. These articles will provide evidence-based strategies that can be implemented in the local WIC clinics.

The Utah WIC Program will also offer additional WIC training courses to all local WIC staff. The

new USDA Nutrition Services Standards (NSS) will be reviewed and considered as a component of management evaluations. The primary purpose of the NSS is to provide a tool for state and local WIC agencies to self-assess how well they deliver nutrition services. The NSS identify a level of quality which all state and local WIC agencies can achieve to stimulate greater accomplishment and to encourage agencies to employ continuous quality improvement. In addition, the USDA Final Food Rule regulations will be implemented. These regulations include food package revisions that better reflect current nutrition science and dietary recommendations related to less fat and more fruits, vegetables and whole grains. These food package revisions will also support long-term breastfeeding, provide a wider variety of food, accommodate cultural food preferences and better meet the nutritional needs of WIC participants.

Another resource that will be reviewed for application as an evaluation tool is GENIE which is The Guide for Effective Nutrition Interventions and Education. GENIE is a validated online checklist tool now available to help program planners and evaluators. GENIE identifies characteristics associated with strong nutrition education programs and allows a complete self-assessment of a nutrition program. It provides resources for strengthening any areas that may be missing from a program proposal. GENIE was developed through an Academy of Nutrition and Dietetics Foundation Nutrition Education Research Fellowship. GENIE will be accessed online at <http://sm.eatright.org/GENIE>.

The Utah WIC Program will continue to collaborate with the developers of wichealth.org to pilot and implement an Online Peer Counselor (OPC) program based on feedback provided by the Utah local WIC Directors. Utah WIC participants will be able to access this secure OPC computer application, enabling them to communicate instantly with Utah WIC Peer Counselors who can provide immediate support for initiation and continuation of breastfeeding. This immediate support will encourage longer breastfeeding duration rates which can potentially reduce pediatric overweight.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 4 | 3.8 | 3.5 | 3.2 | 3.2 |
| Annual Indicator | 3.6 | 3.2 | 3.3 | 3.4 | 3.4 |
| Numerator | 1936 | 1666 | 1668 | 1732 | 1732 |
| Denominator | 53894 | 52164 | 51144 | 51439 | 51439 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 3.3 | 3.2 | 3.1 | 3 | 3 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 3.2% and the Annual Indicator was 3.4%.

During 2012, the Utah Department of Health's Tobacco Prevention and Control Program (TPCP) distributed educational brochures and tobacco cessation tools via local health departments. Through TPCP funding a few local health departments (LHDs) offer one-on-one counseling to pregnant women to help them and their family members quit smoking. Most refer pregnant women to the enhanced counseling services offered through the Utah Tobacco Quit Line using a fax referral system. Enhanced services for pregnant women through the Utah Tobacco Quit Line include: additional outbound calls, all calls with the same female coach, unlimited inbound calls, text messages, postpartum coaching calls and nicotine replacement therapy with medical provider consent. During FY2013 there were 68 pregnant women that utilized Quit Line services.

During 2012, LHD staff visited private providers' offices to provide consultations regarding incorporation of tobacco cessation materials and messages into their practices. 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. With the implementation of a new computer system at WIC clinics, the Quit Line fax referral process has become more difficult. More training for WIC staff is needed to ensure that this service is being utilized to its full capacity. A few locals have also sought additional funding and resources to serve this important population group. For example, the Utah County Health Department obtained a grant to offer diaper incentives to pregnant women and their spouses/partners that quit and stay tobacco free the months following delivery.

Medicaid offered tobacco cessation to pregnant women through a variety of outreach efforts. During a pregnant woman's initial Medicaid intake, the Department of Workforce Services, the state agency in Utah tasked with determination of Medicaid eligibility, screened women regarding tobacco use. A woman with a positive screen was referred to a Medicaid Health Program Representative (HPR) who, with the consent of the woman, contacted her every six weeks throughout her pregnancy. Medicaid also covered nicotine replacement therapy when prescribed by the woman's health care provider. During FY2013 1,599 Medicaid-insured pregnant women received free counseling and prescriptions for medications to help them quit using tobacco. A total of 31.5% of participants in the TPCP-funded Medicaid program for pregnant women was able to quit using tobacco and 27.6% reduced their tobacco use.

An article on the effects of tobacco use before, during and following pregnancy was placed on the Maternal and Infant Health Program website, along with a link for health care providers to access educational materials and resources for professionals to aid women in tobacco cessation.

The Maternal and Infant Health Program analyzed Utah Vital Records birth data from 2012 and used the findings to update the IBIS indicator on third trimester smoking so that partners and stakeholders are aware of potential intervention efforts.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Tobacco Prevention and Control Program provided some LHD's funding to hold counseling sessions to help pregnant women quit smoking. However, most LHDs referred pregnant women to the counseling services offered by the Utah Tobacco Quit Line. | | | | X |
| 2. Local health department staff met with private providers' and WIC offices to provide guidance regarding bringing tobacco cessation materials and messages into their practices. | | | | X |
| 3. Pregnant women who were eligible for Medicaid, and used tobacco were referred to a Medicaid Health Program Representative (HPR) who, with consent, contacted her every six weeks throughout her pregnancy for counseling. | | X | | |
| 4. The Maternal and Infant Health Program (MIHP) updated the IBIS indicator on third trimester smoking. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The TPCP continues to promote the TRUTH Network's Quit Line fax referral system and integrate this into health systems reaching pregnant women. WIC screens all enrollees for tobacco use. WIC clinics, local health departments and private providers use the system to refer pregnant clients using tobacco to the Quit Line.

The Department of Workforce Services staff refers pregnant Medicaid applicants to HPRs for cessation support via phone calls every six weeks throughout pregnancy. In 2012, the number of Quit Line calls covered by Medicaid for pregnant clients was increased by the addition of a call postpartum to women successful in quitting or reducing tobacco use. TPCP tracks and the number of women using the Utah Tobacco Quit Line enhanced services and evaluate the effectiveness.

The MIHP analyzed 2012 Utah Vital Records birth data, which indicate that 3.37% of women smoked during the last trimester of their pregnancies. The highest rates were noted among 18-19 year-olds (6.8%) and 20-24 year-olds (5.4%). Smoking rates were higher among women who had a high school education (7.1%) or less (11.3%). There are also geographical areas of the state that have much higher rates than the state average: Tri-County (9.5%) and Southeastern (11%). Unmarried women and women with "Other" relationship status were more likely to smoke (10.6% and 17.1%, respectively) in the last three months. These data were used to update and publish the IBIS indicator on third trimester smoking.

c. Plan for the Coming Year

During 2014 the Tobacco Prevention and Control Program (TPCP) will change the name of the Truth Network Tobacco Cessation Program to Way to Quit. The Way to Quit program will be used 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.

The Department of Workforce Services, the state agency responsible for Medicaid enrollment, 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 client via phone every six weeks during her pregnancy to support the client's 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. Additionally, TPCP will educate LHDs on what Medicaid and the Quitline offer for pregnant women, so they may disseminate this information to their local health care providers and other organizations.

The Maternal and Infant Health Program will maintain the article on tobacco use during the perinatal period along with the link for health care providers to cessation resources for professionals on their website. 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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 10.6 | 11 | 12.1 | 11.4 | 10.8 |
| Annual Indicator | 12.1 | 11.4 | 10.8 | 16.4 | 16.4 |
| Numerator | 26 | 25 | 24 | 36 | 36 |
| Denominator | 215470 | 219146 | 221712 | 218983 | 218983 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 16.4 | 16.4 | 16.3 | 16.2 | 16 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2012

Denominator: IBIS Population estimates for 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2012
Denominator: IBIS Population estimates for 2012

Notes - 2011

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2010
Denominator: IBIS Population estimates for 2010 (GOPB).

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 10.8 and the Annual Indicator was 16.44.

The Violence and Injury Prevention Program (VIPP) continued to conduct surveillance on Utah suicides (suicide fatalities, suicide emergency room visits, and suicide hospitalizations) and provide data and analysis expertise to partners and the media. VIPP developed five suicide fact sheets and two suicide infographics in FY2013. VIPP made presentations to Utah's Governor on the issue of youth suicide, in conjunction with the Department of Human Services and Utah State Office of Education. VIPP was heavily involved in providing expertise, background information, data, and fiscal impact of suicide-related legislation and provided weekly updates on proposed legislation to partners and state agencies during the general legislative session. VIPP staff was also invited to attend a meeting sponsored by the National Conference of State Legislators and the Safe States Alliance which brought together injury experts (VIPP), state health department directors, and legislators to discuss policies that could decrease the rates of injury (for Utah, specifically these were suicides, dating violence, motor vehicle crashes, and prescription drug overdoses) in their respective states. VIPP also developed a suicide policy agenda, which was then adopted by the local health departments and included in a statewide policy agenda for public health.

VIPP staff participated on the Utah Suicide Prevention Coalition, serving as co-chairs for several committees. VIPP played an integral role in the development and now implementation of the Utah Suicide Prevention Plan and in bringing the Utah Suicide Prevention Coalition together. VIPP has provided technical assistance and expertise to the Utah Department of Human Services on many of the suicide prevention efforts in the state. In 2013, the Utah Legislature provided funding for two Suicide Prevention Coordinators, one at the Department of Human Services and one at the Utah State Office of Education.

VIPP facilitated the state Child Fatality Review Committee (CFRC). The CFRC reviews all child deaths under age 18 in the state. In-depth reviews are done for suspicious cases. The CFRC has seen an increase in the number of suicide deaths reviewed in recent years, as evident by the increasing suicide rate and number of high school students reporting they have had suicidal thoughts. Utah has one of the highest suicide rates in the nation, for all ages.

VIPP responded to 27 media requests on suicide in FY13 and continued to serve as a primary source of data on suicides across the lifespan. VIPP has noticed an increased in the number of media requests for data and interviews on suicide in the past year. One of Utah's largest T.V. news stations dedicated an entire 30 minute newscast to the issue of suicide, which has helped spark conversation by many on suicide prevention.

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. Hope 4 Utah continues to expand in communities across the state, forming Hope Squads in schools. Hope Squads are a school-based, peer-to-peer training and support program that also includes school staff and administration training in prevention and intervention procedures. To date, more than 18,000 Utahns have been educated about Hope 4 Utah's mission, 37 Hope Squads have been formed,

1,700 volunteers are working with Hope 4 Utah, and 87 students have been referred for help due to suicidal risks.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. VIPP co-chaired the Utah Suicide Prevention Coalition and several of its subcommittees. | | | | X |
| 2. VIPP facilitated the Child Fatality Review Committee (CFRC) which reviews all child deaths under age 18 in the state, including youth suicides. | | | | X |
| 3. VIPP provided surveillance, data, and policy expertise to partners and legislators on suicide issues. This included presentations to the Governor and Legislature; development of 5 suicide fact sheets and 2 infographics; and dozens of interviews. | | | | X |
| 4. The Hope 4 Utah program continued to expand, forming 37 Hope Squads in local schools and referring 87 students at risk for suicide to services. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Violence and Injury Prevention Program (VIPP) continues to conduct surveillance on suicides, utilizing the National Violent Death Reporting System, Youth Risk Behavior Surveillance Survey, Indicator Based Information System for Public Health (IBIS-PH), and Child Fatality Databases in this process. VIPP also participated in the development of a plan to prevent suicide among youth ages 15 to 19, the Utah Suicide Prevention Plan, and remained actively involved in the Utah Suicide Prevention Coalition. Three new fact sheets (with three more planned for FY2014) on suicide across the lifespan (youth, young adult, and men) were produced and disseminated. VIPP has responded to 16 media requests on suicide prevention or suicide-related data in FY2014. VIPP has seen an increasing interest in suicide prevention among the media and policymakers. VIPP and Department of Human Services Division of Substance Abuse and Mental Health staff gave several presentations on suicide prevention to local school districts, community groups, and policymakers. VIPP has also begun to utilize social media more to provide education on current trends, circumstances surrounding suicides, and prevention tips. VIPP provided funding to each of the 12 LHDs to have a minimum of one staff person or one community member from their area trained in the evidence-based suicide prevention program, QPR (Question Persuade Refer). To date, 10 LHD staff have become certified QPR Trainers.

c. Plan for the Coming Year

VIPP will stay actively involved on the Utah Suicide Prevention Coalition and provide support to the Suicide Prevention Coordinator at the Division of Substance Abuse and Mental Health in the Department of Human Services. VIPP will also participate on the policy subcommittee of the Coalition. VIPP will continue to provide surveillance, data collection, analysis and fact sheet publication and dissemination to community partners, the media, and policymakers. VIPP will utilize the National Violent Death Reporting System, Child Fatality Database, Youth Risk Behavior Surveillance Survey, and IBIS-PH for surveillance and data collection.

VIPP will continue to facilitate the Child Fatality Review Committee (CFRC) which conducts reviews of all child deaths under age 18 in the state. All youth suicides are reviewed in-depth by the CFRC. Recommendations for policy and system changes, education, and interventions are given annually by the CFRC to prevent future deaths.

Many of Utah's 12 local health departments (LHDs) have recognized the growing problem of suicide in their communities. VIPP staff has worked closely with the LHDs to develop activities in their contracts that address youth suicide. Examples of activities the LHDs will undertake in FY15 include participating on their local prevention coalitions, holding youth prevention summits, including suicide as a priority area in community assessments, working with Utah's Native American tribes, promoting the National Suicide Prevention Lifeline, engaging community leaders, utilizing local media to di-stigmatize mental illnesses and suicide, and teaching the evidence-based QPR (Question Persuade Refer) program in their areas.

VIPP will continue efforts to reduce youth suicide, but the extent of involvement will be dependent on resources. VIPP will remain actively involved in the Utah Suicide Prevention Coalition and co-chair the policy subcommittee of the Coalition.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 81 | 82 | 80.5 | 90 | 90.2 |
| Annual Indicator | 78.3 | 89.8 | 90.1 | 91.8 | 91.8 |
| Numerator | 440 | 520 | 499 | 505 | 505 |
| Denominator | 562 | 579 | 554 | 550 | 550 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 91.8 | 91.9 | 92 | 92 | 92 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
 Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 10 self-designated level III hospitals.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 90.2% and the Annual Indicator was 91.8%.

The Healthy People 2020 Target for this objective is 83.7%. Utah had a total of 550 very low birth weight infants (VLBW) in 2012 (latest year for which data are available) with 505 of these infants being born in one of the ten self-designated Level III facilities.

UDOH staff from the Maternal and Infant Health Program and the Neonatal Follow-up Program collaborated to develop and implement the Premie Facts survey to gather information from parents on their experiences with the NICU facilities that cared for their infants after birth. The purpose of the survey was to secure better understanding of parental knowledge regarding NICU services. Parents of children born prematurely who had been invited to enroll in the Neonatal Follow-up Program at the Utah Department of Health participated in the survey. The survey response rate was almost 50%. Information about how families chose the hospital of delivery, how much education they received regarding the reduction of future preterm births and how happy they were with their care providers will be useful for program planning.

The Utah Department of Health's MCH Bureau, the Utah Chapter of the March of Dimes, the University of Utah Health Sciences Center and the Intermountain Healthcare developed the Utah Women and Newborns Quality Improvement Collaborative (UWNQC). UWNQC consists of over 50 members. UWNQC is a multi-stakeholder network comprised of neonatal and perinatal partners from Utah's ten self-designated Level III NICUs as well as members from pertinent professional organizations and third party payers. UWNQC met quarterly to develop a quality improvement framework utilizing facility specific morbidity and care data to work toward quality improvement in neonatal and perinatal care in Utah.

Draft Guidelines for Neonatal Care based on the Seventh edition of the AAP/ACOG Guidelines for Perinatal Care have been developed and will be reviewed by the neonatal subcommittee of the UWNQC for adoption.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. MCH developed and implemented the Preemie Facts survey to gather information from parents on their experiences with the NICU facilities that cared for their infants after birth. | | | | X |
| 2. MCH developed the Utah Women and Newborns Quality Improvement Collaborative (UWNQC), a network comprised of partners from Utah's ten self-designated Level III NICUs and members from pertinent professional organizations and third party payers. | | | | X |
| 3. The task of UWNQC was to develop a quality improvement framework utilizing facility specific morbidity and care data to work toward quality improvement in neonatal and perinatal care in Utah. | | | | X |

| | | | | |
|---------------------------------------------------------------------------------------------------------------------------------|--|--|--|---|
| 4. MCH developed draft Guidelines for Neonatal Care based on the Seventh edition of the AAP/ACOG Guidelines for Perinatal Care. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

UWNQC has been meeting quarterly to develop a quality improvement framework utilizing facility specific morbidity and care data to work toward implementing quality improvement projects in neonatal and perinatal care in Utah.

The first neonatal QI project has been identified and will be centered on the issue of Neonatal Abstinence Syndrome management. The University of Utah and Intermountain Healthcare have just completed a standardized approach to education of staff and management of these babies. A similar QI project is in process for 2014 by the Ohio Perinatal Quality Collaborative, with quite an extensive set of resources including data sharing agreements and data collection tools that Utah will be able to replicate.

The UWNQC maternal subcommittee has yet to decide on their first QI project, there is general agreement that the topic should be focused on the reduction of preterm births.

A new Utah Administrative rule to mandate reporting of VLBW morbidities is in its final stages of development.

c. Plan for the Coming Year

The Utah Women and Newborns Quality Collaborative (UWNQC) will continue to meet quarterly to develop and implement a quality improvement framework utilizing facility specific morbidity and care data to implement quality improvement projects in neonatal and perinatal care in Utah. It is expected that through the learning collaborative nature of this work, care and treatment of VLBW infants in Utah will improve.

The Maternal and Child Health Bureau will continue to monitor trends in perinatal regionalization. Once adopted, the Utah Guidelines for Neonatal/Perinatal Care will be implemented. The VLBW infant morbidity reporting rule, if adopted, will require all hospitals that admit and care for VLBW infants to report severe morbidities to the UDOH. The data will be compiled and utilized for learning purposes among the ten self-designated level III facilities that participate in UWNQC.

Another requirement of the administrative rule is for hospitals to submit to the MCH Bureau data that can be used to assess whether the hospital is self-designating appropriately and in accordance with the published ACOG/AAP Guidelines for Perinatal Care (7th ed).

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------|------|------|------|------|------|
|---------------------------------------|------|------|------|------|------|

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 79 | 79.1 | 71.7 | 73.1 | 74.9 |
| Annual Indicator | 71.6 | 73.1 | 74.7 | 75.5 | 75.5 |
| Numerator | 38562 | 38124 | 38228 | 38829 | 38829 |
| Denominator | 53894 | 52164 | 51144 | 51439 | 51439 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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 |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 75.7 | 75.9 | 76.1 | 76.3 | 76.5 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2011

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments

The performance measure was achieved during 2013. The Annual Performance Objective was 74.9 % and the Annual Indicator was 75.5% in FY 2013.

Using data from the past three years collected by the revised birth certificate we are able to see improvement in the number of Utah resident mothers entering into prenatal care during the first trimester of pregnancy. The 2013 indicator is up from 74.9% in FY2012.

During FY13, Baby Your Baby (BYB) applications were submitted via paper and Utah Clicks, an online application system that permits women and families to apply for BYB and services from Baby Watch, Children with Special Health Care Needs, Early Head Start and Head Start. In FY13, 4,881 applications were submitted to BYB via Utah Clicks compared to the 4,744 from FY12.

The Maternal and Infant Health Program (MIHP) continued to support "Text4Baby", a campaign sponsored by the National Healthy Mothers, Healthy/Babies Coalition. BYB began placing "Text4Baby" information in all Keepsake booklet mailings. Utah has 3,718 mothers enrolled into the "Text4Baby" Program. However, Utah's enrollment rates continue to be among the lowest in the nation.

MIHP participated on the Office of Health Disparities Reduction's Birth Outcomes Advisory Board to support development of culturally appropriate health brochures and videos for Latino, Pacific Islander and African American communities. The videos encourage early prenatal care, folic acid, healthy diets and weight and are linked on the MIHP website. There are clear disparities in early

entry into prenatal care in these populations. Only 59.8% of African American mothers reported entering prenatal care in the first trimester (Utah Vital Records, 2012). There is a positive trend for Hispanic women entering into early prenatal care reaching 65.2% in 2012, up from 60.2% in 2010.

The Maternal and Child Health Bureau provided funding to support the Salt Lake Community Health Centers, Inc. in providing early and continuous prenatal care for under and uninsured women in their clinics throughout Salt Lake County.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Baby Your Baby (BYB) applications were submitted via paper and electronically through the Utah Clicks system. | | X | | |
| 2. The Maternal and Infant Health Program (MIHP) continued supporting the "Text4Baby" Program. Information about the campaign was placed in all Keepsake booklet mailings done by Baby Your Baby. | | | X | |
| 3. The Maternal and Child Health Bureau provided funding to support the Salt Lake Community Health Centers, Inc. in providing early and ongoing prenatal care for under and uninsured women throughout Salt Lake County. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The MIHP is educating local health departments, community health centers, hospitals and other appropriate agencies about BYB and the national "Text4Baby" campaign. The MIHP will continue to provide funding for under/uninsured women seeking prenatal care via the Salt Lake Community Health Centers, Inc.

BYB and our partners at Intermountain have launched a new media campaign which involves weekly segments on KUTV beginning in March of 2013 to discuss pregnancy and prenatal care. They also share presence with the highly successful Intermountain Moms Facebook, Twitter, Pinterest, and the Intermountain Moms Blog.

UDOH is sponsoring the Utah Bees baseball team and BYB information will be announced over the PA and in the programs at several home games.

BYB is also partnering with Broadway Media to conduct radio segments and advertisements on pregnancy stories for five different stations in Utah.

c. Plan for the Coming Year

The MIHP will continue to assess its role in the ensuring access to prenatal care through Medicaid, Community Health Centers (CHC), and connecting individuals to available resources. With changes required by the Affordable Care Act in 2014, the income level to qualify for prenatal

Medicaid was raised to 138% and the asset test for pregnant women was eliminated. In addition, prenatal care should now be offered without cost sharing for women with private insurance. We hope that these changes will have a positive impact on early prenatal care entry in the future. The MIHP will work on helping potential mothers navigate the Affordable Care Act (ACA) as it rolls out.

The MIHP will continue to track reasons for late prenatal care entry and disparities in early entry to prenatal care using Utah PRAMS data. Using results, messages will be developed to increase the awareness of the importance of early and continuous prenatal care and a "PRAMS Perspectives" report will be created for moms and providers.

BYB plans to continue to promote its services and accept applications via phone and online. "Text4Baby" will be actively promoted on social media outlets such as Facebook and Twitter alongside "Power Your Life" and the national preconception campaign that will launch in October 2013.

The Pregnancy Risk Line (MotherToBaby) will include questions regarding timing of entry into prenatal care, percent of callers with insurance coverage and caller's level of education.

The MIHP will continue to provide funding for under/uninsured women seeking prenatal care via the Salt Lake Community Health Centers, Inc. as resources allow.

Throughout FY14 commercials encouraging women to seek early and adequate prenatal care will continue on KUTV (CBS) as well as on all Broadway Media radio stations. KUTV will continue to air its 2 -minute segments and news stories featuring information that pregnant women need to know to have a healthy pregnancy. During FY14 we are hoping to add additional stories in all newscasts with information on prenatal care and pregnancy. Although the rates of early entrance into prenatal care are improving, differences among population groups exist. Women under 25 years of age are significantly less likely to enter into prenatal care during their first trimester. During the FY2014 UDOH and MIHP will initiate campaigns focusing on these younger women.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 38 | 37.6 | 37.7 |
| Annual Indicator | | 37.6 | 37.6 | 39.0 | 39.0 |
| Numerator | | 52274 | 52274 | 210880 | 210880 |
| Denominator | | 138948 | 138948 | 541138 | 541138 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 38.9 | 39 | 39.2 | 39.4 | 39.6 |

Notes - 2013

Data based on Utah Behavioral Risk Factor Surveillance System, 2012
(This question only asked even year, N & D represents weighted numbers)

Notes - 2012

Data based on Utah Behavioral Risk Factor Surveillance System, 2012
(This question only asked even year, N & D represents weighted numbers)

Notes - 2011

Data based on Utah Behavioral Risk Factor Surveillance System, 2010
Utah BRFSS 2012 data are not yet available

a. Last Year's Accomplishments

The performance measure was met. The annual performance objective was 37.7%, and the annual indicator was 39.0%.

The Utah Birth Defect Network (UBDN) continued monitoring the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Neural tube defects (NTDs) are monitored closely since congenital malformations are responsive to public health intervention with folic acid. From 1994 through 2010, 615 (7.5 per 10,000 births) affected cases occurred in Utah.

In the spring of 2013, the UBDN requested that the folic acid module be included on the 2014 BRFSS statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

Birth Defect Prevention Month 2013 theme was "Birth Defects are Common, Costly, and Critical". The UBDN was a major contributor to the success of the month's activities Nationally and Internationally, as we created a PSA with the theme of "Birth defects affect us all. What effect will you have on birth defects?". View the PSA at www.youtube.com/NBDPN. UBDN working with many agencies disseminated over 4000 bottles of vitamins.

The UBDN in conjunction with the Power Your Life (PYL) campaign attended the Utah Bees baseball game and handed out over 200 Power bags which included a 3 month supply of multivitamins and Power Your Life magazine for women childbearing age.

More than 3000 non-pregnant and breastfeeding women called the Pregnancy Risk Line's MotherToBaby (PRL/MTB) program. Almost 25% were asked about multivitamin with folic acid. Those callers not consuming a vitamin with folic acid were educated on the importance of the vitamin.

Facebook and Twitter messages continued to be posted on the importance of taking folic acid for women of childbearing age. Message sent: Got #FolicAcid? Taking a multivitamin with 400 mcg of folic acid right now protects your future babies.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. UBDN monitored the occurrence of neural tube defects. | | | X | |
| 2. UBDN promoted Birth Defect Prevention Month and Folic Acid Awareness week. | | | X | |
| 3. MTB reached more non-pregnant and breastfeeding callers who were counseled regarding folic acid. | | | X | |

| | | | | |
|------------------------------------------------------------------------------------------------------------------------------------|--|--|---|--|
| 4. UBDN and MTB incorporated use of social media to promote folic acid use and promoted the use of folic acid at community events. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The tracking of neural tube defect (NTDs) occurrence is crucial in planning, carrying out, and assessing folic acid programs to reduce preventable cases. From 1994 through 2011, 647 (7.4 per 10,000 births) affected cases occurred in Utah.

In January the 2014 BRFSS statewide telephone survey queries women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

Birth Defect Prevention Month 2014 theme was "Every 4 & 1/2 minutes a baby is born with a birth defect". The UBDN worked with CDC, MOD, and NBDPN to promote birth defect awareness and prevention. Read more at <http://www.nbdpn.org/bdpm2014.php>

MTB program continues to counsel non-pregnant and breastfeeding callers regarding the importance of taking folic acid prior to conception and continues to distribute folic acid outreach materials at health fairs and conferences. To stay current on published research, MTB is reviewing articles on vitamin efficacy and safety during its weekly Seminar.

MTB continues to post messages on the importance of taking folic acid for women of childbearing age. The UBDN works with other programs such as March of Dimes, Power Your Life (PYL), and local health departments using their social media channels to get messages out about birth defects and prevention. As a result of those efforts, CDC reported that several Utah social media channels ranked high on their #1in33 trending list during January's birth defect prevention month.

c. Plan for the Coming Year

The Utah Birth Defect Network 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 Utah Birth Defect Network will make the request for the folic acid question to be put on the 2016 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 for 2015.

Pregnancy Risk Line's MotherToBaby (MTB) program will continue to counsel non-pregnant and breastfeeding MTB callers regarding the importance of taking folic acid prior to conception. MTB program also plans to attend additional health fairs and conferences throughout Utah distributing folic acid outreach materials.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 17 | 17 | 16.9 |
| Annual Indicator | 17.8 | 17.6 | 16.9 | 17.1 | 17.1 |
| Numerator | 2695 | 2566 | 2410 | 2463 | 2463 |
| Denominator | 15150 | 14581 | 14244 | 14435 | 14435 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 17 | 16.9 | 16.9 | 16.8 | 16.8 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2011

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments

This performance measure was not met. The annual performance objective was 16.9%, and the annual indicator was 17.1%.

The Maternal and Infant Health Program (MIHP) continued to track the number of primary cesarean deliveries to low risk women giving birth for the first time, since a number of experts have recommended decreasing this category of cesarean sections to more rapidly impact the overall number of cesarean births in this country. It was the intent of the MIHP to author a report on primary cesarean sections; however, inaccuracies on the birth certificate were discovered during this analysis. We found that data for number of previous cesarean sections was not being recorded appropriately. This field is necessary to determine if a cesarean was primary or repeat. Staff met with Vital Records staff and the MCH epidemiologist to determine the programming changes needed to correct the system and increase data accuracy.

MIHP continued to collect data from PRAMS (Pregnancy Risk Assessment Monitoring System) surveys on delivery type and reasons for cesarean delivery. The MIHP authored a two page brief on primary cesarean delivery, using PRAMS data, for the Department's Utah Health Status Update. Two of the largest contributors to primary cesarean sections were labor taking too long and failed induction.

The IBIS-PH indicator on cesarean birth was updated during FY2013.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Maternal and Infant Health Program (MIHP) identified problems with how cesarean section data was being collected on the revised birth certificate. Corrections to the Vital Records data entry system were developed. | | | | X |
| 2. The MIHP published a two page brief on reasons for primary cesarean delivery using Utah PRAMS data. | | | | X |
| 3. The IBIS-PH indicator on cesarean birth was updated during FY2013. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

A programming fix was implemented to the data entry system for birth certificates. This coding change will no longer allow birth certificate clerks to leave the field for number of previous cesarean sections blank if the method of delivery was a cesarean. These changes will be reflected with the 2014 births.

As PRAMS data found that labor induction was a contributing factor to primary cesarean section, rates of elective labor induction are being tracked through birth certificate and PRAMS data. Due to staff shortages in MIHP, a PRAMS Perspective report on reasons for labor induction has not been undertaken.

The first two meetings of the Utah Women and Newborn Quality Collaborative (UWNQC) have been held. The Collaborative is a statewide, multi-stakeholder network dedicated to improving perinatal outcomes. Five subcommittees address neonatal issues, maternal morbidity and mortality, data collection and reporting, funding sources for UWNQC, and out-of-hospital birth. The mission for the group is to improve maternal and neonatal outcomes through collaborative efforts centered on quality improvement methodology and data sharing. Proposed projects focus on prematurity prevention and reductions of elective induction.

c. Plan for the Coming Year

MIHP will continue to evaluate the rate of primary and repeat cesarean birth, based upon the fix to the Vital Records system. We will observe the difference in numbers since implementation of the birth certificate programming changes on 1/1/2014. If the data are more reassuring, MIHP is planning a report on cesarean births in the state.

MIHP will continue to collect data from PRAMS surveys and compare these data with birth certificate data for reasons for primary cesareans. MIHP will also look at PRAMS data on reasons given for cesarean birth and the contribution of labor induction to primary cesarean birth.

Finally, MIHP will continue its support of and participation in the UWNQC and offer input on numbers of cesarean births and other issues relevant to this topic.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 9.7 | 9.7 | 9.4 |
| Annual Indicator | 9.8 | 9.5 | 9.4 | 9.1 | 9.1 |
| Numerator | 5272 | 4957 | 4830 | 4692 | 4692 |
| Denominator | 53894 | 52164 | 51144 | 51439 | 51439 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 9.1 | 8.9 | 8.8 | 8.5 | 8.3 |

Notes - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Notes - 2011

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 9.4% and the Annual Indicator was 9.1%.

Utah continues to rank better than the nation as a whole for preterm births. While as a state we are currently below the Healthy People 2020 goal of 11.4% for preterm births, subpopulations in Utah have higher rates. In 2012, Utah women of Pacific Islander descent had a preterm birth rate of 10.9%, Black women had a rate of 11.3% and Asian women 10.7%. In addition, women who were enrolled in Medicaid during their pregnancy, which can be used as a proxy for SES, had a preterm birth rate of 9.8%. Another common risk factor for preterm birth is maternal age. In 2012, the highest rates of premature birth were found in women ages 35 and older (12%). A focus on these highest risk groups will help Utah to decrease our overall preterm birth rates and improve pregnancy outcomes.

The Maternal and Infant Health Program (MIHP) continued to educate providers and women at risk for recurrent preterm birth on the use of 17 alpha hydroxyprogesterone. Downloadable educational materials were made available on our website for distribution and are also shared with local health departments and other community partners on request.

The MIHP brochure on the danger signs of pregnancy, geared towards helping women understand the signs and symptoms of preterm labor or other complications, was also downloadable on our website and shared with community partners on request.

Utah committed to joining the Association of State and Territorial Health Officers (ASTHO) and

the March of Dimes (MOD) challenge to reduce our preterm birth (PTB) rate by 8% by 2014 using our 2009 rate as a baseline. Utah's PTB goal for 2014 is 8.9%.

In November 2012, the UDOH partnered with the MOD to hold a Prematurity Symposium. There were four goals for the symposium: Encourage collaboration for the prevention of PTB, raise awareness of the scope of the problem, identify specific characteristics and consequences associated with PTB, and identify the areas of focus and make recommendations for interventions. Day two of the symposium gathered key stakeholders to develop actionable recommendations for PTB reduction. The four strategies identified were: 1) Optimization of inter-pregnancy interval, 2) Early identification and treatment of high-risk pregnant women, 3) Increasing the use of progesterone supplementation during high risk for PTB pregnancies to reduce recurrent PTBs, and 4) Increasing single embryo transfers for in vitro fertilization to reduce selective multiple gestations and resultant PTBs. A Utah Health Status Update was published in February 2013 outlining the ASTHO challenge and the recommendations from the Prematurity Symposium.

An article titled "Reducing Utah Medicaid Costs for Preterm Birth" was written and published in the April edition of the "Utah Health Status Update" publication.

The MCH Bureau surveyed parents of NICU graduates to assess their knowledge around PTB recurrence and provider education they received around prevention of future PTBs. Surveys were sent to 504 families with a response rate of 50%.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The MIHP continued to educate providers and women at risk for recurrent preterm birth on the use of 17 alpha hydroxyprogesterone. | | | X | |
| 2. The MIHP continued to make available a brochure on the danger signs of pregnancy, geared towards helping women understand the signs and symptoms of preterm labor or other complications. | | | X | |
| 3. Utah committed to joining the Association of State and Territorial Health Officers (ASTHO) and the March of Dimes (MOD) challenge to reduce Utah's prematurity rate to 8.9% by the end of 2014. | | | X | |
| 4. The UDOH of Health and March of Dimes sponsored a prematurity summit in November 2012. At this meeting four strategies were developed to reduce Utah's prematurity rate. Recommendations were published on the MIHP's website. | | | | X |
| 5. The MCH Bureau surveyed parents of NICU graduates to assess their knowledge about PTB recurrence and provider education they received about prevention of future PTBs. | | | X | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Utah Department of Health strategic plan has a goal for being the "Healthiest People-The people of Utah will be the healthiest in the country." One of the key strategies under this goal is to

"focus efforts on women to achieve healthier pregnancies and births". To accomplish this, we continue to promote optimal health among reproductive aged women by promoting the "Power Your Life" social media campaign to promote healthy lifestyles and adequate birth spacing. The MIHP produced a report on preconception health, incorporating the core preconception health indicators. A second summit on prematurity prevention, sponsored by the UDOH and the MOD, was held in October 2013, with a focus on preconception/interconception care to prevent PTB.

Work continues on the formation of the Utah Women and Newborn's Quality Collaborative (UWNQC) to improve perinatal and neonatal service quality in Utah. The UWNQC is a statewide, multi-stakeholder network dedicated to improving perinatal outcomes in Utah. Areas of focus will be determined by membership; however quality improvement projects related to PTBs will be among the top priorities.

The MIHP and Vital Records partnered with faculty from the University of Utah to conduct a study to validate specific data elements on the birth certificates of preterm infants and assess the feasibility of collecting additional data for a new PTB classification system. Chart reviews are complete and pending analysis.

c. Plan for the Coming Year

Utah will continue to work on our commitment to the Association of State and Territorial Health Officers (ASTHO) to reduce preterm birth (PTB).

The MIHP will continue to promote optimal preconception/interconception health among reproductive aged women. The MIHP will continue to promote the "Power Your Life" social media campaign to promote healthy lifestyles and adequate birth spacing. As part of the campaign, Facebook and Pinterest pages will continue to educate women and plans to increase the reach of these social media platforms will be developed.

A third summit on prematurity prevention, sponsored by the UDOH and the MOD, is planned for October 2014. The focus of the symposium will be on emerging topics around preterm birth.

The Utah Department of Health will continue to participate in the Utah Women and Newborn's Quality Collaborative (UWNQC). The focus of the perinatal subgroup will be on educating women on recurrent preterm birth.

The MIHP and Vital Records partnered with faculty from the University of Utah to conduct a study to validate specific data elements on the birth certificates of preterm infants and assess the feasibility of collecting additional data for a new PTB classification system. Analysis of completed chart reviews will be conducted and findings disseminated.

As there are disparities in preterm birth and infant mortality by maternal race, the Office of Health Disparities Reduction (OHD) conducted interviews with African American and Pacific Islander women who had a preterm infant, or a fetal or infant death. The OHD will qualitatively analyze these interviews and publish their findings. These results will help both the OHD and MIHP to target interventions among these vulnerable populations.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------|------|------|------|------|------|
|----------------------|------|------|------|------|------|

| Performance Data | | | | | |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 39 | 37.2 | 39.5 |
| Annual Indicator | | 37.5 | 37.2 | 39.1 | 40.1 |
| Numerator | | 32945 | 33907 | 35396 | 34858 |
| Denominator | | 87885 | 91229 | 90431 | 86978 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 40.2 | 40.3 | 40.5 | 42 | 42 |

Notes - 2013

Numerator: Medicaid CMS 416, FFY2013
Denominator: Medicaid CMS 416, FFY2013

Notes - 2012

Numerator: Medicaid CMS 416, FFY2012
Denominator: Medicaid CMS 416, FFY2012

Notes - 2011

Numerator: Medicaid CMS 416, FFY2011
Denominator: Medicaid CMS 416, FFY2011

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 39.5% and the Annual Indicator was 40.1%.

The Oral Health Program (OHP) worked closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. We continued to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. Oral health education materials were posted on the OHP website and are being promoted.

The OHP collaborated with staff in Medicaid to expand current EPDST/CHEC outreach programs and promote the CHEC dental case management system. In addition, the OHP worked 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 continued 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.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------|------------|-----------|
| | DHC | ES | PBS | IB |
| 1. The OHP worked with Medicaid staff in training pediatricians and other health care providers in performing oral health risk assessments and fluoride varnish applications for children as an enhanced benefit procedure during well child exams. | | | | X |
| 2. The OHP continued to work closely with the UDA and the | | | | X |

| | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 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 eliminating barriers. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Oral Health Program (OHP) is working closely with the Utah Oral Health Coalition (UOHC) to improve access to dental services and in the development of public awareness campaigns. The UOHC will be holding a retreat of its members to discuss future priorities and strategies to improve oral health. The OHP continues to provide statewide training and education to all twelve Head Start Programs. Training and education are also given to WIC and LHD staff. We continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. Educational 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 is also working with Medicaid staff to address dental provider concerns regarding the two new Accountable Care Organizations for dental care which are Delta Dental and Premier Access. These plans are managing most of the dental Medicaid claims for Salt Lake, Davis, Weber and Utah counties.

The OHP continues to work closely with the UDA and the UOHC to increase the number of dentists willing to see Medicaid patients.

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 posted on the OHP website will be updated and further promoted.

The OHP will collaborate with staff in Medicaid to expand current EPDST/CHEC outreach programs to promote the CHEC dental case management. 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 continue to collaborate with Medicaid staff to address concerns that dental providers have working with the two new Accountable Care Organizations which are Delta Dental and Premier Access.

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.

The OHP will trend utilization data from the Medicaid 416 report to help identify counties and local health departments which may need additional technical assistance to address access to dental care for children. The OHP will continue to work with Head Start and WIC programs for training

and education this year. The OHP will continue to 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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 0 | 0 | 70.2 |
| Annual Indicator | | | | 70.2 | 70.2 |
| Numerator | | | | 80 | 80 |
| Denominator | | | | 114 | 114 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 70.2 | 70.2 | 70.2 | 72 | 72 |

Notes - 2013

Utah Developmental Screening Survey 2012-2013

Notes - 2012

Utah Developmental Screening Survey 2012-2013

Notes - 2011

State will be implementing a developmental screening survey during summer, CY 2012. Based on the survey results, projections will be set in future for this measure.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 70.2% and the Annual Indicator was 70.2%.

A survey was developed and distributed to pediatric and family practices that provide well child care for children birth to 6 years to determine their awareness of existing policies and the use of standardized developmental screening tools. Utah Medicaid continued to bundle the well child check and developmental screening codes. Survey questions were developed to assess if unbundling these codes would change primary care providers' current method of providing developmental screening.

The state's ECCS grant provided funding to the Help Me Grow Utah (HMGU) program which implemented the first phase of its statewide expansion plan with outreach into Salt Lake County. The DFHP Medical Director was the Pediatric Champion for this expansion. Help Me Grow Utah is a resource and referral program that has been successful in creating an integrated child and family referral service. The Program incorporated the use of the ASQ (Ages and Stages Questionnaire), a standardized developmental screening tool, with families. Help Me Grow Utah distributes ASQs to all parents of young children who enroll in the HMGU program. HMGU helped parents score the questionnaire and shared the results with the child's medical homes.

Help Me Grow Utah connected more than 1300 families to over 800 resources and has

administered 1573 ASQs in the previous three years. As a result of HMGU's expansion activities, to date, over 200 families were enrolled in HMGU in Salt Lake County. The Help Me Grow Utah call center noted an increase in volume and had over 600 active families (families that are in the process of care coordination to resources or child monitoring).

The Bureau of Child Development's Parent Support Programs Manager continues to support and train local health department staffs on the use of the Ages and Stages Developmental Screening program. The training includes setting up Family Access which allows families and targeted case managers to complete ASQs online. To date, 10 of the 12 local health departments have implemented ASQ screening as part of their Medicaid targeted case management and have conducted over 2,700 ASQ screenings.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-----------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Help Me Grow Utah connected more than 1300 families to over 800 resources. | | X | | |
| 2. Help Me Grow Utah has administered almost 1600 ASQs in the last three years. | | X | | |
| 3. Local health departments have administered over 2,700 ASQs in the past year. | | X | | |
| 4. The Help Me Grow call center has over 600 families in the process of care coordination to resources or child monitoring. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Developmental Screening Survey has been distributed to UAAP members. Of those who responded, 88% were aware of the AAP policy on the use of standardized developmental screening tools but only 70.2% were using one in their practice.

The survey indicated 79% of pediatricians would be more likely to implement a developmental screening tool into their practice if the Medicaid codes were unbundled.

An article summarizing the findings has been written and submitted to the Utah Health Status Update publication (March, 2014) and also presented at the Utah Public Health Association (UPHA) conference (April, 2014).

The expansion of HMG in Salt Lake County is progressing. The Medical Director for the Division is the pediatric champion for HMG and works closely with the efforts being made on the importance of developmental screening.

Early Childhood Utah (ECU) focuses on the importance of developmental screening utilizing evidence-based tools. ECU currently has four standing sub-committees, and increasing developmental screening utilizing evidence-based tools is infused in the strategic action plan of all ECU sub-committees. The Parent Support Programs Manager continues to work with Utah's LHDs on the use of the ASQ in Medicaid targeted case management. Utah's local CCR&R agencies offer periodic Career Ladder training on developmental screening. To date, 271 child care providers have completed the ASQ-3 Career Ladder class and 106 have completed the

ASQ:SE Career Ladder training.

c. Plan for the Coming Year

The UDOH Developmental Screening Survey will be distributed every 5 years to pediatric practices to assess change from baseline in awareness of existing policies and the use of standardized developmental screening tools in assessing their patients' development.

Results of the 2012 -- 2013 developmental screening surveys, specific to unbundling of codes, will be shared with Medicaid. We will continue to work with Medicaid to discuss opportunities for unbundling.

An article will be submitted to the Utah Chapter of the AAP newsletter with updates and information regarding developmental screening.

The Division will continue to work closely with the Help Me Grow staff to maximize the number of children's health care providers who receive the ASQ (Ages and Stages Questionnaire) results, and will assist in the follow-up process to assure early and appropriate referrals are made. HMG will be meeting with directors of the pediatric residency program at the University of Utah to establish a HMG curriculum for residents.

The Division will also work with the Help Me Grow Utah (HMGU) Program to continue implementation of the plan for the statewide expansion of HMGU. Currently, Phase 2, a pilot rural expansion into Carbon, Vernal and Duchesne counties, is underway. HMGU has begun work on Phase 3 of the statewide expansion which will implement services in northern Utah. Currently, staff has been hired and being trained. Resource collection has also begun for northern Utah. The Division believes that HMGU has the potential to be an umbrella service that could link multiple early childhood programs, medical homes and services and integrate them with ongoing developmental screening among other services.

HMG Utah and child care providers recognize the need for interagency communication and cooperation to ensure young children are connected to resources as early as possible, therefore fostering optimal child development. HMGU and the Parent Support Programs Manager encourage child care providers participating in the developmental screening program to enter into a Memorandum of Understanding with HMGU. The MOU specifies that HMGU follows up with any child that the provider screens who falls below the ASQ cut off score. HMGU follows up with these families to refer the family to needed services and to verify that the family is connected to the referral and/or to verify the child is progressing.

The Parent Support Programs Manager will continue to work with Utah's local health departments on the use of the ASQ in Medicaid targeted case management. Utah's local CCR&R agencies will continue to offer periodic Career Ladder training on developmental screening using the ASQ.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | 10.6 | 7.8 | 7.8 |

| | | | | | |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Indicator | 10.7 | 10.7 | 7.8 | 7.8 | 5.7 |
| Numerator | 164 | 164 | 127 | 127 | 114 |
| Denominator | 1533 | 1533 | 1628 | 1628 | 2001 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 5.5 | 5.5 | 5.5 | 5.5 | 5.5 |

Notes - 2013

Numerator: YRBS, 2013, survey sample data
Denominator: YRBS, 2013, survey sample data

Notes - 2012

Numerator: YRBS, 2011, survey sample data
Denominator: YRBS, 2011, survey sample data

Notes - 2011

Numerator: YRBS, 2011, survey sample data
Denominator: YRBS, 2011, survey sample data

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was to reduce high school tobacco use to 7.8% and the Annual Indicator was 5.7% (Source 2013 YRBS).

Health Communication Interventions: The Utah Tobacco Prevention and Control Program (TPCP) used a variety of media types and messages to counter tobacco industry advertising. Television and print ads featured graphic and emotionally hard hitting images and messages to prevent youth tobacco use.

Cessation Interventions: The TPCP continued to offer tobacco cessation services for youth through a group program for youth cited for tobacco possession (Ending Nicotine Dependence) and telephone counseling (Utah Teen Tobacco Quit Line). The Quit Line counselors were trained in youth-oriented motivational interviewing and focused on helping youth tobacco users to quit by assisting them with moving through the stages of change.

Community Interventions: The TPCP partnered with local health departments (LHD) and school districts to strengthen tobacco-free policies in schools and communities and to improve school-based prevention education. The TPCP provided schools and communities with accurate information about new addiction-forming tobacco products such as dissolvable tobacco, e-cigarettes, and hookahs. Outrage, Utah's statewide anti-tobacco youth group, educated Utahns about new tobacco products. The composition, packaging, and flavoring of these products might be particularly appealing to children/youth. Youth groups around the state provided peer-to-peer education and grassroots marketing for youth who are at increased risk for tobacco use. The TPCP partnered with LHDs to conduct an average of three compliance checks in each tobacco retail outlet. In addition to civil penalties, outlets not in compliance with laws that prohibit sales to minors received educational interventions to assist with preventing future sales to underage youths. To lower the rate of noncompliance and to educate retailers about Utah's tobacco access laws, LHDs shared educational materials and conducted trainings.

Evaluation: The TPCP worked with an independent evaluation team to conduct telephone surveys to evaluate anti-tobacco media campaigns. Survey results were used to inform prevention programming. For cessation interventions, the TPCP tracked enrollment, as well as satisfaction and quit rates. Community interventions were evaluated through standardized

surveys for policy development, educational strategies, and public opinion regarding tobacco related topics. Since 2002, 21 of Utah's 41 school districts worked with TPCP and LHDs to strengthen tobacco-free school policies, tobacco education, and policy enforcement. These districts served nearly 220,000 students in 469 schools. Since 2001, illegal tobacco sales to underage youth during compliance checks declined by 62%. The rate of non-compliance was 6.1%.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Utah Tobacco Prevention and Control Program (TPCP) used a variety of media types and messages to counter tobacco industry advertising. | | | X | |
| 2. The TPCP continued to offer tobacco cessation services through a group program for youth cited for tobacco possession. | | | X | |
| 3. The TPCP partnered with local health departments and school districts to strengthen tobacco-free policies in schools and communities and to improve school-based prevention education. | | | X | |
| 4. The TPCP worked with an independent evaluation team to conduct telephone surveys to evaluate anti-tobacco media campaigns. | | | X | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Health Communication Interventions: The TPCP will continue to prevent youth tobacco use through anti-tobacco advertising in a variety of media. Following national research findings, adult cessation ads that also resonate with youth have been selected for the youth media TV market.

Cessation Interventions: The TPCP offers tobacco cessation services through a group program for youth cited for tobacco possession (Ending Nicotine Dependence) and free telephone counseling (Utah Teen Tobacco Quit Line).

Community Interventions: The TPCP partners with local health departments and school districts to develop and strengthen tobacco-free policies in schools and communities. The TPCP provides information about new tobacco products such as e-cigarettes and hookahs. TPCP's anti-tobacco youth coalition "Outrage" provides peer-to-peer education and grassroots marketing for youth who are at increased risk for tobacco use.

Evaluation: In addition to telephone surveys to evaluate anti-tobacco media campaigns, the TPCP partners with RTI to conduct an online study of youth who are smokers or susceptible to tobacco use. Youth are being recruited at alternative schools and through the TPCP's disparities networks. For cessation interventions, the TPCP tracks enrollment, satisfaction and quit rates. Community interventions are assessed through standardized surveys for policy development, educational strategies, and public opinion regarding 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 for Comprehensive Tobacco Control Programs as a guideline to plan interventions to decrease tobacco use among youth. The TPCP will use national media research and findings from an online study with Utah youth who are susceptible to smoking to identify prevention strategies and media messages to prevent initiation of smoking among youth and to encourage youth smokers to quit. Results will be evaluated through telephone and online surveys.

In addition to promoting tobacco-free norms and policies through community partnerships, the TPCP's community interventions will focus on youth access to tobacco products and point of sale advertising. 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, tobacco retail density, and tobacco pricing strategies. The reviews will guide the local health departments (LHD) in local efforts to restrict tobacco advertising, pricing discounts, and limit the density of tobacco retail outlets near schools and other areas frequented by children and teenagers.

The program will work with LHDs to strengthen the statewide youth coalition that was formed last year. This group will use a youth-led statewide coalition model to increase visibility of the youth anti-tobacco movement and assist with tobacco policy change.

In FY2015, LHDs will oversee comprehensive school tobacco policy changes with the remaining school districts. School districts will be selected based on high tobacco use rates in their areas.

The TPCP will continue to monitor experimentation and use of traditional and emerging tobacco products and work with partners to identify strategies to prevent youth tobacco addiction.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 25.9 | 25.5 | 25.9 | 26.7 | 26.6 |
| Annual Indicator | 26.0 | 26.0 | 26.7 | 26.7 | 26.4 |
| Numerator | 408 | 408 | 450 | 450 | 570 |
| Denominator | 1569 | 1569 | 1687 | 1687 | 2157 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 26.3 | 26.2 | 26.1 | 26 | 25.9 |

Notes - 2013

Numerator: YRBS, 2013
Denominator: YRBS, 2013

Notes - 2012

Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2011

Numerator: YRBS, 2011
Denominator: YRBS, 2011

a. Last Year's Accomplishments

The Performance Measure was achieved. The Annual Performance Objective was 26.6% and the Annual Indicator was 26.4%.

The Violence and Injury Prevention Program (VIPP) continued to conduct surveillance on Utah suicides (suicide fatalities, emergency room visits, and hospitalizations) and provided data and analysis expertise to partners and the media. VIPP developed five suicide fact sheets and two suicide infographics. VIPP made presentations to Utah's Governor on the issue of youth suicide in conjunction with the Department of Human Services and Utah State Office of Education. VIPP was heavily involved in providing expertise, background information, data, and fiscal impact of suicide-related legislation and provided weekly updates on proposed legislation to partners and state agencies during the general legislative session. VIPP staff was also invited to attend a meeting sponsored by the National Conference of State Legislators and the Safe States Alliance which brought together injury experts (VIPP), state health department directors, and legislators to discuss policies that could decrease the rates of injury (for Utah, specifically these were suicides, dating violence, motor vehicle crashes, and prescription drug overdoses) in their respective states. VIPP also developed a suicide policy agenda, which was adopted by the local health departments and included in a statewide policy agenda for public health.

VIPP staff participated on the Utah Suicide Prevention Coalition, serving as co-chairs for several committees. VIPP played an integral role in the development and implementation of the Utah Suicide Prevention Plan and in bringing the Utah Suicide Prevention Coalition together. VIPP has provided technical assistance and expertise to the Utah Department of Human Services on many of the suicide prevention efforts in the state. In 2013, the Utah Legislature provided funding for two Suicide Prevention Coordinators, one at the Department of Human Services and one at the Utah State Office of Education.

VIPP facilitated the state Child Fatality Review Committee (CFRC). The CFRC reviews all child deaths under age 18 in the state. In-depth reviews are done for suspicious cases. The CFRC has seen an increase in the number of suicide deaths reviewed in recent years, as evident by the increasing suicide rate and number of high school students reporting they have had suicidal thoughts. Utah has one of the highest suicide rates in the nation, for all ages.

VIPP responded to 27 media requests on suicide in FY13 and continued to serve as a primary source of data on suicides across the lifespan. VIPP has noticed an increased in the number of media requests for data and interviews on suicide in the past year. One of Utah's largest T.V. news stations dedicated an entire 30 minute newscast to the issue of suicide, which has helped spark conversation by many on suicide prevention.

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. Hope 4 Utah continues to expand in communities across the state, forming Hope Squads in schools. Hope Squads are a school-based, peer-to-peer training and support program that also includes school staff and administration training in prevention and intervention procedures. To date, more than 18,000 Utahns have been educated about Hope 4 Utah's mission, 37 Hope Squads have been formed, 1,700 volunteers are working with Hope 4 Utah, and 87 students have been referred for help due

to suicidal risks.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. VIPP co-chaired the Utah Suicide Prevention Coalition and several of its subcommittees. | | | | X |
| 2. VIPP facilitated the Child Fatality Review Committee (CFRC) which reviews all child deaths under age 18 in the state, including youth suicides. | | | | X |
| 3. VIPP provided surveillance, data, and policy expertise to many partners. This included presentations to Utah's Governor, Legislature, state agency leadership; development of 5 suicide fact sheets and 2 suicide infographics; and media interviews. | | | | X |
| 4. The Hope 4 Utah program continued to expand, forming 37 Hope Squads in local schools and referring 87 students at risk for suicide to services. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Violence and Injury Prevention Program (VIPP) continues to conduct surveillance on suicides, utilizing the National Violent Death Reporting System, Youth Risk Behavior Surveillance Survey, Indicator Based Information System for Public Health (IBIS-PH), and Child Fatality Databases. VIPP also participated in the development of a plan to prevent suicide among youth ages 15 to 19, the Utah Suicide Prevention Plan, and remains actively involved in the Utah Suicide Prevention Coalition. Three new fact sheets (with three more planned for FY2015) on suicide across the lifespan (youth, young adult, and men) were produced and disseminated. VIPP has responded to 16 media requests on suicide prevention or suicide-related data. VIPP has seen an increasing interest in suicide prevention among the media and policymakers. VIPP and Department of Human Services Division of Substance Abuse and Mental Health staff has given several presentations on suicide prevention to local school districts, community groups, and policymakers. VIPP has also begun to utilize social media more to provide education on current trends, circumstances surrounding suicides, and prevention tips. VIPP provided funding to the 12 LHDs to have a minimum of one staff person or one community member from their area trained in the evidence-based suicide prevention program, QPR (Question Persuade Refer). To date, 10 LHD staff have become certified QPR Trainers.

c. Plan for the Coming Year

VIPP will stay actively involved on the Utah Suicide Prevention Coalition and provide support to the Suicide Prevention Coordinator at the Division of Substance Abuse and Mental Health in the Department of Human Services. VIPP will also participate on the policy subcommittee of the Coalition. VIPP will continue to provide surveillance, data collection, analysis and fact sheet publication and dissemination to community partners, the media, and policymakers. VIPP will utilize the National Violent Death Reporting System, Child Fatality Database, Youth Risk Behavior Surveillance Survey, and IBIS-PH for surveillance and data collection.

VIPP will continue to facilitate the Child Fatality Review Committee (CFRC) which conducts

reviews of all child deaths under age 18 in the state. All youth suicides are reviewed in-depth by the CFRC. Recommendations for policy and system changes, education, and interventions are given annually by the CFRC to prevent future deaths.

Many of Utah's 12 local health departments (LHDs) have recognized the growing problem of suicide in their communities. VIPP staff have worked closely with the LHDs to develop activities in their contracts that address youth suicide, such as participating on their local prevention coalitions, holding youth prevention summits, including suicide as a priority area in community assessments, working with Utah's Native American tribes, promoting the National Suicide Prevention Lifeline, engaging community leaders, utilizing local media to di-stigmatize mental illnesses and suicide, and teaching the evidence-based QPR (Question Persuade Refer) program in their areas.

VIPP will continue efforts to reduce youth suicide, but the extent of involvement will be dependent on resources. VIPP will remain actively involved in the Utah Suicide Prevention Coalition and co-chair the policy subcommittee of the Coalition.

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)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 47.5 | 48.5 | 48.5 |
| Annual Indicator | 47.3 | 47.3 | 48.5 | 48.5 | 48.7 |
| Numerator | 744 | 744 | 811 | 811 | 1045 |
| Denominator | 1572 | 1572 | 1672 | 1672 | 2145 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 48.7 | 48.8 | 48.8 | 49 | 49 |

Notes - 2013

Numerator: YRBS, 2013 (unweighted n=1029, IBIS)

Denominator: YRBS, 2013

Notes - 2012

Numerator: YRBS, 2011

Denominator: YRBS, 2011

Notes - 2011

Numerator: YRBS, 2011

Denominator: YRBS, 2011

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 48.5% and the Annual Indicator was 48.7%.

The Gold Medal School program (GMS), a school-based offshoot of the A Healthier You Legacy Awards Program, continued to help elementary schools set up policy and environmental supports making it easier for students and staff to be physically active and eat healthy food.

The "Unplug 'n Play" program continued to encourage students and their families to limit TV and other screen time to less than two hours per day. In April 2013, the PANO program participated in the Unplug n' Play and the National TV Turn Off Week projects. The PANO program provided Parent Teacher Associations information focused on family activities other than TV, computer games, or other screen-related activities.

Walk to School Day was promoted in the first week of October 2012 to encourage students and their parents to walk to school safely. The goal of this project was to encourage regular walking or cycling to school throughout the year. Information was shared with local Parent Teacher Associations. The information focused on how to support parents and students walking or cycling to school.

Action for Healthy Kids (AFHK) continued to bring partners together to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies. AFHK currently serves as the Utah Physical Activity and Nutrition (U-PAN) school workgroup and completed activities in both the U-PAN State plan and Utah's AFHK action plan.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The GMS program continued to help elementary schools set up policy and environmental supports for nutrition and physical activity. | | | X | |
| 2. The "Unplug 'n Play" program continued to encourage students and their families to limit TV and other screen time to less than two hours per day. | | | X | |
| 3. Walk to School Day was promoted the first week of October 2012 and encouraged students and their parents to walk or bike to school safely. | | | X | |
| 4. AFHK continued to bring partners together to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies. | | | | X |
| 5. AFHK currently serves as the U-PAN school workgroup and completed activities in both the U-PAN State plan and Utah's AFHK action plan. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In July 2013, the Utah Department of Health (UDOH) Physical Activity, Nutrition and Obesity Program (PANO) was merged into a new program entitled Healthy Living through Environment, Policy and Improved Clinical Care (EPICC). EPICC is comprised of the previous Heart Disease and Stroke Prevention, Diabetes Prevention and Control and School Health. The former PANO program is represented in the new EPICC program through Domain 2, Environmental Approaches that Promote Health.

The following activities are being implemented: (1) The Gold Medal Schools (GMS) Program is being phased out. Eight schools are completing their final level by establishing environmental policies that enable students and staff to be physically active and eat healthful food. (2) Previous

GMS and other schools have been encouraged to participate in other programs including Healthier US Schools Challenge, Let's Move and Fuel Up to Plan 60. (3) The "Unplug 'n Play" program encourages students and their families to limit TV and other screen time to less than two hours per day. (4) Walk to School Day encourages students and their parents to walk to school safely. (5) Body mass index trends are tracked in a sample of elementary students to see how Utah students compare to national students. (6) Teachers in five school districts are being trained to implement a Davis School District pilot program to increase physical activity in schools based on research by Dr. John Ratey in the book SPARK.

c. Plan for the Coming Year

The Utah Department of Health's Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) Program has the following activities planned under the required strategy of implementing quality physical education and physical activity in K-12 schools:

- (1) Work with the Utah State Office of Education (USOE) to provide professional development opportunities on Comprehensive School Physical Activity Programs (CSPAP) to Local Education Agencies (LEA) and Local Health Departments (LHD). Resources will be provided via list-servs and web downloads. Provide technical assistance (TA) on resources, trainings and other professional development opportunities to LHDs.
- (2) Develop a registry of schools and/or LEAs that have implemented CSPAP in Utah and share information with LHDs and LEAs.
- (3) Identify LEA wellness policies to determine if district policies exist that require schools to provide or require daily physical education.
- (4) Work with USOE to train PE and classroom teachers on the benefits of required daily physical activity, recess guidance and policies. Provide TA and support to schools and LEAs on the Healthy Bodies, Healthy Minds initiative (piloted in Davis School District).
- (5) Work with USOE, LHDs, and LEAs to compile school level, district level and state level physical activity, physical education, and wellness policies.
- (7) 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.
- (8) The Action for Healthy Kids Coalition will continue to meet with the goal of improving nutrition and physical activity environments in Utah's schools by implementing school-based U-PAN state plan strategies.

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 | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 12 | 11 | 5.5 | 4 | 2.8 |
| Annual Indicator | 10.4 | 5.2 | 4.0 | 2.8 | 3.3 |

| | | | | | |
|-----------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Numerator | 2305 | 1190 | 1083 | 798 | 927 |
| Denominator | 22080 | 22745 | 26880 | 28039 | 28094 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 |

Notes - 2013

Numerator: The number of children served in the rural area based on the CSHCN billing system, 2013

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

Notes - 2012

Numerator: The number of children served in the rural area based on the CSHCN billing system, 2012.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

Notes - 2011

Numerator: The number of children served in the rural area based on the Mega West billing system, 2011.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

a. Last Year's Accomplishments

This Performance Measure was met. The Performance Objective was 2.8% and the annual indicator was 3.3%.

Despite the challenges of flat Federal and State funding, an increasing rural population and demand for services, Children with Special Health Care Needs demonstrated success in achieving the performance measure.

Even though no additional funding was secured, we were able to increase the level of rural services over the previous year. Although some services were cut in previous years, special attention was given to determining the most effective changes and cuts to make to ensure continued service provision in these underserved areas. Efforts were made to continue to focus on providing the highest level of care possible to the children in rural areas of Utah with a focus on the providers and services that were most in demand. Changing scheduling and appointment formats increased efficiency and access. Children with Special Health Care Needs (CSHCN) continued contractual agreements with two local health departments and with Intermountain Healthcare to provide services in six different sites. The contracts provided for local clerical support and nurse care coordinators to handle clinic operations in the rural areas and provide care coordination. CSHCN provided training in care coordination; patient, chart and workload management. CSHCN completed implementation of a new electronic health record (EHR), CaduRx, providing statewide training on the new system. Contracts with the University of Utah, Department of Pediatrics were continued to provide consistent pediatric, sub-specialty evaluation services for rural clinics. A new collaboration by the Oral Health Program with CSHCN focused on providing dental hygiene education and fluoride varnish to interested families and their children. This program was initiated by the Oral Health Program which identified selected local dental hygienists or dental hygiene schools at each clinic site.

The Bureau continued the use of the referral form, available on-line, to be used to solidify closer

coordination with primary providers. CSHCN continued its efforts to support the statewide Medical Home effort and provided close contact and coordination with local primary care medical home providers on optimal care for children. The Bureau continued to support and promote collaboration and coordination among rural clinics, other CSHCN programs and ancillary agencies for the Neonatal Follow-up Program, Specialty Services; Fostering Healthy Children and Baby Watch Early Intervention programs. CSHCN continued its agreement with Intermountain Healthcare, the primary health care provider in the State, to allow for access to their electronic health records (EHR) system.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. CSHCN engaged in service delivery planning and reorganization of services and resources in response to increasing population and flat funding. | | | | X |
| 2. Local RN and office support staff provided clinic coordination, scheduling, management, chart maintenance, and follow-up for each clinic. | | X | | |
| 3. CSHCN continued its support and training on covering care coordination, patient and chart management involved in the complete implementation of electronic medical record system. | | X | | |
| 4. 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 |
| 5. Maintained ongoing use of referral forms available on-line, to better facilitate communication and coordination with primary health providers. | | X | | |
| 6. The Oral Health Program has collaborated with CSHCN clinics to provide dental hygiene education and fluoride varnish to interested patients and families at rural sites. | X | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Flat State and Federal funding, along with increases in rural population, continue to pose challenges in the area of provision of services to the rural communities. The CSHCN Bureau is continuing its efforts to provide optimal care and services to rural children with special health care needs through specialty clinics. In an effort to bolster our capacity and level of access to our clinical services, recent discussions with the University Of Utah Department Of Pediatrics have been initiated to enter into a collaboration to expand services.

CSHCN contracts with local health departments and other agencies to conduct itinerant clinics in six sites in the state. In response to flat funding on the Federal and State levels, the Bureau has continued to focus on maximizing our provision of services to the most needy of children and families in the areas with most demand and least availability. The Oral Health Program continues it collaboration with CSHCN to provide access to dental hygiene education and services for clients at rural clinics.

CSHCN continues to promote 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. Care coordination is facilitated via access to private electronic health (EHR) records, along with the completed implementation of our own EHR system, CaduRx, in all of our clinics statewide.

c. Plan for the Coming Year

Continued flat Federal and State funding, combined with an increase of population in rural areas, and on-going shortage of pediatric sub-specialists, will continue to present challenges in providing needed care for Utah's Special Needs Children. Ongoing discussions with the University of Utah, Dept. of Pediatrics on increased collaboration and maximizing access to our rural clinics will proceed, focusing on increasing services in our rural clinics. While these discussions and planning continue, 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. 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 hard copy and new electronic medical charts. CSHCN will provide ongoing consultation and support on care coordination issues to contract staff, along with training in these areas. CSHCN will continue to meet Meaningful Use attestation for the 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, to meet these Federally required criteria.

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 Specialty Services. These efforts will provide opportunities for community providers to join and interact with CSHCN clinical staff regarding specific care management issues. Efforts with the Emergency Medical Services for Children (EMS-C) and the Oral Health Program will continue in order to maximize access to these services and care for our patients.

The CSHCN Bureau is encouraged by negotiations with the University of Utah to optimize services in the face of increasing population challenges and costs with no increase in resources. Additionally, CSHCN, in concert with the use of our EHR, will continue its 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 Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | 85 | 92.5 | 96.3 |
| Annual Indicator | 75.0 | 92.5 | 92.0 | 96.3 | 94.9 |
| Numerator | 3821 | 4899 | 5070 | 5502 | 5426 |
| Denominator | 5093 | 5295 | 5511 | 5715 | 5715 |

| | | | | | |
|-----------------------------------|------------------------------|--------------|--------------|--------------|--------------|
| Data Source | See footnote for data source | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 94.9 | 94.9 | 94.9 | 94.9 | 94.9 |

Notes - 2013

Numerator

UDOH Medicaid Data Warehouse, 2013, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type

Denominator

Number of unique children (0-17) receiving SSI during specific month by age (December). Social Security Report

Notes - 2012

Numerator

UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type

Denominator

Number of unique children (0-17) receiving SSI during specific month by age (December). Social Security Report

Notes - 2011

Numerator

UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type.

Denominator

SOURCE: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table—Number and percentage distribution of children in Utah receiving federally administered SSI payments, by selected characteristics, December 2010.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 96.3% and the Annual Indicator was 94.9%.

CSHCN and the F2F staff is provided Care Notebooks to families and information about the benefit of effective record keeping when applying for resources and services such as Medicaid and SSI. The Spanish version of the Care Notebook was reviewed and found to need additional editing and formatting before being published. Information for families with linguistic differences including those who are deaf was addressed and current materials were gathered to distribute to families and professionals through presentations and materials on the Utah Parent Center and Medical Home Portal websites.

Intake workers with expanded knowledge of the unique challenges faced by families from the Department of Workforce Services were identified and relationships built in efforts of helping the families have someone who had some experience and expertise in processing applications for the Aged, Blind and Disabled program of Medicaid. Identifying the key intake workers throughout the state was and continues to be challenging. Data tracking on the challenges and barriers with the Disability program in Medicaid was started because of the need for timely and accurate information from Department of Workforce Services.

Publication of materials with information about Medicaid Disability, Social Security Income and

other relevant public and private health care resources were distributed in collaboration with disability partners. Materials that were developed were shared with Parent Partners in the Medical Homes and Specialty Clinics to distribute to families and on disability specific support group pages on Facebook and blogs. The material was also formatted into content for modules on the Medical Home Portal to reach additional families and professionals.

The CSHCN UFV Director participated in the Utah Department of Health Strategic Planning workgroups to provide input and expertise from families perspectives of families throughout the state and continued to work on various committees to continually advocate for the need of Medicaid programs for children and individuals with special health care needs and disabilities to provide for services that their private insurance didn't offer or cover. The explanation and definition of EPSDT was presented in five presentations that had an audience of professionals, families and advocates. Information about the Disability Medicaid program continued to be one of the top 10 topics that were discussed through an intake process with Utah Family Voices Family to Family Health Information Center.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Care Notebooks were given to families to highlight the need of record keeping when applying for Medicaid and SSI. | | X | | |
| 2. Data were and are continuing to be tracked about the challenges in the intake process for Medicaid Disability program. | | | | X |
| 3. Family friendly materials were developed about Medicaid Disability and EPSDT. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The roll over to Accountable Care Organizations (ACO) came with challenges such as denials and reduction of benefits and/or services for children who have very complex medical needs. Many families and advocates have helped to provide education and explanation about EPSDT and Medicaid Waivers to key staff coordinating benefits in the ACOs. Families advocating for their children, also brought some specific problems to the attention of the Medicaid Medical Care Advisory Committee that has resulted in Medicaid partnering with the Health Plans and the parents to resolve the issues.

UFV held a focus group and developed survey questions to gather information about health care funding. The information collected will be utilized to develop information about the access and barriers to health care related resources. Each of the parents involved received consultation and educational materials about the Medicaid disability program, Medicaid waiver programs, SSI and EPSDT and the relevance of each program to a child with special health care needs.

An important vehicle in assuring family needs and perspective is the ability to have a UFV staff member continues to serve on the Medicaid Advisory Committee. Another mechanism that is working is the sharing of data collected from UFV about themes and trends identified by families, professionals and systems to address gaps in services as well as highlight successful initiatives.

c. Plan for the Coming Year

The goal of having all children with special health care needs accessing Medicaid EPSDT services if they are eligible is an area that needs collaborative work. Staff from the CSHCN Bureau and UFV will meet with Medicaid and the four contracted health plans serving as the ACOs to discuss the challenges that families have reported and develop a plan to solve the issues. The strengths and successes families have had with the ACOs will also be shared to spread some of the best practices in meeting the needs of families with special needs.

Research will be conducted on billing practices to Medicaid for Family Support and Peer to Peer Counseling. Successful pilots and models have been developed in other states around the nation for a Family-to-Family service delivery system. This approach would be an effective way of helping families navigate the system and utilize services in a cost efficient manner with the help of a peer parent. Having such a program will help to add to the number of families that are eligible for both the Medicaid Disability program and SSI to help meet their medical and related needs.

Documentation of specific trends will be implemented in the UFV database, allowing Title V and other partners to understand the impact of the ACA and any Medicaid expansions that may or may not happen in the state. The CSHCN Survey Questions for the 5-year needs assessment will enable us to get a fuller picture from families in the state.

Information and data gathered about the TEFRA option will be shared with family leaders, advocates and policy-makers about the costs of serving children in different programs including Home and Community Based Waivers. Cost analysis, family stories, results from surveys and focus groups will supplement the documents on the importance of Medicaid disability programs for families of children with special health care needs.

Updated fact sheets and website modules will be developed to include information on obtaining health insurance in the Market Place as well as any new eligibility criteria for individuals with disabilities and their families in a family friendly reading format. Both family leaders and professional partners will vet all information.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 7.0 | 7.0 | 6.9 | 6.9 | 6.9 |
| Numerator | 3780 | 3650 | 3546 | 3533 | 3533 |
| Denominator | 53894 | 52164 | 51144 | 51439 | 51439 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2011

Data reported are the most recent data available.
 Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSI?
 Utah saw a small decline in the percentage of low birth weight (LBW) births - from 7.0% in 2010 to 6.87% in 2012. Utah's rate was below the 2012 national rate of 8.0% and meets the Healthy People 2020 goal of 7.8%. Level MCH Block grant funding and a lack of State General funding limit the program's ability to address LBW rates. Utah continues to promote its "Power Your Life" preconception social marketing campaign. The campaign promotes optimal preconception health and interpregnancy intervals. In addition, Utah received 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 HSI?
 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, appropriate interpregnancy intervals and improved pregnancy outcomes. In addition, contracts for Abstinence Education and Personal Responsibility Education Programs (PREP) were implemented in 2011 which is expected to reduce the rate of teen births in Utah and may have an impact on our LBW rates. Because the majority of low birth weight infants are born preterm, Utah's focus on reducing prematurity rates will have an impact on this measure as well.

c. Interpretation of what the data indicate:
 The percent of live born infants weighing less than 2,500 grams in Utah has increased slightly over the past decade (2001-6.4% to 2012 6.9%). LBW rates among teens aged 15-19 decreased from 8.7% in 2011 to 7.5% in 2012. Women ages 35 and older had the highest rate at 8.5%. Utah Hispanic women had a rate of 7.3% in 2012 compared to non-Hispanic women (6.7%). Lastly, Utah women of color experienced higher rates of LBW than Utah White women (6.7%): Black women had a rate of 10.8% and Asian women had a rate of 9.7%. There is a link to prematurity with 73% of low birth weight infants being born prematurely.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|----------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 5.2 | 5.3 | 5.2 | 5.1 | 5.1 |
| Numerator | 2736 | 2690 | 2585 | 2560 | 2560 |
| Denominator | 52164 | 50475 | 49484 | 49742 | 49742 |

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------|-------------|
| 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 - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2011

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSI?
[Please see HSI #01A a.]

Utah saw a small decline in the percentage of low birth weight (LBW) births - from 7.0% in 2010 to 6.87% in 2012. Utah's rate was below the 2012 national rate of 8.0% and meets the Healthy People 2020 goal of 7.8%. Level MCH Block grant funding and a lack of State General funding limit the program's ability to address LBW rates. Utah continues to promote its "Power Your Life" preconception social marketing campaign. The campaign promotes optimal preconception health and interpregnancy intervals. In addition, Utah received 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 HSI?
The American College of Obstetricians and Gynecologists recommends the use of 17 alpha-hydroxy- progesterone (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 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 17P beginning at 16-20 weeks of gestation. The MIHP continued its campaign to increase the use of this medication. Because the majority of low birth weight infants are born preterm, Utah's focus on reducing prematurity rates will have an impact on this measure as well.

c. Interpretation of what the data indicate:
The percent of singleton live births weighing less than 2,500 grams in Utah has remained stable over the past decade fluctuating slightly from 5.0% - 5.4% over the last decade. Due to the small changes in low birth weight among singletons, most changes in the overall rate of low birth weight can be attributed to multiple births. Because 67% of low birth weight singleton infants are born preterm, Utah's focus on reducing prematurity rates will have an impact on this measure as well.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 1.0 | 1.1 | 1.1 | 1.1 | 1.1 |
| Numerator | 562 | 579 | 554 | 550 | 550 |
| Denominator | 53894 | 52164 | 51144 | 51439 | 51439 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Narrative:

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

The rate of very low birth weight (VLBW) births has remained stable over the past decade (2000 - 1.1%, 2012 - 1.1%). 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. Level MCH Block grant funding and a lack of State General funding limit the program's ability to address LBW rates. Utah continues to promote its "Power Your Life" preconception social marketing campaign. The campaign promotes optimal preconception health and interpregnancy intervals. In addition, Utah received over \$825,000 in teen pregnancy prevention funds for a five year period 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 HSI?

Utah continues its "Power Your Life" campaign to educate women about the importance of preconception health and adequately spaced pregnancies. In addition, contracts for Abstinence Education and Personal Responsibility Education Program (PREP) programs were 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. Interpretation of what the data indicate:

As previously mentioned, the rate of very low birth weight (VLBW) births has remained stable over the past decade. As with LBW births, several subpopulations of Utah women have higher rates of VLBW. In 2012, women aged 18-19 and 40-44 had the highest VLBW rates at 1.6%. Women who reported an obese pre-pregnancy body mass index experienced significantly higher rate of VLBW births (1.5%) compared to women with a normal pre-pregnancy BMI (1.0%). Women who reported smoking during pregnancy had a higher rate than women who did not (1.6% vs. 1.0%). Lastly, Black women (1.9%) and Pacific Islander women (2.3%) had rates higher

than White women (1.0%). The largest percentage of VLBW births are seen multiple gestations with a VLBW rate of 8.0% in twins and 42.3% in triplets.

A high percent of VLBW infants do not survive. The 2011 birth weight specific mortality rate for VLBW infants was 236.5/1000 births. The biggest risk for mortality is in infants under 500 grams as evidenced by the mortality rate of 951.6/1000 births. Among VLBW infant deaths, 77% are attributable to Perinatal Conditions. These cases are reviewed in our Perinatal Mortality Review Program and findings from reviews are used to develop educational materials for both pregnant women and care providers.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 |
| Numerator | 399 | 422 | 381 | 388 | 388 |
| Denominator | 52164 | 50475 | 49484 | 49742 | 49742 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSI?
Please see HSI #02A, a.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
Please see HSI #02A, b.

c. Interpretation of what the data indicate:
Please see HSI #02A, c.

The percent of singleton live births weighing less than 1,500 grams in Utah has remained relatively stable over the past decade (2001-0.76%, 2012-0.78%). Risk factors for VLBW

singletons mirror those of all VLBW infants.

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 03A - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 6.9 | 6.4 | 8.3 | 4.8 | 4.8 |
| Numerator | 51 | 48 | 62 | 36 | 36 |
| Denominator | 736615 | 749214 | 749774 | 754356 | 754356 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2012

Denominator: IBIS Population Estimates 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2012

Denominator: IBIS Population Estimates 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2011

Denominator: IBIS Population Estimates 2011

Narrative:

a.

Utah has 14 active Safe Kids coalitions/affiliates, in addition to the state Safe Kids Utah Coalition, coordinated through the Violence and Injury Prevention Program (VIPP). Recently, Safe Kids Worldwide has expanded the target age from birth to age 19. Safe Kids members advocate for policies and legislation focused on preventing injury among children. VIPP facilitates the Domestic Violence Fatality Review Committee (DVFRC) and Utah Child Fatality Review Committee (CFRC) which conducts reviews of all child deaths under age 18 in the state. Deaths with suspicious circumstances are reviewed in-depth by the CFRC or DVFRC. Recommendations for policy and system changes, education, and interventions are given annually. VIPP funds Utah's 12 LHDs and requires LHD participation on their local Safe Kids coalition/affiliate. LHDs work on a variety of prevention activities including child passenger safety, ATV/OHV, bicycle, and pedestrian safety, seat belt education, and poisoning and falls prevention. LHDs work closely with a variety of state and community partners on these projects. VIPP also maintains the web-based Student Injury Reporting System (SIRS). For more than 30 years, the SIRS has collected data on school-related injuries that helps to identify where, when, how and why students get hurt at school. By using this information, education officials can pinpoint risk factors at individual schools

and develop safety guidelines and prevention programs which can minimize the physical and financial impact of injury on the individual, family, school, and community.

b.

Safe Kids is continually looking to attract new partners with similar goals. Allied partners outside of state/local government have been helpful when advocating for new laws and when bills are introduced in the legislature. Safe Kids coalitions conduct annual assessments to determine priorities for their areas. VIPP produced the Preventing Pediatric Exposure to Buprenorphine fact sheet in response to an increase in the number of accidental overdoses of buprenorphine among young children. VIPP worked collaboratively with the Utah Poison Control Center, Division of Substance Abuse and Mental Health, and the Division of Occupational Professional Licensing to send letters warning physicians of the increase in buprenorphine overdoses among children and a patient safety agreement. VIPP included data on sports-related concussions among adolescents and a new teen driving strategic plan. VIPP used local media to promote the report and prevention of unintentional injuries and deaths among children.

c.

Utah's mortality rate of unintentional injuries to children decreased 42% from a rate of 8.27 per 100,000 in 2011 to 4.77 per 100,000 in 2012. This increase may be due decreased drowning and motor vehicle traffic deaths. In 2011, Utah had an extremely wet spring which impacted the number of child drowning cases but in 2012 Utah experienced drier than normal spring weather.

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 03B - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 2.2 | 2.0 | 2.8 | 1.6 | 1.6 |
| Numerator | 16 | 15 | 21 | 12 | 12 |
| Denominator | 736615 | 749214 | 749774 | 754356 | 754356 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2012

Denominator: IBIS Population Estimates 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2012

Denominator: IBIS Population Estimates 2012

Notes - 2011

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2011

Denominator: IBIS Population Estimates 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSI?
 Utah has 14 active Safe Kids Coalitions/affiliates in communities around the state, in addition to the statewide Safe Kids Utah Coalition. This effort is coordinated through the Violence and Injury Prevention Program (VIIPP) and LHD contracts require an active role in the coalitions/affiliates. Annual educational efforts focus on preventing injuries among children ages 1-14 and their families, with a majority of the activities focusing on car seat and booster seat education, seat belt education, and bicycle and pedestrian safety. Safe Kids members have been strong advocates for any necessary changes in laws focused on preventing motor vehicle related deaths and injury among children. Safe Kids Coalitions/affiliates conduct regular car seat inspections and checkpoints, distribute low-cost seats to families in need, and provide car seat installation classes to community members particularly those in underserved areas (immigrant and Hispanic populations). VIIPP maintains close working relationships with Primary Children's Hospital, the Utah Department of Transportation Zero Fatalities Program, and Utah Highway Safety Office.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
 VIIPP provides funding to Utah's 12 local health departments (LHDs). In past years, LHDs have been able to leverage additional funding provided by the Utah Highway Safety Office and Safe Communities grants to enhance child passenger safety efforts (e.g., purchasing low-cost car seats and booster seats and bicycle helmets for families in need). However, recent changes to the MAP-21 federal initiative through the National Traffic Safety Administration has drastically impacted the amount of funding available to Utah communities for these efforts, particularly for child passenger safety education. This may impact the rate of unintentional injuries due to motor vehicle crashes in future years if LHDs are unable to sustain current levels of infrastructure and community intervention/education. MCH Block Grant funding is vital to this process, as it provides the bulk of funding for motor vehicle crash prevention activities at the LHDs. Many LHDs have begun implementing a Click it Club program for adolescents that focus on seat belts.

c. Interpretation of what the data indicate:
 Utah's mortality rate of child motor vehicle fatalities has decreased by 43%, from 2.8 per 100,000 in 2011 to 1.6 per 100,000 in 2012. Utah also gathers ED data which, combined with hospitalization data, continue to give partners a good understanding of where problems exist. Motor vehicle crashes include five indicators: motor vehicle traffic occupant, motor vehicle traffic motorcyclist, motor vehicle traffic pedal cyclist, motor vehicle traffic pedestrian, and motor vehicle traffic other and unspecified.

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 03C - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 13.1 | 9.1 | 10.5 | 9.3 | 9.3 |
| Numerator | 59 | 42 | 48 | 43 | 43 |
| Denominator | 451656 | 459367 | 457721 | 460603 | 460603 |
| 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 - 2013

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2012
Denominator: IBIS Population Estimates 2012

Notes - 2012

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2012
Denominator: IBIS Population Estimates 2012

Notes - 2011

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2011
Denominator: IBIS Population Estimates 2011

Narrative:

a.

The Utah Teen Driving Task Force was formed in 2007, chaired by the Violence and Injury Prevention Program (VIPP) and Utah Highway Safety Office. The Task Force brings together stakeholders with an interest in teen driving to ensure activities and resources are coordinated throughout the state. Teen driving has also been a priority for LHD contracts since that time. All participating partners use the "Don't Drive Stupid" and Zero Fatalities program slogans and messaging. For the past six years, VIPP has worked closely with families who have lost a teenager in a motor vehicle crash to tell their stories in a memorial book. Copies of the memorial are also distributed to each of Utah's public high school driver education programs, with support from the Utah State Office of Education. An estimated 6,000 printed memorial books have been distributed and 65,000+ downloaded from the VIPP website since the first memorial book was published in 2008.

b.

The Utah Teen Driving Task Force meets monthly and released its first ever strategic plan to ensure coordination of data, educational programs, media, etc. The Task Force is supportive of the Don't Drive Stupid campaign's media contest, which includes a poster and YouTube video contest. The winning posters are assembled into a calendar and the winning video is shown in movie theaters. A Parent Night Program was developed by Zero Fatalities and VIPP to educate parents on Utah's Graduated Driver Licensing (GDL) laws and keeping their teen safe on the road. A parent guide was developed and is available online. Utah's largest school district requires the program for all driver education students. VIPP, Zero Fatalities, and Utah Department of Transportation developed a media campaign targeting parents of teens ages 15-17. A YouTube video of parents and teens discussing Utah's GDL laws and the importance of parental involvement in driver education training, web banner ads, Facebook and Twitter ads, and a radio ad were developed. LHDs conduct seat belt observation studies and promote seat belt use among teens. The Alive at 25 program has been integrated into county court systems for teens who receive a traffic safety violation by the LHDs. This program was designed by the National Safety Council.

c.

Utah's rate of motor vehicle deaths for those aged 15-24 has decreased by 46%, from 17.23 per 100,000 in 2007 (2011 when the Utah Teen Driving Safety Task Force was formed) to 9.34 per 100,000 in 2012. This decrease is statistically significant and a major public health victory. This decrease can be attributed to the combined efforts of the partners involved in the statewide educational campaign, Don't Drive Stupid, and most notably, Utah's GDL laws which went into effect in 1999. Motor vehicle crashes include five indicators: motor vehicle traffic occupants, motor vehicle traffic motorcyclist, motor vehicle traffic pedal cyclist, motor vehicle traffic

pedestrian, and motor vehicle traffic other and unspecified.

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 04A - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 124.6 | 116.9 | 5,850.0 | 5,958.0 | 5,958.0 |
| Numerator | 918 | 876 | 43404 | 44665 | 44665 |
| Denominator | 736615 | 749214 | 741951 | 749662 | 749662 |
| 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 - 2013

* Data based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined to report for this measure.

Numerator: Hospital Discharge Database Injury Query Module, 2011
Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 119.4 per 100,000 (N=955, D=749662) for 2012.

Notes - 2012

* Data based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined to report for this measure.

Numerator: Hospital Discharge Database Injury Query Module, 2011
Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 119.4 per 100,000 (N=955, D=749662) for 2012.

Notes - 2011

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 119.7 per 100,000 (N=888, D=741951) for 2010.

Narrative:

a. What has influenced the program's ability to maintain the HSI?
The Violence and Injury Prevention Program (VIPP) requires each of Utah's 12 local health

departments (LHDs) to be actively involved in Safe Kids coalitions/affiliates in their communities. LHDs work on child passenger safety education, car seat inspections, distribution ATV/OHV and bicycle helmets, pedestrian safety, seat belt education, and poisoning and falls prevention. In FY2012, 979 activities addressing injury were conducted by the LHDs reaching approximately 89,560 individuals. Safe Kids advocates have also provided education to policymakers on the importance of carbon monoxide detectors in response to a recent incident at an extremely rural elementary school in Southern Utah in which dozens of students and teachers were sickened and hospitalized due to CO poisoning. VIPP facilitates the Utah Child Fatality Review Committee (CFRC) and Domestic Violence Fatality Review Committee (DVFRC). Recommendations for policy and system changes, education, and interventions are given annually by the CFRC and DVFRC to prevent further child deaths and injuries. VIPP has provided the Student Injury Reporting System (SIRS) for more than 30 years to the State Office of Education, local school districts, and local schools. The SIRS tracks injuries on school property or during school-sponsored events. Data are used by school administrators to make policy and environmental changes to prevent further student injuries. VIPP provides fact sheets and district-specific data to school administrators to aid in this process.

b. What efforts are being made by the program?

Safe Kids works closely with traffic safety and poisoning prevention partners such as the Utah Highway Safety Office, Utah Poison Control Center, and Primary Children's Hospital. Safe Kids coalitions conduct annual assessments to determine priorities for their areas, in addition to data provided by the VIPP. All VIPP data fact sheets include small area data. VIPP uses media to promote the prevention of unintentional injuries and deaths among children. VIPP issues news releases on child passenger safety, teen driving, drowning prevention, and hyperthermia and kids in cars, suicide prevention, poisoning prevention, domestic and dating violence, rape and sexual abuse prevention, ATV/OHV safety, etc. VIPP is well respected with media agencies in the state and responsive to all data requests from the media and program partners. VIPP staff track and provide weekly updates on all injury and violence related legislation during the legislative session and provide fact sheets to advocates and partners on relevant data and programs.

c. Interpretation of data:

Utah has seen a nearly 20% decrease in the non-fatal rate of unintentional injuries among children under age 14 in the last five years, from 7347.05 per 100,000 in 2006 to 5958.01 per 100,000 in 2011. Rates are calculated from combined hospital discharge and emergency department data.

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 04B - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 19.4 | 14.8 | 244.2 | 240.5 | 240.5 |
| Numerator | 143 | 111 | 1812 | 1803 | 1803 |
| Denominator | 736615 | 749214 | 741951 | 749662 | 749662 |
| 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 - 2013

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011
Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 10.4 per 100,000 (N=96, D=749662) for 2011.

Notes - 2012

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011
Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 10.4 per 100,000 (N=96, D=749662) for 2011.

Notes - 2011

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 15.4 per 100,000 (N=114, D=741951) for 2010.

Narrative:

a.

Utah has 14 active Safe Kids coalitions/affiliates in communities around the state, in addition to the statewide Safe Kids Utah Coalition. This effort is coordinated through the Violence and Injury Prevention Program (VIPP). VIPP contracts with each of Utah's 12 local health departments (LHDs) and required LHDs to be actively engaged in their local coalition/affiliate. Annual educational efforts, Safe Kids Week, and Child Passenger Safety Week activities focus on preventing injuries among children ages 1-14 and their families with a particular focus on motor vehicle crashes and child passenger safety (such as booster seat and car seat education). Safe Kids members have been strong advocates for legislation focused on preventing injury among children; they have also been crucial in protecting the booster seat law from attempts to weaken it as well as efforts to eliminate data collection in schools (VIPP relies heavily on school-based surveys for information on adolescent safety behaviors). LHDs conducted checkpoints, checked child safety seats during community checkpoints, fitting stations, or individual appointments at the LHD, and distributed low cost car seat or booster seats during FY2012.

b.

The VIPP, Safe Kids Utah coalitions/affiliates, and other traffic safety partners are continuing to improve motor vehicle safety. Efforts include educating on the value of a primary seat belt law for all ages and the importance of booster seats. The Click it Club program, developed for adolescents to improve seat belt use, is being implemented by many LHDs in conjunction with Zero Fatalities program (under the Utah Department of Transportation). Most LHDs are doing an excellent job in training LHD staff or other staff from community agencies to inspect car seats as

a way of expanding available resources. Several Child Passenger Safety Technician trainings were held in rural areas of the state, greatly increasing the LHDs' capacity to conduct child safety seat inspections and checkpoints in the future. Multiple LHDs participated in re-certification trainings for technicians whose certification was close to expiring. In this way LHDs were able to use resources more efficiently by keeping skilled technicians rather than needing to train new individuals.

c.

Utah has seen a 42% decrease in the rate of non-fatal motor vehicle rate of injuries to children under age 14 in the last decade, from 415.83 per 100,000 in 2001 to 240.5 per 100,000 in 2011. Rates are calculated from combined hospital discharge and emergency department data. This decrease can be attributed to new laws (e.g., Utah's "Booster Seat" law passed in 2008) and the combined educational campaign efforts of all the partners. Motor vehicle crashes include five indicators: motor vehicle traffic occupants, motor vehicle traffic motorcyclist, motor vehicle traffic pedal cyclist, motor vehicle traffic pedestrian, and motor vehicle traffic other and unspecified.

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 04C - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 70.9 | 62.5 | 1,037.8 | 1,051.0 | 1,051.0 |
| Numerator | 320 | 287 | 4689 | 4749 | 4749 |
| Denominator | 451656 | 459367 | 451817 | 451836 | 451836 |
| 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 - 2013

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011

Denominator: IBIS Population Estimates 2011

** If Hospital Discharge data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

Notes - 2012

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011

Denominator: IBIS Population Estimates 2011

** If Hospital Discharge data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

Notes - 2011

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If Hospital Discharge data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

Narrative:

a.

The Utah Teen Driving Safety Task Force, co-chaired by the Violence and Injury Prevention Program (VIPP) and Utah Highway Safety Office, was formed in 2007 to better coordinate activities as well as resources for teen driving across the state. 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 (LHD) contracts with the VIPP for several years. All participating partners are operating under the same slogan and outreach campaigns, Don't Drive Stupid and Zero Fatalities.

b.

The Utah Teen Driving Task Force meets monthly to better coordinate activities and resources. Recently, the Task Force released its first ever strategic plan. This year a teen video and poster contest for a PSA was conducted and the sixth Teen Memorial book was released during National Teen Driver Safety Week. A Parent Night Program targeting parents of teens in public high school driver education classes was developed and has been highly successful. A parent guide was developed to accompany the class and is available online. VIPP contracted with Zero Fatalities and Utah Department of Transportation to develop a media campaign targeting parents of teens ages 15-17. The campaign included a YouTube video of parents and teens discussing GDL laws and the importance of parental involvement in driver education training, social media ads, and a radio ad. LHDs also conduct seatbelt observation studies at high schools in their areas and work with law enforcement to promote seat belt use. However, Utah currently only has primary seat belt enforcement for those under 18. The political climate makes it difficult to pursue a primary seat belt enforcement law with several proposed pieces of legislation failing in recent years. The Utah Legislature passed a ban on all cell phone use for drivers under age 19 in 2013 (texting use while driving was already banned). VIPP staff attends the Utah Coalition for Traffic Safety Coalition to stay up-to-date on pending legislation and provides weekly legislation updates to partners during the general legislative session.

c.

Utah's rate of non-fatal motor vehicle injuries for those aged 15-24 has decreased 38%, from 1712.05 per 100,000 (2006) to 1051.04 per 100,000 (2011). This rate was calculated using hospitalization and emergency department combined data. This decrease can be attributed to the combined efforts of the partners in a statewide educational campaign, Don't Drive Stupid, and changes in Utah's Graduated Driver Licensing laws which went into effect in 1999. Motor vehicle crashes include five indicators: motor vehicle traffic occupants, motor vehicle traffic motorcyclist, motor vehicle traffic pedal cyclist, motor vehicle traffic pedestrian, and motor vehicle traffic other

and unspecified.

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 05A - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 13.4 | 14.0 | 14.6 | 15.9 | 15.1 |
| Numerator | 1451 | 1543 | 1620 | 1772 | 1647 |
| Denominator | 108205 | 110053 | 110810 | 111682 | 109126 |
| 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 - 2013

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2013 (preliminary)
Denominator: IBIS Population Estimates 2013 (preliminary)

Notes - 2012

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2012 preliminary
Denominator: IBIS Population Estimates 2012 preliminary

Notes - 2011

Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2011
Denominator: IBIS Population Estimates 2011

Narrative:

a.

Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention, increased surveillance capacity, and improved services through reassignment of staff responsibilities within the Bureau of Epidemiology. A designated HIV/STD Surveillance Coordinator focuses solely on surveillance, reports, and data integrity activities. This shift allows STD prevention staff to conduct more technical assistance activities, which include supporting clinical and treatment services at local health departments, as well as providing education upon request. UDOH continues to coordinate with public and providers that offer STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 years of age.

CDC funding for prevention, testing, treatment, and local health department support has been impacted by a 2% sequestration cut in funding. The 2014-2018 grant years funding allocation continues to support testing and treatment services for 15-24 year old females and their partners.

Utah law regarding sexuality education in public schools prohibits advocacy of the use of

contraceptive methods or devices and restricts discussion of prevention methods to abstinence until marriage only. These policies pose some unique challenges in providing STD prevention education to 15-19 year old females. State law does, however, allow for minors to obtain STD testing and treatment without parental consent.

There are currently five sites in Utah providing Personal Responsibility Education Programs (PREP), which include information on contraceptives and STI prevention. As these programs are delivered outside of school systems, this does not conflict with laws on education in schools.

b.

Changes in organization at the UDOH provide new opportunities for collaboration between programs. Within the Bureau of Epidemiology, the Communicable Disease Analysis Reporting Program (CDARP) and the Communicable Disease Investigation and Response Program (CDIRP), have increased their collaborative efforts. This has allowed UDOH to better connect trends in rates to strategic interventions. As rates fluctuate, programs, strategies, and funding allocations are reviewed for effectiveness.

As programs continue to integrate and increase collaborative activities, UDOH staff is discovering additional areas where at-risk populations can be accessed and made efforts to reach these populations statewide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, such as the Statewide Chlamydia Screening Workgroup and Safety Net Workgroup, leading to more comprehensive and successful services by the programs involved.

c.

Preliminary 2013 data shows a Chlamydia rate of 15.1 per 1,000 females aged 15 through 19 years, a 5% decrease from the preliminary 2012 rate of 15.9. This decline is suggestive of the standard fluctuation seen over time in these rates.

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 05B - Multi-Year Data

| Annual Objective and Performance Data | 2009 | 2010 | 2011 | 2012 | 2013 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator | 4.9 | 5.5 | 6.2 | 6.6 | 6.3 |
| Numerator | 2493 | 2847 | 3113 | 3342 | 3270 |
| Denominator | 510434 | 519153 | 502558 | 509257 | 521020 |
| 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 - 2013

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2013 (Preliminary)

Denominator: IBIS Population Estimates 2013 (Preliminary)

Notes - 2012

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2012 (Preliminary)
Denominator: IBIS Population Estimates 2012 (Preliminary)

Notes - 2011

Numerator: Bureau of Epidemiology, Utah Department of Health, 2011
Denominator: IBIS Population Estimates 2011

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSI?
Please see HIS#5A, a.

CDC funding for prevention, testing, treatment, and local health department support has been impacted by a 2% sequestration cut in funding. Additionally, the 2014-2018 grant years restrict funding allocations to services for 15-24 year old females, their partners, and the men who have sex with men (MSM) population. This change has decreased access to testing and treatment services for women over the age of 24. However, STD prevention staff is hopeful that new provisions through the Affordable Care Act will assist in increasing accessibility to services for this population.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
Changes in organization at the UDOH provide new opportunities for collaboration between programs. Within the Bureau of Epidemiology, the Communicable Disease Analysis Reporting Program (CDARP) and the Communicable Disease Investigation and Response Program (CDIRP), have increased their collaborative efforts. This has allowed UDOH to better connect trends in rates to strategic interventions. As rates fluctuate, programs, strategies, and funding allocations are reviewed for effectiveness. STD prevention staff participates in meetings with outside partners to address issues related to this sexually transmitted disease.

As programs continue to integrate and increase collaborative activities, UDOH staff is discovering additional areas where at-risk populations can be accessed through connections other programs and staff have already made, as well as ways to strengthen efforts to reach these populations statewide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, such as the Statewide Chlamydia Screening Workgroup and Safety Net Workgroup, leading to more comprehensive and successful services by the programs involved.

c. Interpretation of what the data indicate:
Preliminary 2013 data shows a Chlamydia rate of 6.3 per 1,000 females aged 20 through 44 years, a 4.5% decrease from the preliminary 2012 rate of 6.6. This decline is suggestive of the standard fluctuation seen over time in these rates. Overall, the indicator allows UDOH to track trends in rates over time, monitor significant improvement or decline, and compare Utah statistics to national rates and trends.

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 National Performance Measures or our state priorities, such as preconception health and health care, promotion of healthy spacing between pregnancies, review of infant and 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 infants 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//

/2013/We recently created a half time position to address MCH quality improvement. This work is focused on defining the capacities of tertiary newborn intensive care units since hospitals self-declare as Level III. As we looked at hospitals that self-designate as tertiary units, we noted that some do not necessarily follow the AAP/ACOG guidelines. It is a very sensitive political issue which we hope will result in consensus about needed capacity.//2013//

We work closely with the Baby Your Baby Program (BYB) to promote healthy pregnancies and well children. /2013/We are transferring BYB to Medicaid for oversight. //2013// 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.

/2013/ With our early childhood efforts, we are working closely with the Bureau of Child Development on better integrating the Office of Home Visiting with MCH and CSHCN programs. The Connecticut "Help Me Grow" program is thriving in Utah County and we are exploring how we can support it in the Salt Lake Valley. We are excited about the possibility of having a program in the Salt Lake area. We have done some training and involved staff in the MCH grant planning process.//2013// **/2015/ HMG has been expanded into Salt Lake County. The Division Medical Director is the designated pediatric champion to assist with continued expansion.//2015//**

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.

/2013/Fostering Healthy Children Program works closely with the Department of Human Services to improve the mental, dental and physical health of children in the foster care system. We are also working with the Bureau of Health Promotion on a CDC grant application to establish a Center for Disability Health. The project will improve the health of adults with disabilities through accessible health promotion that is focused on people with disabilities, such as smoking cessation, asthma and diabetes prevention and improved vaccination rates. //2013//

In 2001, legislation known as Safe Haven 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". They will be responsible for public awareness activities, distribution of brochures, web site maintenance.//2012// ***//2015/The YWCA chose not to continue the program which is now managed by the Pregnancy Risk Line staff. The responsibilities for all of the Safe Haven work are covered by these staff members. In collaboration with EMS, another Bureau in our Division, phone calls are handled through on-call staff.//2015//***

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, agency partners and professional associations 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// //2013/ VISION was successfully rolled out in fall 2011. Due to the diligence of the WIC Director, the processes of system development, user testing, trainings and hardware installation etc. were thorough resulting in a high quality product that easily was rolled out. Local clinic staff is very pleased with the system. //2013//

//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// //2013/The Department continues its move towards accreditation through numerous efforts, such as strategic planning with four goals:

- Utahns are the Healthiest People in the Nation
- Putting Health into Health Care Reform
- Transforming Medicaid
- The Department is a Great Organization

Within the first goal, one area of focus is healthy babies which will enable Utah MCH to share our experiences, data, programs, etc. to move this agenda forward. It is a superb opportunity for us to have the Department focus on this area. We will be able to promote life course, preconception and interconception health, etc. It is a perfect fit for us to have such high level support to better address the issues we have identified over the years for mothers and infants. We are working with the March of Dimes and other partners to focus on this important area.//2013// //2014/Healthy Utah Babies is the assigned strategic plan goal for MCH and CSHCN. The work is being done by a cross section of Department staff including Medicaid, Health Promotion, Child Development, etc.//2014//

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 2013 | | FY 2014 | | FY 2015 | |
|----------------------------------------------------------|-----------|----------|----------|----------|-----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | 6238800 | 5997152 | 6629200 | | 6573700 | |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | 2152885 | 0 | 416900 | | 1871600 | |
| 3. State Funds <i>(Line3, Form 2)</i> | 11571700 | 13580276 | 12328100 | | 15572450 | |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | 2432253 | 3681100 | 2931400 | | 3681100 | |
| 5. Other Funds <i>(Line5, Form 2)</i> | 8620000 | 12099286 | 10372000 | | 13762100 | |
| 6. Program Income <i>(Line6, Form 2)</i> | 7999700 | 5952274 | 4543900 | | 5777200 | |
| 7. Subtotal | 39015338 | 41310088 | 37221500 | | 47238150 | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | 61386400 | 56874105 | 60152600 | | 58569500 | |
| 9. Total <i>(Line11, Form 2)</i> | 100401738 | 98184193 | 97374100 | | 105807650 | |

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2013 | | FY 2014 | | FY 2015 | |
|-----------------------------------------------------|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | 5908287 | 5695903 | 5042120 | | 6634732 | |
| b. Infants < 1 year old | 5521947 | 6090658 | 5389238 | | 6370482 | |
| c. Children 1 to 22 years old | 10297338 | 11218666 | 10366316 | | 11658292 | |
| d. Children with | 15693160 | 14533681 | 14863979 | | 18042358 | |

| | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|--|----------|--|
| Special Healthcare Needs | | | | | | |
| e. Others | 421606 | 2679514 | 579647 | | 3458836 | |
| f. Administration | 1173000 | 1091666 | 980200 | | 1073450 | |
| g. SUBTOTAL | 39015338 | 41310088 | 37221500 | | 47238150 | |
| 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 | 90000 | | 90000 | | 86000 | |
| c. CISS | 0 | | 150000 | | 137400 | |
| d. Abstinence Education | 343600 | | 953500 | | 908200 | |
| e. Healthy Start | 0 | | 0 | | 0 | |
| f. EMSC | 0 | | 0 | | 0 | |
| g. WIC | 49698600 | | 48448700 | | 45839600 | |
| h. AIDS | 0 | | 0 | | 0 | |
| i. CDC | 1191000 | | 974800 | | 842500 | |
| j. Education | 6990400 | | 7485600 | | 6382500 | |
| k. Home Visiting | 0 | | 0 | | 0 | |
| k. Other | | | | | | |
| Other | 3072800 | | 2050000 | | 4373300 | |

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

| | FY 2013 | | FY 2014 | | FY 2015 | |
|---------------------------------------------------------------|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Direct Health Care Services | 10067046 | 4619337 | 3342758 | | 6118740 | |
| II. Enabling Services | 15923520 | 24741915 | 21724395 | | 27417746 | |
| III. Population-Based Services | 4539187 | 4615645 | 4485847 | | 4707314 | |
| IV. Infrastructure Building Services | 8485585 | 7333191 | 7668500 | | 8994350 | |
| V. Federal-State Title V Block Grant Partnership Total | 39015338 | 41310088 | 37221500 | | 47238150 | |

A. Expenditures

Please see notes related to each Form.

An attachment is included in this section. VA - Expenditures

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

FY12 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 FY12 [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 \$15,572,000 of state funds appropriated by the Legislature for MCH activities. A total of \$5,997,000 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of \$4,497,864. 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 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 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 provides 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.

An attachment is included in this section. VB - Budget

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.

TITLE V BLOCK GRANT APPLICATION
FORMS (2-21)
STATE: UT
APPLICATION YEAR: 2015

- [FORM 2 - MCH BUDGET DETAILS](#)
- [FORM 3 - STATE MCH FUNDING PROFILE](#)
- [FORM 4 - BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED AND SOURCES OF FEDERAL FUNDS](#)
- [FORM 5 - STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES](#)
- [FORM 6 - NUMBER AND PERCENTAGE OF NEWBORN AND OTHERS SCREENED, CASE CONFIRMED, AND TREATED](#)
- [FORM 7 - NUMBER OF INDIVIDUALS SERVED \(UNDUPLICATED\) UNDER TITLE V](#)
- [FORM 8 - DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX](#)
- [FORM 9 - STATE MCH TOLL-FREE TELEPHONE LINE DATA](#)
- [FORM 10 - TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT STATE PROFILE FOR FY 2013](#)
- [FORM 11 - NATIONAL AND STATE PERFORMANCE MEASURES](#)
- [FORM 12 - NATIONAL AND STATE OUTCOME MEASURES](#)
- [FORM 13 - CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CHILDREN WITH SPECIAL HEALTH CARE NEEDS](#)
- [FORM 14 - LIST OF MCH PRIORITY NEEDS](#)
- [FORM 15 - TECHNICAL ASSISTANCE \(TA\) REQUEST AND TRACKING](#)
- [FORM 16 - STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEETS](#)
- [FORM 17 - HEALTH SYSTEM CAPACITY INDICATORS \(01 THROUGH 04,07,08\) - MULTI-YEAR DATA](#)
- FORM 18
 - [MEDICAID AND NON-MEDICAID COMPARISON](#)
 - [MEDICAID ELIGIBILITY LEVEL \(HSCI 06\)](#)
 - [SCHIP ELIGIBILITY LEVEL \(HSCI 06\)](#)
- FORM 19
 - [GENERAL MCH DATA CAPACITY \(HSCI 09A\)](#)
 - [ADOLESCENT TOBACCO USE DATA CAPACITY \(HSCI 09B\)](#)
- [FORM 20 - HEALTH STATUS INDICATORS 01-05 - MULTI-YEAR DATA](#)
- FORM 21
 - [POPULATION DEMOGRAPHICS DATA \(HSI 06\)](#)
 - [LIVE BIRTH DEMOGRAPHICS DATA \(HSI 07\)](#)
 - [INFANT AND CHILDREN MORTALITY DATA \(HSI 08\)](#)
 - [MISCELLANEOUS DEMOGRAPHICS DATA \(HSI 09\)](#)
 - [GEOGRAPHIC LIVING AREA DEMOGRAPHIC DATA \(HSI 10\)](#)
 - [POVERTY LEVEL DEMOGRAPHIC DATA \(HSI 11\)](#)
 - [POVERTY LEVEL FOR CHILDREN DEMOGRAPHICS DATA \(HSI 12\)](#)

FORM 2
MCH BUDGET DETAILS FOR FY 2015

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: UT

1. FEDERAL ALLOCATION

(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

\$

A.Preventive and primary care for children:

\$ (%)

B.Children with special health care needs:

\$ (%)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V administrative costs:

\$ (%)

(The above figure cannot be more than 10% [Sec. 504(d)])

2. UNOBLIGATED BALANCE (Item 15b of SF 424)

\$

3. STATE MCH FUNDS (Item 15c of the SF 424)

\$

4. LOCAL MCH FUNDS (Item 15d of SF 424)

\$

5. OTHER FUNDS (Item 15e of SF 424)

\$

6. PROGRAM INCOME (Item 15f of SF 424)

\$

7. TOTAL STATE MATCH (Lines 3 through 6)

(Below is your State's FY 1989 Maintenance of Effort Amount)

\$

\$

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL)

(Total lines 1 through 6. Same as line 15g of SF 424)

\$

9. OTHER FEDERAL FUNDS

(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS: \$

b. SSDI: \$

c. CISS: \$

d. Abstinence Education: \$

e. Healthy Start: \$

f. EMSC: \$

g. WIC: \$

h. AIDS: \$

i. CDC: \$

j. Education: \$

k. Home Visiting: \$

l. Other: \$

\$

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9)

\$

11. STATE MCH BUDGET TOTAL

(Partnership subtotal + Other Federal MCH Funds subtotal)

\$

FORM NOTES FOR FORM 2

The 424 form was not able to input the unobligated amount. Amount is \$0. This amount on the 424 form must match and therefore is not included. Actual amount \$1,871,600 which should be distributed between the classifications

FIELD LEVEL NOTES**1. Section Number:** Form2_Main**Field Name:** FedAlloc**Row Name:** Federal Allocation**Column Name:****Year:** 2015**Field Note:**

This amount includes all allocations as well as budgeting of unobligated balances to some programs in need of additional funding.

2. Section Number: Form2_Main**Field Name:** UnobligatedBalance**Row Name:** Unobligated Balance**Column Name:****Year:** 2015**Field Note:**

This field did not work as it didn't automatically put the value in from the 424. Numerous attempts were made, numerous contacts with HRS Call Center were made with no ability to resolve the software problem. We are not able to input the value into 424.

Actual unobligated amount \$1,871,600.

3. Section Number: Form2_Main**Field Name:** ProgramIncome**Row Name:** Program Income**Column Name:****Year:** 2015**Field Note:**

Program income \$5,777,200 same as 424 but it states that it is not the same.

FORM 3
STATE MCH FUNDING PROFILE

[Secs. 506(a) and 506(a)(1-3)]

STATE: UT

| | FY 2010 | | FY 2011 | | FY 2012 | |
|---------------------------------------------------|----------------|----------------|---------------|---------------|----------------|---------------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | \$ 6,013,898 | \$ 3,705,505 | \$ 6,013,353 | \$ 4,988,285 | \$ 5,967,609 | \$ 5,832,700 |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | \$ 567,502 | \$ 1,263,658 | \$ 1,424,947 | \$ 2,457,000 | \$ 2,521,991 | \$ 1,148,100 |
| 3. State Funds <i>(Line3, Form 2)</i> | \$ 23,484,900 | \$ 22,398,950 | \$ 12,431,500 | \$ 12,551,600 | \$ 12,581,700 | \$ 12,126,800 |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | \$ 4,548,728 | \$ 3,257,004 | \$ 4,337,379 | \$ 2,432,253 | \$ 3,257,004 | \$ 2,931,400 |
| 5. Other Funds <i>(Line5, Form 2)</i> | \$ 13,234,300 | \$ 10,697,300 | \$ 11,254,500 | \$ 9,059,900 | \$ 10,259,000 | \$ 11,760,100 |
| 6. Program Income <i>(Line6, Form 2)</i> | \$ 8,475,400 | \$ 8,193,000 | \$ 6,542,100 | \$ 6,392,300 | \$ 6,404,800 | \$ 4,615,000 |
| 7. Subtotal | \$ 56,324,728 | \$ 49,515,417 | \$ 42,003,779 | \$ 37,881,338 | \$ 40,992,104 | \$ 38,414,100 |
| (THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP) | | | | | | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | \$ 63,537,300 | \$ 63,707,300 | \$ 56,604,500 | \$ 60,151,100 | \$ 60,298,300 | \$ 58,848,600 |
| 9. Total <i>(Line11, Form 2)</i> | \$ 119,862,028 | \$ 113,222,717 | \$ 98,608,279 | \$ 98,032,438 | \$ 101,290,404 | \$ 97,262,700 |
| (STATE MCH BUDGET TOTAL) | | | | | | |

FORM 3
STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506(a)(1-3)]

STATE: UT

| | FY 2013 | | FY 2014 | | FY 2015 | |
|----------------------------------------------------------|----------------|---------------|---------------|----------|----------------|----------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | \$ 6,238,800 | \$ 5,997,152 | \$ 6,629,200 | \$ | \$ 6,573,700 | \$ |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | \$ 2,152,885 | \$ 0 | \$ 416,900 | \$ | \$ 1,871,600 | \$ |
| 3. State Funds <i>(Line3, Form 2)</i> | \$ 11,571,700 | \$ 13,580,276 | \$ 12,328,100 | \$ | \$ 15,572,450 | \$ |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | \$ 2,432,253 | \$ 3,681,100 | \$ 2,931,400 | \$ | \$ 3,681,100 | \$ |
| 5. Other Funds <i>(Line5, Form 2)</i> | \$ 8,620,000 | \$ 12,099,286 | \$ 10,372,000 | \$ | \$ 13,762,100 | \$ |
| 6. Program Income <i>(Line6, Form 2)</i> | \$ 7,999,700 | \$ 5,952,274 | \$ 4,543,900 | \$ | \$ 5,777,200 | \$ |
| 7. Subtotal | \$ 39,015,338 | \$ 41,310,088 | \$ 37,221,500 | \$ 0 | \$ 47,238,150 | \$ 0 |
| (THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP) | | | | | | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | \$ 61,386,400 | \$ 56,874,105 | \$ 60,152,600 | \$ | \$ 58,569,500 | \$ |
| 9. Total <i>(Line11, Form 2)</i> | \$ 100,401,738 | \$ 98,184,193 | \$ 97,374,100 | \$ 0 | \$ 105,807,650 | \$ 0 |
| (STATE MCH BUDGET TOTAL) | | | | | | |

FORM NOTES FOR FORM 3

Unobligated amount is incorrect. actual amount is \$1,871,600

FIELD LEVEL NOTES

1. **Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2013
Field Note:
MCH was not able spend as much as the previous year to to open positions that were not filled as fast as would have like including a bureau director position that had to be recruited twice to find an adiquate interview pool with proper qualifications.
2. **Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2012
Field Note:
Unobligated balance from previous year will compensate for the additional allocation that will be spent for FY2014.
3. **Section Number:** Form3_Main
Field Name: UnobligatedBalanceExpended
Row Name: Unobligated Balance
Column Name: Expended
Year: 2013
Field Note:
There has been a difference in the way that we account for the unobligated balance in the current years spending. All funds are spend before moving to the next years funding. It is more of timing as opposed to a cut of and restart balance.

Unobligated amount is incorrect. actual amount is \$1,871,600
4. **Section Number:** Form3_Main
Field Name: UnobligatedBalanceExpended
Row Name: Unobligated Balance
Column Name: Expended
Year: 2012
Field Note:
Acual Unobligated Balance differs due acutual expended amount in the time period of the grant. All funds from each grant are now expended and track to the grant until the grant is fully expended before going to the next years allocated funding.
5. **Section Number:** Form3_Main
Field Name: StateMCHFundsExpended
Row Name: State Funds
Column Name: Expended
Year: 2013
Field Note:
Child Care funding was included in the expenses which has been remove to a more fitting area.
6. **Section Number:** Form3_Main
Field Name: LocalMCHFundsExpended
Row Name: Local MCH Funds
Column Name: Expended
Year: 2013
Field Note:
Local fund have incorporated more spending than was expected.
7. **Section Number:** Form3_Main
Field Name: OtherFundsExpended
Row Name: Other Funds
Column Name: Expended
Year: 2013
Field Note:
Certain programs have been included that were not including in the budget of previous years.
8. **Section Number:** Form3_Main
Field Name: OtherFundsExpended
Row Name: Other Funds
Column Name: Expended
Year: 2012
Field Note:
From the previous year fund were located in Program Income that should been located in OTHER FUNDS
9. **Section Number:** Form3_Main
Field Name: ProgramIncomeExpended
Row Name: Program Income
Column Name: Expended
Year: 2013
Field Note:
Programs that were included in other funds are now included therefore the funding has increase. This movement more fully reflects what is actualy happening in the progams.
10. **Section Number:** Form3_Main
Field Name: ProgramIncomeExpended
Row Name: Program Income
Column Name: Expended
Year: 2012
Field Note:
Funds that were located in Program Income were moved to Other Income to more correlate with proper definitions.
11. **Section Number:** Form3_Main

Field Name: OtherFedFundsExpended

Row Name: Other Federal Funds

Column Name: Expended

Year: 2013

Field Note:

Other funds included programs that were eliminated or moved to other sections of the department and no longer reside under the management of the MCH Director.

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: UT

| | FY 2010 | | FY 2011 | | FY 2012 | |
|-------------------------------------------------------------------------------------------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | \$ 6,691,853 | \$ 5,804,468 | \$ 5,894,708 | \$ 5,624,234 | \$ 5,870,240 | \$ 5,839,882 |
| b. Infants < 1 year old | \$ 7,444,465 | \$ 6,317,659 | \$ 6,318,827 | \$ 7,453,764 | \$ 5,910,108 | \$ 5,764,797 |
| c. Children 1 to 22 years old | \$ 22,621,976 | \$ 19,183,095 | \$ 12,667,704 | \$ 8,056,320 | \$ 11,751,736 | \$ 10,645,895 |
| d. Children with Special Healthcare Needs | \$ 15,530,885 | \$ 14,834,457 | \$ 15,484,711 | \$ 15,129,556 | \$ 15,726,864 | \$ 14,697,553 |
| e. Others | \$ 2,767,349 | \$ 2,400,075 | \$ 664,829 | \$ 419,380 | \$ 575,156 | \$ 522,873 |
| f. Administration | \$ 1,268,200 | \$ 975,663 | \$ 973,000 | \$ 1,198,084 | \$ 1,158,000 | \$ 943,100 |
| g. SUBTOTAL | \$ 56,324,728 | \$ 49,515,417 | \$ 42,003,779 | \$ 37,881,338 | \$ 40,992,104 | \$ 38,414,100 |
| 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 | \$ 80,200 | | \$ 89,500 | | \$ 95,000 | |
| c. CISS | \$ 140,000 | | \$ 104,100 | | \$ 124,000 | |
| d. Abstinence Education | \$ 288,000 | | \$ 0 | | \$ 319,000 | |
| e. Healthy Start | \$ 0 | | \$ 0 | | \$ 0 | |
| f. EMSC | \$ 0 | | \$ 0 | | \$ 0 | |
| g. WIC | \$ 44,042,500 | | \$ 45,088,500 | | \$ 49,939,600 | |
| h. AIDS | \$ 0 | | \$ 0 | | \$ 0 | |
| i. CDC | \$ 10,275,800 | | \$ 1,382,100 | | \$ 1,293,300 | |
| j. Education | \$ 7,177,100 | | \$ 8,432,900 | | \$ 8,527,400 | |
| k. Home Visiting | \$ 0 | | \$ 0 | | \$ 0 | |
| l. Other | | | | | | |
| See Notes | \$ 1,533,700 | | \$ 1,507,400 | | \$ | |
| III. TOTAL | \$ 63,537,300 | | \$ 56,604,500 | | \$ 60,298,300 | |

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: UT

| | FY 2013 | | FY 2014 | | FY 2015 | |
|-------------------------------------------------------------------------------------------------------------------------|---------------|---------------|---------------|----------|---------------|----------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | \$ 5,908,287 | \$ 5,695,903 | \$ 5,042,120 | | \$ 6,634,732 | |
| b. Infants < 1 year old | \$ 5,521,947 | \$ 6,090,658 | \$ 5,389,238 | | \$ 6,370,482 | |
| c. Children 1 to 22 years old | \$ 10,297,338 | \$ 11,218,666 | \$ 10,366,316 | | \$ 11,658,292 | |
| d. Children with Special Healthcare Needs | \$ 15,693,160 | \$ 14,533,681 | \$ 14,863,979 | | \$ 18,042,358 | |
| e. Others | \$ 421,606 | \$ 2,679,514 | \$ 579,647 | | \$ 3,458,836 | |
| f. Administration | \$ 1,173,000 | \$ 1,091,666 | \$ 980,200 | | \$ 1,073,450 | |
| g. SUBTOTAL | \$ 39,015,338 | \$ 41,310,088 | \$ 37,221,500 | \$ 0 | \$ 47,238,150 | \$ 0 |
| 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 | \$ 90,000 | | \$ 90,000 | | \$ 86,000 | |
| c. CISS | \$ 0 | | \$ 150,000 | | \$ 137,400 | |
| d. Abstinence Education | \$ 343,600 | | \$ 953,500 | | \$ 908,200 | |
| e. Healthy Start | \$ 0 | | \$ 0 | | \$ 0 | |
| f. EMSC | \$ 0 | | \$ 0 | | \$ 0 | |
| g. WIC | \$ 49,698,600 | | \$ 48,448,700 | | \$ 45,839,600 | |
| h. AIDS | \$ 0 | | \$ 0 | | \$ 0 | |
| i. CDC | \$ 1,191,000 | | \$ 974,800 | | \$ 842,500 | |
| j. Education | \$ 6,990,400 | | \$ 7,485,600 | | \$ 6,382,500 | |
| k. Home Visiting | \$ 0 | | \$ 0 | | \$ 0 | |
| l. Other | | | | | | |
| Other | \$ 3,072,800 | | \$ 2,050,000 | | \$ 4,373,300 | |
| III. TOTAL | \$ 61,386,400 | | \$ 60,152,600 | | \$ 58,569,500 | |

FORM NOTES FOR FORM 4

The 424 form was not able to input the unobligated amount. Amount is \$0. This amount on the 424 form must match and therefore is not included. Actual amount \$1,871,600 which should be distributed between the classifications

FIELD LEVEL NOTES

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2015
Field Note:
Use of unobligated balances reflect the additional funding in this area.
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenExpended
Row Name: Pregnant Women
Column Name: Expended
Year: 2013
Field Note:
Movement of some programs within the division have adjusted where the funding was distributed. Overall fund has stayed relatively constant
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Budgeted
Row Name: Infants <1 year old
Column Name: Budgeted
Year: 2015
Field Note:
Programs have remained constant with prior years funding
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Expended
Row Name: Infants <1 year old
Column Name: Expended
Year: 2013
Field Note:
Funding will remain constant with prior years
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Budgeted
Row Name: Children 1 to 22 years old
Column Name: Budgeted
Year: 2015
Field Note:
Funding has increase slightly for additional possible rendering of services
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Expended
Row Name: Children 1 to 22 years old
Column Name: Expended
Year: 2013
Field Note:
Funding has remain constant with these programs
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2015
Field Note:
Use of unobligated balances reflect the additional funding in this area.
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2013
Field Note:
Funding in this area will be increase in the coming years to due program movement and unobligated balances.
9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2015
Field Note:
Use of unobligated balances reflect the additional funding in this area.
10. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others
Column Name: Expended
Year: 2013
Field Note:
Use of unobligated balances reflect the additional funding in this area for the years to come. Also movement of programs to this area reflect what is actually happening with the programs.
11. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminBudgeted
Row Name: Administration
Column Name: Budgeted
Year: 2015

Field Note:

Funding in this area has remained constant to prior years services

12. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminExpended

Row Name: Administration

Column Name: Expended

Year: 2013

Field Note:

Funding has remain constant with prior years level of service

13. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminExpended

Row Name: Administration

Column Name: Expended

Year: 2012

Field Note:

Administration has decrease due to budgetary cuts and reassignment of duties.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 506(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: UT

| TYPE OF SERVICE | FY 2010 | | FY 2011 | | FY 2012 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.) | \$ 11,181,494 | \$ 9,836,115 | \$ 10,036,795 | \$ 9,284,467 | \$ 9,742,362 | \$ 3,187,924 |
| II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.) | \$ 19,487,351 | \$ 16,848,654 | \$ 18,134,409 | \$ 16,170,389 | \$ 17,510,487 | \$ 22,977,045 |
| III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.) | \$ 14,772,033 | \$ 12,878,405 | \$ 5,575,435 | \$ 4,227,188 | \$ 5,253,125 | \$ 4,442,341 |
| IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.) | \$ 10,883,850 | \$ 9,952,243 | \$ 8,257,140 | \$ 8,199,294 | \$ 8,486,130 | \$ 7,806,790 |
| V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.) | \$ 56,324,728 | \$ 49,515,417 | \$ 42,003,779 | \$ 37,881,338 | \$ 40,992,104 | \$ 38,414,100 |

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: UT

| TYPE OF SERVICE | FY 2013 | | FY 2014 | | FY 2015 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|---------------|----------|---------------|----------|
| | BUDGETED | EXPENDED | BUDGETED | EXPENDED | BUDGETED | EXPENDED |
| I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.) | \$ 10,067,046 | \$ 4,619,337 | \$ 3,342,758 | \$ | \$ 6,118,740 | \$ |
| II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.) | \$ 15,923,520 | \$ 24,741,915 | \$ 21,724,395 | \$ | \$ 27,417,746 | \$ |
| III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.) | \$ 4,539,187 | \$ 4,615,645 | \$ 4,485,847 | \$ | \$ 4,707,314 | \$ |
| IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.) | \$ 8,485,585 | \$ 7,333,191 | \$ 7,668,500 | \$ | \$ 8,994,350 | \$ |
| V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.) | \$ 39,015,338 | \$ 41,310,088 | \$ 37,221,500 | \$ 0 | \$ 47,238,150 | \$ 0 |

FORM NOTES FOR FORM 5

The 424 form was not able to input the unobligated amount. Amount is \$0. This amount on the 424 form must match and therefore is not included. Actual amount \$1,871,600 which should be distributed between the classifications

FIELD LEVEL NOTES

1. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2015
Field Note:
Movement of programs within the MCH Bureau have cause shifts in allocation of fund as well as the use of unobligated fund to increase some programs and services.
2. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2013
Field Note:
Programs will be move to reflect actual program functions and will cause a redistribution of funding.
3. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2012
Field Note:
Direct service allocations were being overreported previously. We re-evaluated how we reported allocations for direct services and realized that we had included administration in those figures. In addition, we moved Early Intervention out of direct services into enabling since it is an educational program.
4. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2015
Field Note:
Movement of programs within the MCH Bureau have cause shifts in allocation of fund as well as the use of unobligated fund to increase some programs and services.
5. **Section Number:** Form5_Main
Field Name: EnablingExpended
Row Name: Enabling Services
Column Name: Expended
Year: 2013
Field Note:
Programs will be move to reflect actual program functions and will cause a redistribution of funding.
6. **Section Number:** Form5_Main
Field Name: EnablingExpended
Row Name: Enabling Services
Column Name: Expended
Year: 2012
Field Note:
Enabling service allocations have increased significantly mainly due to a shift of Early Intervention allocations from direct services to enabling services since it is an educational program.
7. **Section Number:** Form5_Main
Field Name: PopBasedBudgeted
Row Name: Population-Based Services
Column Name: Budgeted
Year: 2015
Field Note:
Movement of programs within the MCH Bureau have cause shifts in allocation of fund as well as the use of unobligated fund to increase some programs and services.
8. **Section Number:** Form5_Main
Field Name: PopBasedExpended
Row Name: Population-Based Services
Column Name: Expended
Year: 2013
Field Note:
Programs will be move to reflect actual program functions and will cause a redistribution of funding.
9. **Section Number:** Form5_Main
Field Name: PopBasedExpended
Row Name: Population-Based Services
Column Name: Expended
Year: 2012
Field Note:
Enabling funding was increase due to administrative adjustment in duties and responsibilities
10. **Section Number:** Form5_Main
Field Name: InfrastrBuildBudgeted
Row Name: Infrastructure Building Services
Column Name: Budgeted
Year: 2015
Field Note:
Movement of programs within the MCH Bureau have cause shifts in allocation of fund as well as the use of unobligated fund to increase some programs and services.

11. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2013
Field Note:

Programs will be move to reflect actual program functions and will cause a redistribution of funding.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: UT

Total Births by Occurrence:

Reporting Year: 2012

| 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. | % |
| Phenylketonuria | 50,873 | 96.5 | 4 | 2 | 2 | 100 |
| Congenital Hypothyroidism | 50,873 | 96.5 | 23 | 14 | 14 | 100 |
| Galactosemia | 50,873 | 96.5 | 2 | 0 | 0 | |
| Sickle Cell Disease | 50,873 | 96.5 | 256 | 0 | 0 | |
| Other Screening (Specify) | | | | | | |
| Congenital Adrenal Hyperplasia | 50,873 | 96.5 | 8 | 7 | 7 | 100 |
| Cystic Fibrosis | 50,873 | 96.5 | 24 | 15 | 15 | 100 |
| Biotinidase | 50,873 | 96.5 | 1 | 1 | 1 | 100 |
| Amino Acid Disorders** | 50,873 | 96.5 | 19 | 5 | 5 | 100 |
| Galactosemia (non-classical) | 50,873 | 96.5 | 2 | 0 | 0 | |
| Hemoglobinopathies (non-sickle cell disease) | 50,873 | 96.5 | 256 | 225 | 225 | 100 |
| Hearing Screening*** | 51,880 | 98.4 | 696 | 100 | 70 | 70 |
| Acylcarnitine Disorder* | 50,873 | 96.5 | 39 | 13 | 13 | 100 |
| Screening Programs for Older Children & Women (Specify Tests by name) | | | | | | |
| Diet Monitoring, 0-18y (Ref 1) | 672 | | 82 | 82 | 82 | 100 |
| Diet Monitoring Pregnant Women (Ref 2) | 46 | | 3 | 3 | 3 | 100 |

(1) Use occurrent births as denominator.
 (2) Report only those from resident births.
 (3) Use number of confirmed cases as denominator.

FORM NOTES FOR FORM 6

None

FIELD LEVEL NOTES**1. Section Number:** Form6_Main

Field Name: BirthOccurence

Row Name: Total Births By Occurence

Column Name: Total Births By Occurence

Year: 2015

Field Note:

Occurence births: 52727

Resident births: 51439

2. Section Number: Form6_Other Screening Types

Field Name: Other

Row Name: All Rows

Column Name: All Columns

Year: 2015

Field Note:

*Confirmed acylcarnitine disorders include: medium-chain acyl-CoA dehydrogenase deficiency (7); very long-chain acyl-CoA dehydrogenase deficiency (3); isovaleric acidemia (1); multiple carboxylase deficiency (1); propionic acidemia (1)

**Confirmed amino acid disorders include: phenylketonuria, classic (2); phenylketonuria, non-classical (2); ornithine transcarbamylase deficiency (1)

***Number of hearing cases needing treatment that received treatment includes only those confirmed public Early Intervention enrollment.

3. Section Number: Form6_Screening Programs for Older Children and Women

Field Name: OtherWomen

Row Name: All Rows

Column Name: All Columns

Year: 2015

Field Note:

Ref 1: Diet monitoring; 672 specimens submitted from 82 clients

Ref 2: Diet monitoring for pregnant women; 46 specimens submitted from 3 clients

FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: UT

Number of Individuals Served - Historical Data by Annual Report Year

| Types of Individuals Served | 2008 | 2009 | 2010 | 2011 | 2012 |
|----------------------------------------|----------------|---------------|----------------|---------------|---------------|
| Pregnant Women | 10,237 | 9,524 | 8,938 | 9,457 | 8,685 |
| Infants < 1 year old | 56,320 | 56,788 | 55,143 | 53,395 | 52,288 |
| Children 1 to 22 years old | 42,514 | 10,197 | 43,291 | 28,616 | 21,982 |
| Children with Special Healthcare Needs | 5,149 | 4,826 | 3,223 | 2,941 | 2,529 |
| Others | 5,377 | 3,621 | 3,086 | 2,713 | 2,581 |
| Total | 119,597 | 84,956 | 113,681 | 97,122 | 88,065 |

Reporting Year: 2013

| Types of Individuals Served | TITLE V | PRIMARY SOURCES OF COVERAGE | | | | |
|----------------------------------------|---------------------|-----------------------------|--------------------|------------------------|---------------|------------------|
| | (A) Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private/Other % | (E) None % | (F) Unknown % |
| Pregnant Women | 8,736 | 43.6 | 0.2 | 4.8 | 24.4 | 27.0 |
| Infants < 1 year old | 52,727 | 82.0 | 0.2 | 5.1 | 11.1 | 1.6 |
| Children 1 to 22 years old | 16,822 | 36.0 | 1.5 | 28.4 | 34.1 | 0.0 |
| Children with Special Healthcare Needs | 2,678 | 40.2 | 2.7 | 49.9 | 7.2 | 0.0 |
| Others | 2,148 | 4.3 | 0.0 | 2.6 | 72.5 | 20.6 |
| TOTAL | 83,111 | | | | | |

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

1. **Section Number:** Form7_Main
Field Name: PregWomen_TS
Row Name: Pregnant Women
Column Name: Title V Total Served
Year: 2015
Field Note:
The number does not include # of PRL calls for CY13: 7747 (pregnancy related=4328; breastfeeding=3086; other=333).
2. **Section Number:** Form7_Main
Field Name: Children_0_1_TS
Row Name: Infants <1 year of age
Column Name: Title V Total Served
Year: 2015
Field Note:
Vital Record Birth Certificate Data, 2012, Occurrent Births
3. **Section Number:** Form7_Main
Field Name: Children_1_22_TS
Row Name: Children 1 to 22 years of age
Column Name: Title V Total Served
Year: 2015
Field Note:
Data derived from LHD MCH Service Report FY2013

The number of children (1 - 22) served decreased from last few years as some local health departments did not add immunizations in their reporting.

LHD Southwest data derived from 2012 report
4. **Section Number:** Form7_Main
Field Name: CSHCN_TS
Row Name: Children with Special Health Care Needs
Column Name: Title V Total Served
Year: 2015
Field Note:
CSHCN CADURx data CY13
5. **Section Number:** Form7_Main
Field Name: AllOthers_TS
Row Name: Others
Column Name: Title V Total Served
Year: 2015
Field Note:
Data derived from LHD MCH Service Report FY13 (FP)

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(By RACE AND ETHNICITY)
[Sec. 506(a)(2)(C-D)]
STATE: UT

Reporting Year: 2012

I. UNDUPLICATED COUNT BY RACE

| | (A) Total All Races | (B) White | (C) Black or African American | (D) American Indian or Native Alaskan | (E) Asian | (F) Native Hawaiian or Other Pacific Islander | (G) More than one race reported | (H) Other and Unknown |
|---------------------------|------------------------|--------------|----------------------------------|------------------------------------------|--------------|--------------------------------------------------|------------------------------------|--------------------------|
| DELIVERIES | | | | | | | | |
| Total Deliveries in State | 51,833 | 43,195 | 647 | 698 | 1,235 | 669 | | 5,389 |
| Title V Served | 50,604 | 42,185 | 597 | 665 | 1,228 | 664 | | 5,265 |
| Eligible for Title XIX | 17,315 | 13,046 | 456 | 462 | 458 | 349 | | 2,544 |
| INFANTS | | | | | | | | |
| Total Infants in State | 52,727 | 43,987 | 655 | 703 | 1,260 | 678 | | 5,444 |
| Title V Served | 51,439 | 42,950 | 577 | 670 | 1,253 | 673 | | 5,316 |
| Eligible for Title XIX | 17,448 | 13,256 | 345 | 466 | 465 | 353 | | 2,563 |

II. UNDUPLICATED COUNT BY ETHNICITY

| | (A) Total NOT Hispanic or Latino | (B) Total Hispanic or Latino | (C) Ethnicity Not Reported | HISPANIC OR LATINO (Sub-categories by country or area of origin) | | | | |
|---------------------------|-------------------------------------|---------------------------------|-------------------------------|------------------------------------------------------------------|----------------|-----------------------|-------------------------------------|----------------------------|
| | | | | (B.1) Mexican | (B.2) Cuban | (B.3) Puerto Rican | (B.4) Central and South American | (B.5) Other and Unknown |
| DELIVERIES | | | | | | | | |
| Total Deliveries in State | 42,858 | 7,673 | 1,160 | | | | | 7,673 |
| Title V Served | 41,790 | 7,517 | 1,129 | | | | | 7,517 |
| Eligible for Title XIX | 13,049 | 3,712 | 422 | | | | | 3,712 |
| INFANTS | | | | | | | | |
| Total Infants in State | 43,649 | 7,747 | 1,188 | | | | | 7,747 |
| Title V Served | 42,555 | 7,568 | 1,155 | | | | | 7,568 |
| Eligible for Title XIX | 13,267 | 3,743 | 424 | | | | | 3,743 |

FORM NOTES FOR FORM 8

None

FIELD LEVEL NOTES

None

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(a)(E) AND 509(a)(8)]
STATE: UT

| | FY 2015 | FY 2014 | FY 2013 | FY 2012 | FY 2011 |
|-------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|------------------------------------------|------------------------------------------|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (888) 222-2542 | (888) 222-2542 | (888) 222-2542 | (888) 222-2542 | (888) 222-2542 |
| 2. State MCH Toll-Free "Hotline" Name | Children's Health Insurance Program | Children's Health Insurance Program | Children's Health Insurance Program | CHIP Children's Health Insurance Program | CHIP Children's Health Insurance Program |
| 3. Name of Contact Person for State MCH "Hotline" | Marie Nagata | Marie Nagata | Marie Nagata | Marie Nagata | Marie Nagata |
| 4. Contact Person's Telephone Number | (801) 538-6519 | (801) 538-6519 | (801) 538-6519 | (801) 538-6519 | (801) 538-6519 |
| 5. Contact Person's Email | mnagata@utah.gov | mnagata@utah.gov | mnagata@utah.gov | mnagata@utah.gov | mnagata@utah.gov |
| 6. Number of calls received on the State MCH "Hotline" this reporting period | 0 | 0 | 58681 | 9486 | 11723 |

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(a)(E) AND 509(a)(8)]
STATE: UT

| | FY 2015 | FY 2014 | FY 2013 | FY 2012 | FY 2011 |
|-------------------------------------------------------------------------------------|------------------|------------------|------------------|------------------|------------------|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (800) 826-9662 | (800) 826-9662 | (800) 826-9662 | 800) 826-9662 | (800) 826-9662 |
| 2. State MCH Toll-Free "Hotline" Name | Baby Your Baby |
| 3. Name of Contact Person for State MCH "Hotline" | Marie Nagata |
| 4. Contact Person's Telephone Number | 801-538-6519 | 801-538-6519 | 801-538-6519 | (801)-538-6519 | (801) 538-6519 |
| 5. Contact Person's Email | mnagata@utah.gov | mnagata@utah.gov | mnagata@utah.gov | mnagata@utah.gov | mnagata@utah.gov |
| 6. Number of calls received on the State MCH "Hotline" this reporting period | 0 | 0 | 12116 | 12220 | 14758 |

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

None

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2015
[Sec. 506(a)(1)]
STATE: UT

1. State MCH Administration:
(max 2500 characters)

The Utah Department of Health is the State Title V agency. The Department Executive Director, W. David Patton, PhD, sits on the Governor's Cabinet and as such, has opportunities to promote the importance of public health. The State Title V Director is Nan Streeter. Title V is incorporated into two Divisions in the Department, primarily the Division of Family Health and Preparedness (DFHP) has most of the MCH/CSHCN programs and the Division of Disease Control and Prevention houses the violence and injury prevention program. The Division of Family Health and Preparedness is headed by Marc Babitz, MD, a family medicine physician who has been a Division Director for a number of years. Two Bureau Directors serve as Deputy Division Directors. One Deputy Director oversees the Primary Health, EMS and Preparedness side of the Division. Nan Streeter is Deputy Director over the Title V programs including the CSHCN Bureau and the Child Development Bureau. Noel Taxin is the CSHCN Bureau Director and Teresa Whiting is the Director of the Bureau of Child Development. Harper Randall, MD, is the Medical Director for the three Bureaus. Each of the three bureaus focuses on a special population either mother and infants, children or children with special health care needs. The Bureau of Child Development houses all of the early childhood programs including Early Intervention, child care licensing, early childhood systems, and home visiting. The Division oversees all MCH block grant activities. Programs that fall under the purview of the Deputy Director include maternal and infant health, oral health, clinics for children with special health care needs, such as the Neonatal Follow-up Program, Newborn Blood Screening, Newborn Hearing Screening, and traveling clinics in addition to other federally funded programs, such as Part C, WIC, PRAMS, etc. Title V funds portions of other programs, such as violence and injury prevention. Staff from the three bureaus works closely together to promote healthy mothers and children.

Block Grant Funds

| | |
|------------------------------------------------------------|---------------------------------------------------|
| 2. Federal Allocation (Line 1, Form 2) | \$ <input type="text" value="6,573,700"/> |
| 3. Unobligated balance (Line 2, Form 2) | \$ <input type="text" value="1,871,600"/> |
| 4. State Funds (Line 3, Form 2) | \$ <input type="text" value="15,572,450"/> |
| 5. Local MCH Funds (Line 4, Form 2) | \$ <input type="text" value="3,681,100"/> |
| 6. Other Funds (Line 5, Form 2) | \$ <input type="text" value="13,762,100"/> |
| 7. Program Income (Line 6, Form 2) | \$ <input type="text" value="5,777,200"/> |
| 8. Total Federal-State Partnership (Line 8, Form 2) | \$ <input type="text" value="47,238,150"/> |

9. Most significant providers receiving MCH funds:

| |
|--------------------------|
| University of Utah |
| Local health departments |
| |
| |

10. Individuals served by the Title V Program (Col. A, Form 7)

| | |
|-------------------------------|-------------------------------------|
| a. Pregnant Women | <input type="text" value="8,736"/> |
| b. Infants < 1 year old | <input type="text" value="52,727"/> |
| c. Children 1 to 22 years old | <input type="text" value="16,822"/> |
| d. CSHCN | <input type="text" value="2,678"/> |
| e. Others | <input type="text" value="2,148"/> |

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

Most direct and enabling services provided by the Department are through CSHCN clinics held in Salt Lake City, Ogden and Provo and in rural areas of the state. CSHCN clinics provide support services so that families can apply for Medicaid and/or SSI. CSHCN provides specialty services to children with special needs in rural areas without any pediatric or pediatric specialty provider in the community. Utah has vast rural and frontier areas without specialists of any kind including obstetricians/gynecologists and pediatricians. Baby Your Baby is the Title V Hotline and also is a referral line for numerous community resources for the public. The hotline answers more than 20 hotlines for UDOH. One of the hotline's primary functions is referring pregnant women to Medicaid eligibility workers and to help pregnant women get Presumptive Eligibility to begin prenatal care while awaiting determination of eligibility for Medicaid. The Department accesses language translation services for individuals who call and are non-English speaking. With significant increases in non-English speaking populations in the state, local health departments and UDOH are challenged in ensuring that these individuals are able to access services and information they understand. Many materials are printed in Spanish, but there are many more languages spoken in Utah that we are not able to address with our limited resources

b. Population-Based Services:
(max 2500 characters)

The Department of Health provides a large number of population based services. The state Newborn Screening Program tests for 38 conditions having just implemented SCID testing July 1st. The Newborn Hearing Screening program has successfully implemented hearing screening in all birth hospitals and also for home births. Both programs work with lay midwives to ensure that all babies born at home are screened appropriately. Both programs have strong follow-up practices which assist families in obtaining newborn screenings as determined by state law. The Baby Your Baby website continues to promote early entry into prenatal care. Pregnancy RiskLine is a telephone service to callers requesting information about the possible impact of an exposure to infectious agents, chemicals, medications, etc., on the mother, fetus or breastfed infant. The Birth Defects Network conducts surveillance on structural birth defects and works to prevent neural tube defects through promotion of multivitamin use. Breastfeeding is strongly encouraged in Utah and fortunately a large proportion of Utah mothers do initiate breastfeeding. The First Time Motherhood grant work continues as a preconception health effort. Teen pregnancy prevention is a strong focus for us and through the federal abstinence programs, we are able to reach more youth. We believe that abstinence only is a component of a continuum of methods to prevent teen pregnancies, especially among younger school age children. Oral Health promotes the importance of oral health as it impacts overall health. The Violence and Injury Program is focusing on teen motor vehicle deaths to reduce injuries due to alcohol or drugs or poor driving skills. They also focus on bicycle safety, seat belt use, booster seats, etc. The Department conducts surveys to obtain information on health issues in the state. The Department produces a great deal of information to promote health and to quantify health concerns among its populations. The IBIS system is well used by staff and the public to obtain data in a user friendly manner.

c. Infrastructure Building Services:
(max 2500 characters)

Infrastructure capacity is strong in the Department of Health and within Title V programs. Title V includes a large number of health care professionals including physicians, a dentist, registered nurses, social workers, health educators, physical and occupational therapists, psychologists, audiologists, and so on. Department data capacity is exceptional and includes an All Payer

Database, Medicaid Data Warehouse, and online access to vital records, survey data and other data through IBIS (Utah's Indicator Based Information System). Survey data on IBIS include PRAMS, YRBSS, BRFSS, among others. IBIS affords many staff ready access to data to use in our work. Division data capacity is strong. The Division's data capacity is vital in assisting MCH and CSHCN programs with data needs, data analysis and reporting, survey development, and planning and evaluation. With the MCH Epidemiologist in the Division, Title V programs are better able to analyze and utilize data to identify issues that require public health intervention. The MCH Epidemiologist and her team are able to conduct higher level data analysis, participate with partners on research studies, and develop surveys based on sound methodology. Utah PRAMS, YRBS, BRFSS data are widely used in the work of Title V programs. PRAMS is overseen by Title V which is advantageous for our program planning. We use the data often and they guide our program strategies. Data have directed programs to develop interventions that may be very different than originally planned because the data didn't support assumptions. We are currently working with hospitals that self designate as tertiary NICUs due to concern that not all might actually fit the definition of a Level III unit. The Department has been heavily involved in cHIE efforts using Division developed CHARMs the core of cHIE, to be complemented by other data systems, such as pharmacy data, billing data and others. We are advancing our QI efforts by supporting the Utah Womens and Newborns Quality Collaborative work that will focus on prevention of recurrent preterm births, neonatal abstinence syndrome and out of hospital births. These projects include partners from outside UDOH

12. The primary Title V Program contact person:

13. The children with special health care needs (CSHCN) contact person:

14. State Family or Youth Leader Contact person:

| | | | | | |
|---------|---------------------------------------------------|---------|------------------------------------------------------|---------|------------------------------------------------------|
| Name | <input type="text" value="Nan Streeter"/> | Name | <input type="text" value="Noel Taxin"/> | Name | <input type="text" value="Gina Pola-Money"/> |
| Title | <input type="text" value="Title V Director"/> | Title | <input type="text" value="CSHCN Bureau Director"/> | Title | <input type="text" value="Family Representative"/> |
| Address | <input type="text" value="PO Box 142001"/> | Address | <input type="text" value="44 Mario Cappechi Drive"/> | Address | <input type="text" value="44 Mario Cappechi Drive"/> |
| City | <input type="text" value="Salt Lake City"/> | City | <input type="text" value="Salt Lake City"/> | City | <input type="text" value="Salt Lake City"/> |
| State | <input type="text" value="UT"/> | State | <input type="text" value="UT"/> | State | <input type="text" value="UT"/> |
| Zip | <input type="text" value="84114-2001"/> | Zip | <input type="text" value="84113"/> | Zip | <input type="text" value="84113"/> |
| Phone | <input type="text" value="801-538-6869"/> | Phone | <input type="text" value="801-584-8529"/> | Phone | <input type="text" value="801-584-5829"/> |
| Fax | <input type="text" value="801-538-9409"/> | Fax | <input type="text" value="801-584-8488"/> | Fax | <input type="text" value="801-584-8488"/> |
| Email | <input type="text" value="nanstreeter@utah.gov"/> | Email | <input type="text" value="ntaxin@utah.gov"/> | Email | <input type="text" value="gpola-money@utah.gov"/> |
| Web | <input type="text"/> | Web | <input type="text"/> | Web | <input type="text"/> |

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (a)(2)(A)(iii)]
STATE: UT

Form Level Notes for Form 11

None

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.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 423 | 417 | 322 | 302 | 302 |
| Denominator | 423 | 417 | 322 | 302 | 302 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #1
Field Name: PM01
Row Name:
Column Name:
Year: 2013
Field Note:
 Utah Newborn Screening Program Database 2012 Data
- Section Number:** Form11_Performance Measure #1
Field Name: PM01
Row Name:
Column Name:
Year: 2012
Field Note:
 Utah Newborn Screening Program Database 2012 Data
- Section Number:** Form11_Performance Measure #1
Field Name: PM01
Row Name:
Column Name:
Year: 2011
Field Note:
 Data reported are the most recent data available.
 Utah Newborn Screening Program Database 2011 Data

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)

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 55.1 | 55.1 | 55.1 | 71.5 | 71.5 |
| Annual Indicator | 55.1 | 55.1 | 71.5 | 71.5 | 71.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 71.5 | 71.5 | 71.5 | 71.5 | 72 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. Section Number: Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. Section Number: Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2011

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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)

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 52.2 | 52.2 | 52.2 | 46.2 | 46.2 |
| Annual Indicator | 52.2 | 52.2 | 46.2 | 46.2 | 46.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 46.2 | 46.2 | 46.2 | 46.2 | 46.2 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2011

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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)

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 59.5 | 59.5 | 59.5 | 55.9 | 55.9 |
| Annual Indicator | 59.5 | 59.5 | 55.9 | 55.9 | 55.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 55.9 | 55.9 | 55.9 | 56 | 56 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2011

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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)

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 86.2 | 86.2 | 86.2 | 62.2 | 62.2 |
| Annual Indicator | 86.2 | 86.2 | 62.2 | 62.2 | 62.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 62.2 | 62.2 | 62.2 | 62.2 | 62.2 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2011

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|-------------------------|--------------|--------------|--------------|
| Annual Performance Objective | 42.5 | 42.5 | 42.5 | 49.3 | 49.3 |
| Annual Indicator | 42.5 | 42.5 | 49.3 | 49.3 | 49.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote for source | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 49.3 | 49.3 | 49.3 | 49.3 | 49.3 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2011

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 82.5 | 80 | 75.8 | 70.6 | 71.1 |
| Annual Indicator | 75.8 | 70.6 | 70.6 | 71.1 | 74.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 74.9 | 74.9 | 75 | 75.1 | 75.1 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2013

Field Note:

This measure does not have a numerator or denominator because it is taken from CDC's 2012 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

2. Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2012

Field Note:

This measure does not have a numerator or denominator because it is taken from CDC's 2011 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

3. Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2010 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 18.5 | 18.5 | 16.5 | 14.3 | 11.1 |
| Annual Indicator | 16.5 | 14.3 | 11.2 | 10.3 | 10.3 |
| Numerator | 995 | 876 | 706 | 668 | 668 |
| Denominator | 60,127 | 61,154 | 63,253 | 64,625 | 64,625 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 10.2 | 10.1 | 10 | 9.9 | 9.8 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2013

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: IBIS Population estimates for 2012

2. Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2012

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: IBIS Population estimates for 2012

3. Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Denominator: IBIS Population estimates for 2011

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 45.1 | 45.1 | 41.9 | 41.9 | 41.9 |
| Annual Indicator | 45.1 | 41.9 | 41.9 | 41.9 | 41.9 |
| Numerator | 155 | 392 | 392 | 392 | 392 |
| Denominator | 344 | 935 | 935 | 935 | 935 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 41.9 | 41.9 | 45 | 45 | 45 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #9
Field Name: PMD9
Row Name:
Column Name:
Year: 2013
Field Note:
 Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
- Section Number:** Form11_Performance Measure #9
Field Name: PMD9
Row Name:
Column Name:
Year: 2012
Field Note:
 Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
 Unweighted=40.2%, weighted=41.9%
- Section Number:** Form11_Performance Measure #9
Field Name: PMD9
Row Name:
Column Name:
Year: 2011
Field Note:
 Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
 Unweighted=40.2%, weighted=41.9%

PERFORMANCE MEASURE # 10

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

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|---------|---------|---------|---------|---------|
| Annual Performance Objective | 3.4 | 4.3 | 2.2 | 2 | 2.8 |
| Annual Indicator | 2.2 | 2.0 | 2.8 | 1.6 | 1.6 |
| Numerator | 16 | 15 | 21 | 12 | 12 |
| Denominator | 736,615 | 749,214 | 749,774 | 754,356 | 754,356 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 1.6 | 1.6 | 1.6 | 1.6 | 1.6 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2012
 Denominator: IBIS Population estimates for 2012
- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2012
 Denominator: IBIS Population estimates for 2012
- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2010
 Denominator: IBIS Population estimates for 2010

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 60.5 | 69.6 | 58.5 | 61.5 | 65 |
| Annual Indicator | 69.5 | 61.5 | 61.5 | 64.4 | 64.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 64.2 | 64.5 | 65 | 65.2 | 65.4 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes**1. Section Number:** Form11_Performance Measure #11**Field Name:** PM11**Row Name:****Column Name:****Year:** 2013**Field Note:**

The data reported are from the National Immunization Survey, 2010 (Prelim data). These data are only reported by percentage so no numerator or denominator is available for state level reporting.

2. Section Number: Form11_Performance Measure #11**Field Name:** PM11**Row Name:****Column Name:****Year:** 2012**Field Note:**

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2009. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

3. Section Number: Form11_Performance Measure #11**Field Name:** PM11**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2008. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 97.9 | 98.1 | 98.3 | 98.6 | 98.8 |
| Annual Indicator | 96.3 | 98.6 | 98.8 | 97.8 | 97.8 |
| Numerator | 54,225 | 52,624 | 51,661 | 51,541 | 51,541 |
| Denominator | 55,143 | 53,395 | 52,288 | 52,727 | 52,727 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 97.8 | 97.9 | 97.9 | 98 | 98.1 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2012

2. Section Number: Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2012

Field Note:

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2012

3. Section Number: Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2011

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|---------|---------|---------|---------|---------|
| Annual Performance Objective | 9.1 | 8.3 | 5.9 | 5.9 | 7.9 |
| Annual Indicator | 6.9 | 5.9 | 7.9 | 9.0 | 9.0 |
| Numerator | 59,700 | 51,367 | 69,600 | 80,500 | 80,500 |
| Denominator | 860,368 | 870,623 | 886,110 | 892,307 | 892,307 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 9 | 9 | 8.5 | 8.5 | 8 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #13
Field Name: PM13
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2012
 Denominator: IBIS Population estimates 2012
- Section Number:** Form11_Performance Measure #13
Field Name: PM13
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2012
 Denominator: IBIS Population estimates 2012
- Section Number:** Form11_Performance Measure #13
Field Name: PM13
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2011
 Denominator: IBIS Population estimates 2011

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.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 21.8 | 21.8 | 20.7 | 20.7 | 19.1 |
| Annual Indicator | 21.8 | 20.7 | 20.7 | 19.3 | 24.7 |
| Numerator | 6,558 | 7,083 | 7,083 | 9,967 | 11,753 |
| Denominator | 30,083 | 34,217 | 34,217 | 51,735 | 47,644 |

Data Source See footnote for source See footnote See footnote See Footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Final

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 24.6 | 24 | 24 | 23.6 | 23.6 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2013

Field Note:

WIC SharePoint Ad Hoc Report Child Participation Count, 2013 Data
 (Includes infants and 1 year olds at risk in the measure with 2 - 5 year olds)

* CDC no longer provides the data on this measure.

2. **Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2012

Field Note:

WIC SharePoint Ad Hoc Report Child Participation Count, 2012 Data
 (Includes infants and 1 year olds at risk in the measure with 2 - 5 year olds)

* CDC no longer provides the data on this measure.

3. **Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2011

Field Note:

The data are from the 2010 CDC Pediatric Nutrition Surveillance, Table 6F (combining the 85th-95th and greater than or equal to 95th BMI categories).

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 4 | 3.8 | 3.5 | 3.2 | 3.2 |
| Annual Indicator | 3.6 | 3.2 | 3.3 | 3.4 | 3.4 |
| Numerator | 1,936 | 1,666 | 1,668 | 1,732 | 1,732 |
| Denominator | 53,894 | 52,164 | 51,144 | 51,439 | 51,439 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 3.3 | 3.2 | 3.1 | 3 | 3 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15

Field Name: PM15

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

2. **Section Number:** Form11_Performance Measure #15

Field Name: PM15

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

3. **Section Number:** Form11_Performance Measure #15

Field Name: PM15

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|---------|---------|---------|---------|---------|
| Annual Performance Objective | 10.6 | 11 | 12.1 | 11.4 | 10.8 |
| Annual Indicator | 12.1 | 11.4 | 10.8 | 16.4 | 16.4 |
| Numerator | 26 | 25 | 24 | 36 | 36 |
| Denominator | 215,470 | 219,146 | 221,712 | 218,983 | 218,983 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 16.4 | 16.4 | 16.3 | 16.2 | 16 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2012
 Denominator: IBIS Population estimates for 2012
- Section Number:** Form11_Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2012
 Denominator: IBIS Population estimates for 2012
- Section Number:** Form11_Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2010
 Denominator: IBIS Population estimates for 2010 (GOPB).

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 81 | 82 | 80.5 | 90 | 90.2 |
| Annual Indicator | 78.3 | 89.8 | 90.1 | 91.8 | 91.8 |
| Numerator | 440 | 520 | 499 | 505 | 505 |
| Denominator | 562 | 579 | 554 | 550 | 550 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 91.8 | 91.9 | 92 | 92 | 92 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

2. Section Number: Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

3. Section Number: Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 10 self-designated level III hospitals.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 79 | 79.1 | 71.7 | 73.1 | 74.9 |
| Annual Indicator | 71.6 | 73.1 | 74.7 | 75.5 | 75.5 |
| Numerator | 38,562 | 38,124 | 38,228 | 38,829 | 38,829 |
| Denominator | 53,894 | 52,164 | 51,144 | 51,439 | 51,439 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 75.7 | 75.9 | 76.1 | 76.3 | 76.5 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18

Field Name: PM18

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

2. **Section Number:** Form11_Performance Measure #18

Field Name: PM18

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

3. **Section Number:** Form11_Performance Measure #18

Field Name: PM18

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (A)(2)(A)(iii)]
STATE: UT

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - REPORTING YEAR

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.

| | Annual Objective and Performance Data | | | | |
|-----------------------------------|---------------------------------------|--------------|--------------|--------------|--------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Performance Objective | | | 38 | 37.6 | 37.7 |
| Annual Indicator | | 37.6 | 37.6 | 39.0 | 39.0 |
| Numerator | | 52,274 | 52,274 | 210,880 | 210,880 |
| Denominator | | 138,948 | 138,948 | 541,138 | 541,138 |
| Data Source | See footnote | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 38.9 | 39 | 39.2 | 39.4 | 39.6 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #1

Field Name: SM1

Row Name:

Column Name:

Year: 2013

Field Note:

Data based on Utah Behavioral Risk Factor Surveillance System, 2012
 (This question only asked even year, N & D represents weighted numbers)

2. **Section Number:** Form11_State Performance Measure #1

Field Name: SM1

Row Name:

Column Name:

Year: 2012

Field Note:

Data based on Utah Behavioral Risk Factor Surveillance System, 2012
 (This question only asked even year, N & D represents weighted numbers)

3. **Section Number:** Form11_State Performance Measure #1

Field Name: SM1

Row Name:

Column Name:

Year: 2011

Field Note:

Data based on Utah Behavioral Risk Factor Surveillance System, 2010
 Utah BRFSS 2012 data are not yet available

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

The percentage of Primary Cesarean Section Deliveries among Low Risk women giving birth for the first time.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 17 | 17 | 16.9 |
| Annual Indicator | 17.8 | 17.6 | 16.9 | 17.1 | 17.1 |
| Numerator | 2,695 | 2,566 | 2,410 | 2,463 | 2,463 |
| Denominator | 15,150 | 14,581 | 14,244 | 14,435 | 14,435 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| Annual Performance Objective | 17 | 16.9 | 16.9 | 16.8 | 16.8 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

2. **Section Number:** Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

3. **Section Number:** Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

The percentage of live births born before 37 completed weeks gestation.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 9.7 | 9.7 | 9.4 |
| Annual Indicator | 9.8 | 9.5 | 9.4 | 9.1 | 9.1 |
| Numerator | 5,272 | 4,957 | 4,830 | 4,692 | 4,692 |
| Denominator | 53,894 | 52,164 | 51,144 | 51,439 | 51,439 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| Annual Performance Objective | 9.1 | 8.9 | 8.8 | 8.5 | 8.3 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form11_State Performance Measure #3

Field Name: SMB

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

2. Section Number: Form11_State Performance Measure #3

Field Name: SMB

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2012

3. Section Number: Form11_State Performance Measure #3

Field Name: SMB

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

STATE PERFORMANCE MEASURE # 4 - REPORTING YEAR

The percentage of Medicaid eligible children (1-5) receiving any dental service.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 39 | 37.2 | 39.5 |
| Annual Indicator | | 37.5 | 37.2 | 39.1 | 40.1 |
| Numerator | | 32,945 | 33,907 | 35,396 | 34,858 |
| Denominator | | 87,885 | 91,229 | 90,431 | 86,978 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| Annual Performance Objective | 40.2 | 40.3 | 40.5 | 42 | 42 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #4

Field Name: SM4

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Medicaid CMS 416, FFY2013

Denominator: Medicaid CMS 416, FFY2013

2. **Section Number:** Form11_State Performance Measure #4

Field Name: SM4

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Medicaid CMS 416, FFY2012

Denominator: Medicaid CMS 416, FFY2012

3. **Section Number:** Form11_State Performance Measure #4

Field Name: SM4

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Medicaid CMS 416, FFY2011

Denominator: Medicaid CMS 416, FFY2011

STATE PERFORMANCE MEASURE # 5 - REPORTING YEAR

The percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings in their practice.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | | | 0 | 0 | 70.2 |
| Annual Indicator | | | | 70.2 | 70.2 |
| Numerator | | | | 80 | 80 |
| Denominator | | | | 114 | 114 |
| Data Source | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| Annual Performance Objective | 70.2 | 70.2 | 70.2 | 72 | 72 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2013

Field Note:

Utah Developmental Screening Survey 2012-2013

2. **Section Number:** Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2012

Field Note:

Utah Developmental Screening Survey 2012-2013

3. **Section Number:** Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2011

Field Note:

State will be implementing a developmental screening survey during summer, CY 2012. Based on the survey results, projections will be set in future for this measure.

STATE PERFORMANCE MEASURE # 6 - REPORTING YEAR

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.

| | Annual Objective and Performance Data | | | | |
|-----------------------------------|---------------------------------------|--------------|--------------|--------------|--------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Performance Objective | | | 10.6 | 7.8 | 7.8 |
| Annual Indicator | 10.7 | 10.7 | 7.8 | 7.8 | 5.7 |
| Numerator | 164 | 164 | 127 | 127 | 114 |
| Denominator | 1,533 | 1,533 | 1,628 | 1,628 | 2,001 |
| Data Source | See footnote | See footnote | See footnote | See Footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 5.5 | 5.5 | 5.5 | 5.5 | 5.5 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_State Performance Measure #6
Field Name: SM6
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: YRBS, 2013, survey sample data
 Denominator: YRBS, 2013, survey sample data
- Section Number:** Form11_State Performance Measure #6
Field Name: SM6
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: YRBS, 2011, survey sample data
 Denominator: YRBS, 2011, survey sample data
- Section Number:** Form11_State Performance Measure #6
Field Name: SM6
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: YRBS, 2011, survey sample data
 Denominator: YRBS, 2011, survey sample data

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

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.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 25.9 | 25.5 | 25.9 | 26.7 | 26.6 |
| Annual Indicator | 26.0 | 26.0 | 26.7 | 26.7 | 26.4 |
| Numerator | 408 | 408 | 450 | 450 | 570 |
| Denominator | 1,569 | 1,569 | 1,687 | 1,687 | 2,157 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| Annual Performance Objective | 26.3 | 26.2 | 26.1 | 26 | 25.9 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes**1. Section Number:** Form11_State Performance Measure #7

Field Name: SM7

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: YRBS, 2013

Denominator: YRBS, 2013

2. Section Number: Form11_State Performance Measure #7

Field Name: SM7

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: YRBS, 2011

Denominator: YRBS, 2011

3. Section Number: Form11_State Performance Measure #7

Field Name: SM7

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: YRBS, 2011

Denominator: YRBS, 2011

STATE PERFORMANCE MEASURE # 8 - REPORTING YEAR

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.

| | Annual Objective and Performance Data | | | | |
|-----------------------------------|---------------------------------------|--------------|--------------|--------------|--------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Performance Objective | | | 47.5 | 48.5 | 48.5 |
| Annual Indicator | 47.3 | 47.3 | 48.5 | 48.5 | 48.7 |
| Numerator | 744 | 744 | 811 | 811 | 1,045 |
| Denominator | 1,572 | 1,572 | 1,672 | 1,672 | 2,145 |
| Data Source | See footnote | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 48.7 | 48.8 | 48.8 | 49 | 49 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_State Performance Measure #8
Field Name: SMB
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: YRBS, 2013 (unweighted n=1029, IBIS)
 Denominator: YRBS, 2013
- Section Number:** Form11_State Performance Measure #8
Field Name: SMB
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: YRBS, 2011
 Denominator: YRBS, 2011
- Section Number:** Form11_State Performance Measure #8
Field Name: SMB
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: YRBS, 2011
 Denominator: YRBS, 2011

STATE PERFORMANCE MEASURE # 9 - REPORTING YEAR

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.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|-----------------------------------|-------------------------|--------------|--------------|--------------|--------------|
| Annual Performance Objective | 12 | 11 | 5.5 | 4 | 2.8 |
| Annual Indicator | 10.4 | 5.2 | 4.0 | 2.8 | 3.3 |
| Numerator | 2,305 | 1,190 | 1,083 | 798 | 927 |
| Denominator | 22,080 | 22,745 | 26,880 | 28,039 | 28,094 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| Annual Performance Objective | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9

Field Name: SM9

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: The number of children served in the rural area based on the CSHCN billing system, 2013

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

2. **Section Number:** Form11_State Performance Measure #9

Field Name: SM9

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: The number of children served in the rural area based on the CSHCN billing system, 2012.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

3. **Section Number:** Form11_State Performance Measure #9

Field Name: SM9

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: The number of children served in the rural area based on the Mega West billing system, 2011.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

STATE PERFORMANCE MEASURE # 10 - REPORTING YEAR

The percentage of children (birth -17) eligible for Medicaid DMwho are eligible for SSI.

| | Annual Objective and Performance Data | | | | |
|-----------------------------------|---------------------------------------|--------------|--------------|--------------|--------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Performance Objective | | | 85 | 92.5 | 96.3 |
| Annual Indicator | 75.0 | 92.5 | 92.0 | 96.3 | 94.9 |
| Numerator | 3,821 | 4,899 | 5,070 | 5,502 | 5,426 |
| Denominator | 5,093 | 5,295 | 5,511 | 5,715 | 5,715 |
| Data Source | See footnote for data source | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Final |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 94.9 | 94.9 | 94.9 | 94.9 | 94.9 |
| Annual Indicator | Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period. | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Field Level Notes

- Section Number:** Form11_State Performance Measure #10
Field Name: SM10
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator
 UDOH Medicaid Data Warehouse, 2013, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type

 Denominator
 Number of unique children (0-17) receiving SSI during specific month by age (December). Social Security Report
- Section Number:** Form11_State Performance Measure #10
Field Name: SM10
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator
 UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type
 Denominator
 Number of unique children (0-17) receiving SSI during specific month by age (December). Social Security Report
- Section Number:** Form11_State Performance Measure #10
Field Name: SM10
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator
 UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type.

 Denominator
 SOURCE: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table—Number and percentage distribution of children in Utah receiving federally administered SSI payments, by selected characteristics, December 2010.

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 1.6 | 1.6 | 1.3 | 1.9 | 2 |
| Annual Indicator | 1.6 | 1.9 | 2.5 | 2.5 | 2.5 |
| Numerator | 7.4 | 8.9 | 12 | 11.7 | 11.7 |
| Denominator | 4.7 | 4.6 | 4.8 | 4.6 | 4.6 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 2.6 | 2.6 | 2.5 | 2.5 | 2.4 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. Section Number: Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Mortality database and Birth Certificate. UDOH 2010-2012

Denominator: Office of Vital Records and Statistics, Mortality database and Birth Certificate Database. UDOH 2010-2012

The infant mortality rates are based on 3-year moving average (2010-2012). The Black infant mortality rate was 11.73 (21 deaths, 1791 births); White infant mortality rate was 4.55 (656 deaths, 144,065 births).

2. Section Number: Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Mortality database and Birth Certificate. UDOH 2010-2012

Denominator: Office of Vital Records and Statistics, Mortality database and Birth Certificate Database. UDOH 2010-2012

The infant mortality rates are based on 3-year moving average (2010-2012). The Black infant mortality rate was 11.73 (21 deaths, 1791 births); White infant mortality rate was 4.55 (656 deaths, 144,065 births).
 Ratio=2.58

3. Section Number: Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Mortality database and Birth Certificate. UDOH 2009-2011

Denominator: Office of Vital Records and Statistics, Mortality database and Birth Certificate Database. UDOH 2009-2011

The infant mortality rates are based on 3-year moving average (2009-2011). The Black infant mortality rate was 12.03 (22 deaths, 1829 births); White infant mortality rate was 4.8 (688 deaths, 142,590 births).

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 3.4 | 3.2 | 3.4 | 3.2 | 3.6 |
| Annual Indicator | 3.9 | 3.3 | 3.6 | 3.4 | 3.4 |
| Numerator | 209 | 174 | 185 | 173 | 173 |
| Denominator | 53,849 | 52,164 | 51,144 | 51,439 | 51,439 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 3.4 | 3.3 | 3.3 | 3.2 | 3.2 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. Section Number: Form12_Outcome Measure 3

Field Name: OMD3

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH 2012

2. Section Number: Form12_Outcome Measure 3

Field Name: OMD3

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH 2012

3. Section Number: Form12_Outcome Measure 3

Field Name: OMD3

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH 2011

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 1.6 | 1.5 | 1.4 | 1.4 | 1.9 |
| Annual Indicator | 1.4 | 1.5 | 1.9 | 1.5 | 1.5 |
| Numerator | 76 | 77 | 97 | 75 | 75 |
| Denominator | 53,849 | 52,164 | 51,144 | 51,439 | 51,439 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 1.5 | 1.4 | 1.4 | 1.3 | 1.3 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

- Section Number:** Form12_Outcome Measure 4
Field Name: OMD4
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database. UDOH 2012
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH 2012
- Section Number:** Form12_Outcome Measure 4
Field Name: OMD4
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database. UDOH 2012
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH 2012
- Section Number:** Form12_Outcome Measure 4
Field Name: OMD4
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database. UDOH 2011
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH 2011

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|--------|--------|--------|--------|--------|
| Annual Performance Objective | 4.9 | 5 | 5.5 | 5.3 | 4.8 |
| Annual Indicator | 5.7 | 5.4 | 4.8 | 4.3 | 4.3 |
| Numerator | 309 | 281 | 246 | 222 | 222 |
| Denominator | 54,197 | 52,460 | 51,422 | 51,703 | 51,703 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 4.5 | 4.5 | 4.4 | 4.4 | 4.3 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. Section Number: Form12_Outcome Measure 5

Field Name: OMD5

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Stillbirth database and Mortality database, UDOH 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database and Stillbirth database. UDOH 2012

2. Section Number: Form12_Outcome Measure 5

Field Name: OMD5

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Stillbirth database and Mortality database, UDOH 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database and Stillbirth database. UDOH 2012

3. Section Number: Form12_Outcome Measure 5

Field Name: OMD5

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Stillbirth database and Mortality database, UDOH 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database and Stillbirth database. UDOH 2011

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------------------|---------|---------|---------|---------|---------|
| Annual Performance Objective | 17.9 | 20 | 15.2 | 16.3 | 17.1 |
| Annual Indicator | 15.2 | 16.3 | 17.2 | 13.2 | 13.2 |
| Numerator | 104 | 113 | 120 | 93 | 93 |
| Denominator | 682,305 | 693,972 | 698,648 | 704,080 | 704,080 |

Data Source See footnote for source See footnote See footnote See footnote 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final Provisional

Annual Objective and Performance Data

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 17 | 16 | 15 | 14 | 13 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

- Section Number:** Form12_Outcome Measure 6
Field Name: OMD6
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2012
 Denominator: IBIS Population estimates for 2012
- Section Number:** Form12_Outcome Measure 6
Field Name: OMD6
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2012
 Denominator: IBIS Population estimates for 2012
- Section Number:** Form12_Outcome Measure 6
Field Name: OMD6
Row Name:
Column Name:
Year: 2011
Field Note:
 Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2011
 Denominator: IBIS Population estimates for 2011

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (a)(2)(B)(iii) AND 506 (a)(2)(A)(iii)]
STATE: UT

Form Level Notes for Form 12

None

STATE OUTCOME MEASURE # 1 - REPORTING YEAR

Reduce the maternal mortality rate per 100,000 live births.

| | <u>Annual Objective and Performance Data</u> | | | | |
|------------------------------------------|----------------------------------------------|--------------|--------------|--------------|-------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Performance Objective | 16 | 15 | 15 | 15 | 19 |
| Annual Indicator | 16.7 | 17.3 | 19.6 | 15.6 | 15.6 |
| Numerator | 9 | 9 | 10 | 8 | 8 |
| Denominator | 53,849 | 52,164 | 51,144 | 51,439 | 51,439 |
| Data Source | See footnote for source | See footnote | See footnote | See footnote | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | <u>Annual Objective and Performance Data</u> | | | | |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 15 | 15 | 14.8 | 14.8 | 14.7 |
| Annual Indicator | | | | | |
| Numerator | Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data. | | | | |
| Denominator | | | | | |

Field Level Notes

1. Section Number: Form12_State Outcome Measure 1

Field Name: SO1

Row Name:

Column Name:

Year: 2013

Field Note:

The rate is computed based on the women who die within 12 months of completion of pregnancy. Maternal Mortality Review Program. 2012

Numerator:

Hand counted by individual case examination, 2012 data (matched fetal or infant birth/death certificates for women of childbearing ages 15-44 who die within one year of birth due to a perinatal related or associated cause or condition)

Denominator: Office of Vital Records & Statistics (OVRs), Birth Certificate Data, 2012

2. Section Number: Form12_State Outcome Measure 1

Field Name: SO1

Row Name:

Column Name:

Year: 2012

Field Note:

The rate is computed based on the women who die within 12 months of completion of pregnancy. Maternal Mortality Review Program. 2012

Numerator:

Hand counted by individual case examination, 2012 data (matched fetal or infant birth/death certificates for women of childbearing ages 15-44 who die within one year of birth due to a perinatal related or associated cause or condition)

Denominator: Office of Vital Records & Statistics (OVRs), Birth Certificate Data, 2012

3. Section Number: Form12_State Outcome Measure 1

Field Name: SO1

Row Name:

Column Name:

Year: 2011

Field Note:

The rate is computed based on the women who die within 12 months of completion of pregnancy. Maternal Mortality Review Program. 2011

Numerator:

Hand counted by individual case examination (matched fetal or infant birth/death certificates for women of childbearing ages 15-44 who die within one year of birth due to a perinatal related or associated cause or condition).

Denominator: Office of Vital Records & Statistics (OVRs), Birth Certificate Data, 2011

STATE OUTCOME MEASURE # 2 - REPORTING YEAR

Reduce fetal mortality rate per 1000 live births and fetal deaths.

| | Annual Objective and Performance Data | | | | |
|-----------------------------------|---------------------------------------|--------------|--------------|--------------|--------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Performance Objective | | | 5.3 | 5.6 | 5.4 |
| Annual Indicator | 5.5 | 5.6 | 5.4 | 5.1 | 5.1 |
| Numerator | 297 | 296 | 278 | 264 | 264 |
| Denominator | 54,146 | 52,460 | 51,422 | 51,703 | 51,703 |
| Data Source | See footnote | See footnote | See footnote | See footnote | See footnote |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | Annual Objective and Performance Data | | | | |
|------------------------------|---------------------------------------|------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual Performance Objective | 5.1 | 5.1 | 5 | 5 | 5 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. Section Number: Form12_State Outcome Measure 2

Field Name: SO2

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Fetal Mortality database. UDOH 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database 2012 and Fetal Mortality database 2012

2. Section Number: Form12_State Outcome Measure 2

Field Name: SO2

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Fetal Mortality database. UDOH 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database 2012 and Fetal Mortality database 2012

3. Section Number: Form12_State Outcome Measure 2

Field Name: SO2

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Office of Vital Records and Statistics, Fetal Mortality database 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database 2011 and Fetal Mortality database 2011

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: UT

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

4. Family members are involved in service training of CSHCN staff and providers.

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

6. Family members of diverse cultures are involved in all of the above activities.

Total Score:

Rating Key

- 0 = Not Met
- 1 = Partially Met
- 2 = Mostly Met
- 3 = Completely Met

FORM NOTES FOR FORM 13

None

FIELD LEVEL NOTES

None

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(6)]

STATE: UT FY: 2015

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase, list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Increase the percentage of women of childbearing age taking multivitamins with optimum level of folic acid.
2. Reduce the percentage of primary Cesarean Section deliveries among low-risk women giving birth for the first time.
3. Reduce the percentage of live births born before 37 completed weeks' gestation.
4. Increase the percentage of Medicaid eligible children (1-5) receiving any dental service.
5. Increase early and appropriate developmental screening for Utah children (Birth – 5).
6. Decrease the incidence of tobacco use among adolescents.
7. Decrease the percent of adolescents who feel so sad or hopeless almost everyday for two weeks or more in a row during the last 12 months.
8. Increase percentage of students who were physically active at least 60 minutes per day on 5 or more days of the past 7 days.
9. Increase percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.
10. Increase the percentage of children (birth – 17) eligible for Medicaid DM who are eligible for SSI.

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE UT

APPLICATION YEAR: 2015

| No. | Category of Technical Assistance Requested | Description of Technical Assistance Requested <i>(max 250 characters)</i> | Reason(s) Why Assistance Is Needed <i>(max 250 characters)</i> | What State, Organization or Individual Would You suggest Provide the TA (if known) <i>(max 250 characters)</i> |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| 1. | Other If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text" value="NA"/> | Enhancing capacity for Needs Assessment | Since we are going to be doing a needs assessment, we are interested in innovative ways to do it. | ? |
| 2. | Other If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text" value="NA"/> | Selection of State Priorities | Since we need to select new ones, we would be interested in innovative ways to identify them | ? |
| 3. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 4. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 5. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 6. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 7. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 8. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 9. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 10. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the | | | |

| | | | | |
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| | measure number here: <input type="text"/> | | | |
| 11. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |
| 12. | If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/> | | | |

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: UT

SP() #

| | |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PERFORMANCE MEASURE: | 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. |
| STATUS: | Active |
| GOAL | Increase the percentage of women of childbearing age taking multivitamins with optimum level of folic acid |
| DEFINITION | <p>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.</p> <p>Numerator: Number of women ages 18-44 years surveyed who report taking a multivitamin or supplement with 400mcg of folic acid daily.</p> <p>Denominator: Total number of women ages 18-44 years surveyed.</p> <p>Units: 100 Text: Percent</p> |
| HEALTHY PEOPLE 2020 OBJECTIVE | <p>16-16a Consumption of at least 400 mcg of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15-44.</p> <p>16-15 Reduce the occurrence of spina bifida and other neural tube defects</p> |
| DATA SOURCES AND DATA ISSUES | Utah Behavioral Risk Factor Surveillance System (BRFSS). The folic acid module is generally conducted every other year. |
| SIGNIFICANCE | The U. S. Public Health Service and CDC recommend that all women of childbearing age consume 0.4 mg (400 micrograms) of folic acid daily to prevent two common and serious birth defects, spina bifida and anencephaly. That recommendation applies to any woman of childbearing age, even if she's not trying to conceive, since many pregnancies aren't planned. CDC estimates that 50% to 70% of these birth defects could be prevented if this recommendation were followed before conception and during early pregnancy (the periconceptional period). |

SP() #

PERFORMANCE MEASURE:

The percentage of Primary Cesarean Section Deliveries among Low Risk women giving birth for the first time.

STATUS:

Active

GOAL

Reduce the percentage of Primary Cesarean Section Deliveries among Low Risk women giving birth for the first time.

DEFINITION

Reduce the percentage of Primary Cesarean Section Deliveries among Low Risk women giving birth for the first time.

Numerator:

Number of births delivered by cesarean section to low-risk females giving birth for the first time.

Denominator:

Number of live births to low-risk females giving birth for the first time.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

16-9

Reduce cesarean births among low risk (full-term, singleton, vertex presentation) women.

DATA SOURCES AND DATA ISSUES

Utah Vital Statistics Birth Certificate data

SIGNIFICANCE

In 2006, nearly one-third (31%) of all children in the U.S. were born by Cesarean delivery. This represents a 50% increase over the past decade, from 20.7% in 1996. The increases are present in all age groups and for all races and ethnic origins, without identified concurrent sources of increased obstetrical risk. The increase in Cesarean delivery is an issue of importance for all women, but even more so for first time mothers (primigravidas), as the trend is increasingly to schedule repeat Cesareans for all subsequent births, once a woman has had one Cesarean birth. This trend has implications not only for a woman's entire reproductive life, but also for infants and the entire health care system. Since a Cesarean delivery entails major surgery for the mother, the following complications may occur (and occur often at a greater rate than for vaginal delivery): postpartum hemorrhage, infection, anesthetic complications, placental problems in subsequent pregnancies (including placenta previa and accreta), postpartum depression, and increased risk of surgical complications in the presence of maternal obesity. Effects of Cesarean delivery on the newborn may include difficulty with initiation of breastfeeding, prematurity, lacerations, and respiratory problems. Both mother and infant will experience longer and more costly hospital stays than after the normal vaginal delivery.

SP() #

PERFORMANCE MEASURE:

The percentage of live births born before 37 completed weeks gestation.

STATUS:

Active

GOAL

Reduce the percentage of live births born before 37 completed weeks gestation

DEFINITION

Reduce the percentage of live births born before 37 completed weeks gestation

Numerator:

Number of live births born before 37 completed weeks gestation

Denominator:

Number of live births

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

16-11a

Reduce the percent of live births born before 37 completed weeks gestation

DATA SOURCES AND DATA ISSUES

Utah Vital Statistics Birth Certificate data

SIGNIFICANCE

Preterm birth is the leading cause of perinatal death in otherwise normal newborns. Babies born preterm also have increased risks for long term morbidities and often require intensive care after birth. Average hospital stays for preterm infants without complications are three times longer than a term infant, and for a preterm birth with complications, hospital stays are over eight times longer. The March of Dimes estimates that each preterm birth carries a cost of \$51,600 for medical care, early intervention services, and special education.

SP() #

PERFORMANCE MEASURE:

The percentage of Medicaid eligible children (1-5) receiving any dental service.

STATUS:

Active

GOAL

Improve the oral health of children (1-5) through increased access and utilization of dental services.

DEFINITION

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

Numerator:

Number of Medicaid eligible children ages 1 – 5 years who received any dental service during the fiscal year

Denominator:

Total number of Medicaid eligible children ages 1 – 5 years during the fiscal year

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

21-12

Increase the proportion of low-income children and adolescents who received dental services

DATA SOURCES AND DATA ISSUES

Medicaid Federal fiscal year Annual Report entitled as "Form CMS-416: Annual EPSDT Participation Report"

SIGNIFICANCE

Oral health is an important component of overall health and well-being. Regular dental visits provide an opportunity for early diagnosis, prevention and treatment of oral disease and conditions. AAP recommends that children as early as age one needs to be examined and receive dental assessments. In an effort to improve oral health it is imperative that we target interventions at preventing dental diseases among high-risk children. Even though children enrolled in Medicaid are eligible for dental services, many are unable to receive services due to lack of Medicaid dental providers, Medicaid low reimbursement rate for dentists, and lack of knowledge among parents about service availability. A number of state strategies have been undertaken to address such problems.

SP() #

PERFORMANCE MEASURE:

The percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings in their practice.

STATUS:

Active

GOAL

Increase early and appropriate developmental screening for all Utah children (birth – 5).

DEFINITION

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

Numerator:

Number of primary care providers who report conducting routine developmental screenings

Denominator:

Total number of primary care providers respond to the survey

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

DATA SOURCES AND DATA ISSUES

State is planning to develop a new survey to collect the base line data for FY11. Additionally, the survey will be conducted every other year.

SIGNIFICANCE

The AAP recommends developmental screening using formal, validated tools at 9, 18, and 30 months of age or whenever a parent or provider concern is expressed. In addition, the AAP recommends screening for ASD at the age of 18 and 24 months of age or whenever a parent or provider concern is expressed. Developmental screening should be performed within the medical home. Standardized developmental screening tests, such as the ASQ, ASQ-SE, and the M-CHAT, are readily available and should be implemented as a routine part of well child checks. Timely, standardized developmental screening implementation in all medical homes will result in earlier diagnosis and appropriate intervention/therapy for children in Utah. This will result in improved outcome for these children.

SP() #

PERFORMANCE MEASURE:

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.

STATUS:

Active

GOAL

Decrease the incidence of tobacco use and the associated health risks among adolescents

DEFINITION

Decrease 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

Numerator:

The number of students in grades 9-12 that report tobacco use in the past 30 days

Denominator:

The total number of students in grades 9-12 who were surveyed

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

27-2
Reduce tobacco use among adolescents.

DATA SOURCES AND DATA ISSUES

Utah Youth Risk Behavior Survey (YRBS)

SIGNIFICANCE

Tobacco use remains the leading cause of preventable illness and death in the United States. Several studies have linked tobacco and the use of illicit drugs. Classifying nicotine as a gateway drug means that scientists believe people who use tobacco are more likely to experiment with other drugs. Tobacco use in adolescence was found to be associated with a range of health-compromising behaviors, including being involved in fights, carrying weapons, and engaging in higher-risk sexual behavior. Use of smokeless tobacco causes serious oral health problems (including cancer of the mouth and gum, periodontitis, and tooth loss). Since nearly all adult smokers begin smoking during adolescence, preventing youth from starting to use tobacco products is expected to result in a substantial decrease in tobacco-related disease and death.

SP() #

PERFORMANCE MEASURE:

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.

STATUS:

Active

GOAL

To decrease the number of adolescents who are so depressed that they cannot carry on usual activities.

DEFINITION

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.

Numerator:

Number of students in grades 9-12 who report feeling so sad or hopeless almost every day for two weeks or more that they stopped doing usual activities during the prior 12 months.

Denominator:

Total number of students in grades 9-12 responding to the survey.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

HP 18-7 Increase the proportion of children with mental health problems who receive treatment.

DATA SOURCES AND DATA ISSUES

Utah Youth Risk Behavior Survey (YRBS)

SIGNIFICANCE

The most recent Title V Needs Assessment identifies child mental health problems as a major issue. This measure is meant to provide a method of tracking depression that is related to a variety of mental health issues including suicide, risk-taking behaviors, low-self esteem, child abuse, and treatable mental health diagnoses including bipolar disorder.

SP() #

PERFORMANCE MEASURE:

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.

STATUS:

Active

GOAL

Increase physical activity among adolescents.

DEFINITION

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 five or more of the past 7 days

Numerator:

The number of students in grades 9-12 who report being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days

Denominator:

The number of students in grades 9-12 responding to the survey

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

19-3

Reduce the proportion of children and adolescents who are overweight or obese.

DATA SOURCES AND DATA ISSUES

Utah Youth Risk Behavior Survey (YRBS)

SIGNIFICANCE

Obesity has become a global epidemic and prevention of such health issue is a public health priority. Developing patterns of healthy behavior can reduce the higher BMI and associated health risks. According to the 2009 Youth Risk Behavior Survey (YRBS), 10.5 percent of all Utah public high school students were overweight and 6.4 percent were obese. Since diet and physical activity have been shown to help reduce weight and also to maintain weight, monitoring physical activity levels in adolescents is important.

SP() #

PERFORMANCE MEASURE:

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.

STATUS:

Active

GOAL

Increase the percent of children with needed access to specialty care through Children with Special Health Care Needs (CSHCN) clinics in rural areas of Utah.

DEFINITION

Increase the percent of children with needed access to specialty care through Children with Special Health Care Needs (CSHCN) clinics in rural areas of Utah.

Numerator:

The number of children in the State CSHCN program who receive services in rural Utah counties.

Denominator:

The estimated number of children with special health care needs who live in rural counties.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

16-23: Increase the proportion of Territories and States that have service systems for CSHCN.

DATA SOURCES AND DATA ISSUES

UDOH CSHCN service data The CSHCN National Survey data for number of children with special health care needs in Utah. The UDOH website for county rural population data. <http://ibis.health.utah.gov/home>

SIGNIFICANCE

The State CSHCN Program has traditionally provided or financed specialty and subspecialty services to children and youth with special health care need populations when they are not otherwise available. Although there are adequate subspecialty pediatric resources along the Wasatch Front, specialized services are absent or difficult to obtain in rural Utah. By increasing the percentage of children and youth with special health care needs for whom appropriate specialty and subspecialty care is accessible, health outcomes for these children will be improved.

SP() #

PERFORMANCE MEASURE:

The percentage of children (birth -17) eligible for Medicaid DM who are eligible for SSI.

STATUS:

Active

GOAL

Improve access to Medicaid (Category DM) for eligible children birth-17

DEFINITION

Improve access to Medicaid (Category DM) for eligible children birth-17

Numerator:

Number of children (0-17) receiving Medicaid (Category DM) during specific month (December)

Denominator:

Number of children (0-17) receiving SSI payments during specific month (December)

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

DATA SOURCES AND DATA ISSUES

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". Corresponding data is compared against SSI data. Social Security Report: Social Security Administration,
Supplemental Security Record (Characteristic Extract Record format), 100 percent data "Number and percentage
distribution of children in Utah receiving federally administered SSI payments, by selected characteristics,
December 2009". Report is produced annually for a specified month.

SIGNIFICANCE

Health insurance is essential for CYSHCN, permitting access to diagnostic testing, primary care, specialty care,
hospital services, prescription drugs, therapies, mental health services, durable medical equipment and supplies,
hearing aids and other health-related services. Access to these services is critical for detecting health problems,
preventing the deterioration of physical or mental health, and maximizing a child's potential to learn, play and
develop with his or her peers. Many CYSHCN have private insurance but restrictions on the amount or scope of
health benefits create unmet needs for many children and youth with special health care needs leaving them
particularly vulnerable. Families of CYSHCN who completed a 2010 State survey about challenges, barriers and
needs identified health care financing as one of their top priorities. CYSHCN who meet the definition of disability
and the income eligibility criteria for SSI should, in most cases, be eligible for the disability category of Medicaid.
There are many children and youth with chronic conditions or disabilities who are currently receiving SSI or meet
the criteria to receive SSI, who are not enrolled in the Medicaid program. These children and youth require the
comprehensive health coverage that Medicaid provides to thrive and survive.

SO() #

OUTCOME MEASURE:

Reduce the maternal mortality rate per 100,000 live births.

STATUS:

Active

GOAL

Reduce the number of women who die due to pregnancy related causes.

DEFINITION

Reduce the maternal mortality rate per 100,000 live births.

Numerator:

Number of women of childbearing age who die within 12 months of completion of a pregnancy regardless of duration due to pregnancy or pregnancy related causes.

Denominator:

Number of live births.

Units: 100000 **Text:** Rate

HEALTHY PEOPLE 2020 OBJECTIVE

16-4 Reduce maternal deaths

DATA SOURCES AND DATA ISSUES

Utah Vital Records, birth certificate, death certificate and fetal death data. Review of death certificates of women of childbearing age with birth and fetal death certificates, review of deaths and classification of causes.

SIGNIFICANCE

Pregnancy and pregnancy related causes of death may be preventable. Identification of the contributing factors may lead to prevention of future deaths, thus sparing children the loss of the mothers.

SO() #

OUTCOME MEASURE:

Reduce fetal mortality rate per 1000 live births and fetal deaths.

STATUS:

Active

GOAL

Reduce the number of fetal deaths.

DEFINITION

Reduce fetal mortality rate per 1000 live births and fetal deaths.

Numerator:

Number of fetal deaths greater than 20 weeks gestation.

Denominator:

Live births plus fetal deaths.

Units: 1000 **Text:** Rate

HEALTHY PEOPLE 2020 OBJECTIVE

16-1a.

Reduce fetal deaths at 20 or more weeks of gestation.

16-1b.

Reduce fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days or more after birth).

DATA SOURCES AND DATA ISSUES

Utah Vital Records Birth Certificate and Fetal Death Data

SIGNIFICANCE

Fetal death is one of the important indicators of a society's perinatal health. Utah's fetal death rate in 2007 was 4.7 per 1,000 live births and fetal deaths. Although this rate has remained relatively stable for the past decade and is considerably lower than the U.S. rate (6.2 per 1,000 in 2004), it falls short of the Healthy People 2010 Target of 4.1/1,000 live births and fetal deaths.

FORM NOTES FOR FORM 16

None

FIELD LEVEL NOTES

None

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: UT

Form Level Notes for Form 17

None

HEALTH SYSTEMS CAPACITY #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.

| | <u>Annual Indicator Data</u> | | | | |
|------------------|------------------------------|---------|---------|---------|---------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 17.2 | 14.3 | 17.5 | 18.3 | 18.3 |
| Numerator | 461 | 389 | 460 | 473 | 473 |
| Denominator | 268,059 | 272,653 | 262,121 | 257,848 | 257,848 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2013

Field Note:

N: Utah Inpatient Hospital Discharge Data, Office of Health Care Statistics, Utah Department of Health.

D: Utah Population Estimates Committee (UPEC) and the Governor's Office of Planning and Budget (GOPB) for years 1980-1999. For years 2000 and later the population estimates are provided by the National Center for Health Statistics (NCHS) through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2012.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9, 2011

Denominator: IBIS Population Estimates 2011

3. **Section Number:** Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9, 2011

Denominator: IBIS Population Estimates 2011

HEALTH SYSTEMS CAPACITY #02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

| | Annual Indicator Data | | | | |
|------------------|-----------------------|--------|--------|--------|--------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 83.0 | 83.9 | 89.0 | 88.4 | 88.6 |
| Numerator | 18,803 | 18,803 | 15,475 | 14,719 | 14,637 |
| Denominator | 22,647 | 22,404 | 17,393 | 16,644 | 16,515 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Field Level Notes**1. Section Number:** Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: CMS 416 for FFY2013: total eligibles receiving at least one initial or periodic screen (line 9)

Denominator: CMS 416 for FFY2013: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.88 (line 10)

2. Section Number: Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2012

Field Note:

The calculation for this measure has been revised since 2010. Data are not comparable with previous years.

Numerator: CMS 416 for FFY2012: total eligibles receiving at least one initial or periodic screen (line 9)

Denominator: CMS 416 for FFY2012: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.88 (line 10)

3. Section Number: Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2011

Field Note:

The calculation for this measure has been revised since 2010. Data are not comparable with previous years.

Numerator: CMS 416 for FFY2011: total eligibles receiving at least one initial or periodic screen (line 9)

Denominator: CMS 416 for FFY2011: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.89 (line 10)

HEALTH SYSTEMS CAPACITY #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.

| | <u>Annual Indicator Data</u> | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------|------|-------|-------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 97.6 | 97.1 | 97.8 | 97.8 | 97.5 |
| Numerator | 283 | 299 | 175 | 175 | 195 |
| Denominator | 290 | 308 | 179 | 179 | 200 |
| <p>Check this box if you cannot report the numerator because</p> <p>1. There are fewer than 5 events over the last year, and</p> <p>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.</p> <p style="text-align: center;"><i>(Explain data in a year note. See Guidance, Appendix IX.)</i></p> | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

Field Level Notes

- 1. Section Number:** Form17_Health Systems Capacity Indicator #03
Field Name: HSC03
Row Name:
Column Name:
Year: 2013
Field Note:
 Numerator: HEDIS measure "Well Child Vsits in First 15 Months" HCS 2013
 Denominator: HEDIS number of children under one in CHIP, HCS 2013
- 2. Section Number:** Form17_Health Systems Capacity Indicator #03
Field Name: HSC03
Row Name:
Column Name:
Year: 2012
Field Note:
 Numerator: HEDIS measure "Well Child Vsits in First 15 Months" HCS 2012
 Denominator: HEDIS number of children under one in CHIP, HCS 2012
- 3. Section Number:** Form17_Health Systems Capacity Indicator #03
Field Name: HSC03
Row Name:
Column Name:
Year: 2011
Field Note:
 Data reported are the most recent data available.
 Numerator: HEDIS measure "Well Child Vsits in First 15 Months" 2011
 Denominator: HEDIS number of children under one in CHIP, 2011

HEALTH SYSTEMS CAPACITY #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.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|--------|--------|--------|--------|--------|
| Annual Indicator | 82.8 | 84.5 | 84.9 | 84.7 | 84.7 |
| Numerator | 41,794 | 41,430 | 41,269 | 41,740 | 41,740 |
| Denominator | 50,475 | 49,010 | 48,596 | 49,263 | 49,263 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. Section Number: Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

2. Section Number: Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2012

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

3. Section Number: Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 86.6 | 84.6 | 69.1 | 56.9 | 56.3 |
| Numerator | 142,476 | 166,381 | 94,830 | 93,354 | 93,894 |
| Denominator | 164,602 | 196,665 | 137,236 | 163,947 | 166,639 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Field Level Notes**1. Section Number:** Form17_Health Systems Capacity Indicator #07A**Field Name:** HSC07A**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2013 data (ages 0 - 20) (line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2013 data (ages 0 - 20) (line 8)

Participation ratio .56 (line 10)

2. Section Number: Form17_Health Systems Capacity Indicator #07A**Field Name:** HSC07A**Row Name:****Column Name:****Year:** 2012**Field Note:**

The calculation for this measure has been revised since 2010. The data are not comparable with previous years.

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2012 data (ages 0 - 20) (line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2012 data (ages 0 - 20) (line 8)

Participation ratio .57 (line 10)

* The rate now includes data for infants and 19 - 20 year olds.

3. Section Number: Form17_Health Systems Capacity Indicator #07A**Field Name:** HSC07A**Row Name:****Column Name:****Year:** 2011**Field Note:**

The calculation for this measure has been revised since 2010. The data are not comparable with previous years.

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2011 data (ages 0 - 20) (line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2011 data (ages 0 - 20) (line 8)

Participation ratio .69 (line 10)

* The rate now includes data for infants and 19 - 20 year olds.

HEALTH SYSTEMS CAPACITY #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

| | Annual Indicator Data | | | | |
|------------------|-----------------------|--------|--------|--------|--------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 52.6 | 54.3 | 54.8 | 57.0 | 58.1 |
| Numerator | 18,550 | 21,772 | 24,516 | 26,694 | 28,056 |
| Denominator | 35,280 | 40,125 | 44,736 | 46,861 | 48,316 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Field Level Notes

1. Section Number: Form17_Health Systems Capacity Indicator #07B

Field Name: HSC07B

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Medicaid CMS 416, FFY2013

Denominator: Medicaid CMS 416, FFY2013

2. Section Number: Form17_Health Systems Capacity Indicator #07B

Field Name: HSC07B

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Medicaid CMS 416, FFY2012

Denominator: Medicaid CMS 416, FFY2012

3. Section Number: Form17_Health Systems Capacity Indicator #07B

Field Name: HSC07B

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Medicaid CMS 416, FFY2011

Denominator: Medicaid CMS 416, FFY2011

HEALTH SYSTEMS CAPACITY #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.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|-------|-------|-------|-------|-------|
| Annual Indicator | 18.7 | 15.8 | 8.8 | 9.6 | 9.6 |
| Numerator | 846 | 743 | 427 | 482 | 482 |
| Denominator | 4,522 | 4,709 | 4,845 | 5,019 | 5,019 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: CSHCN DDS Log and MegaWest data, 2012

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2012

Data reported are the most recent data available

2. **Section Number:** Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: CSHCN DDS Log and MegaWest data, 2012

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2012

3. **Section Number:** Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2011

Field Note:

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, 2011

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2011

Reason for the decrease in percent (15.8% to 8.8%) is due to seeing fewer and fewer children due to budget cuts.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: UT

| 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 |
| a) <i>Percent of low birth weight (< 2,500 grams)</i> | 2012 | Matching data files | 8.3 | 6.2 | 6.9 |
| b) <i>Infant deaths per 1,000 live births</i> | 2011 | Matching data files | 5.8 | 5.1 | 5.3 |
| c) <i>Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester</i> | 2012 | Matching data files | 65.9 | 80.4 | 75.5 |
| d) <i>Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])</i> | 2012 | Matching data files | 77 | 88.6 | 84.7 |

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06 (MEDICAID ELIGIBILITY LEVEL)
STATE: UT

| INDICATOR #06 <i>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</i> | YEAR | PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------|
| a) <i>Infants (0 to 1)</i> | 2013 | 133 |
| b) <i>Medicaid Children</i> (Age range <input type="text" value="1"/> to <input type="text" value="5"/>) (Age range <input type="text" value="6"/> to <input type="text" value="19"/>) (Age range <input type="text"/> to <input type="text"/>) | 2013 | 133 100 <input type="text"/> |
| c) <i>Pregnant Women</i> | 2013 | 133 |

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: UT

| INDICATOR #06 <i>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.</i> | YEAR | PERCENT OF POVERTY LEVEL SCHIP |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------------|
| a) <i>Infants (0 to 1)</i> | 2013 | 200 |
| b) <i>Medicaid Children</i> (Age range <input type="text" value="1"/> to <input type="text" value="18"/>) (Age range <input type="text"/> to <input type="text"/>) (Age range <input type="text"/> to <input type="text"/>) | 2013 | 200 |
| c) <i>Pregnant Women</i> | | |

FORM NOTES FOR FORM 18

None

FIELD LEVEL NOTES

1. **Section Number:** Form18_Indicator 06 - SCHIP

Field Name: SCHIP_Women

Row Name: Pregnant Women

Column Name:

Year: 2015

Field Note:

Pregnant women usually are not covered under UT CHIP unless they are <18 years old

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: UT

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure 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) |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| ANNUAL DATA LINKAGES | | |
| 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 | 2 | Yes |
| Annual linkage of birth certificates and newborn screening files | 3 | Yes |
| REGISTRIES AND SURVEYS | | |
| 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 |

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: UT

| 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 |
| Other: SAMHSA Prevention Needs Assessment (SHARP/PNA) | 3 | Yes |
| | | |
| | | |

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:
1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

None

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: UT

Form Level Notes for Form 20

None

HEALTH STATUS INDICATOR #01A

The percent of live births weighing less than 2,500 grams.

| | <u>Annual Indicator Data</u> | | | | |
|------------------|------------------------------|--------|--------|--------|--------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 7.0 | 7.0 | 6.9 | 6.9 | 6.9 |
| Numerator | 3,780 | 3,650 | 3,546 | 3,533 | 3,533 |
| Denominator | 53,894 | 52,164 | 51,144 | 51,439 | 51,439 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2013

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

2. **Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

3. **Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2011

Field Note:

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

HEALTH STATUS INDICATOR #01B

The percent of live singleton births weighing less than 2,500 grams.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|--------|--------|--------|--------|--------|
| Annual Indicator | 5.2 | 5.3 | 5.2 | 5.1 | 5.1 |
| Numerator | 2,736 | 2,690 | 2,585 | 2,560 | 2,560 |
| Denominator | 52,164 | 50,475 | 49,484 | 49,742 | 49,742 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #01B**Field Name:** HSI01B**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

2. Section Number: Form20_Health Status Indicator #01B**Field Name:** HSI01B**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

3. Section Number: Form20_Health Status Indicator #01B**Field Name:** HSI01B**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

HEALTH STATUS INDICATOR #02A

The percent of live births weighing less than 1,500 grams.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|--------|--------|--------|--------|--------|
| Annual Indicator | 1.0 | 1.1 | 1.1 | 1.1 | 1.1 |
| Numerator | 562 | 579 | 554 | 550 | 550 |
| Denominator | 53,894 | 52,164 | 51,144 | 51,439 | 51,439 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #02A**Field Name:** HSI02A**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

2. Section Number: Form20_Health Status Indicator #02A**Field Name:** HSI02A**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

3. Section Number: Form20_Health Status Indicator #02A**Field Name:** HSI02A**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

HEALTH STATUS INDICATOR #02B

The percent of live singleton births weighing less than 1,500 grams.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|--------|--------|--------|--------|--------|
| Annual Indicator | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 |
| Numerator | 399 | 422 | 381 | 388 | 388 |
| Denominator | 52,164 | 50,475 | 49,484 | 49,742 | 49,742 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #02B**Field Name:** HSI02B**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

2. Section Number: Form20_Health Status Indicator #02B**Field Name:** HSI02B**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2012

3. Section Number: Form20_Health Status Indicator #02B**Field Name:** HSI02B**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

HEALTH STATUS INDICATOR #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 6.9 | 6.4 | 8.3 | 4.8 | 4.8 |
| Numerator | 51 | 48 | 62 | 36 | 36 |
| Denominator | 736,615 | 749,214 | 749,774 | 754,356 | 754,356 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #03A**Field Name:** HSI03A**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2012
 Denominator: IBIS Population Estimates 2012

2. Section Number: Form20_Health Status Indicator #03A**Field Name:** HSI03A**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2012
 Denominator: IBIS Population Estimates 2012

3. Section Number: Form20_Health Status Indicator #03A**Field Name:** HSI03A**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.
 Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2011
 Denominator: IBIS Population Estimates 2011

HEALTH STATUS INDICATOR #03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 2.2 | 2.0 | 2.8 | 1.6 | 1.6 |
| Numerator | 16 | 15 | 21 | 12 | 12 |
| Denominator | 736,615 | 749,214 | 749,774 | 754,356 | 754,356 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #03B**Field Name:** HSI03B**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2012

Denominator: IBIS Population Estimates 2012

2. Section Number: Form20_Health Status Indicator #03B**Field Name:** HSI03B**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2012

Denominator: IBIS Population Estimates 2012

3. Section Number: Form20_Health Status Indicator #03B**Field Name:** HSI03B**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2011

Denominator: IBIS Population Estimates 2011

HEALTH STATUS INDICATOR #03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 13.1 | 9.1 | 10.5 | 9.3 | 9.3 |
| Numerator | 59 | 42 | 48 | 43 | 43 |
| Denominator | 451,656 | 459,367 | 457,721 | 460,603 | 460,603 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #03C**Field Name:** HSI03C**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2012

Denominator: IBIS Population Estimates 2012

2. Section Number: Form20_Health Status Indicator #03C**Field Name:** HSI03C**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2012

Denominator: IBIS Population Estimates 2012

3. Section Number: Form20_Health Status Indicator #03C**Field Name:** HSI03C**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2011

Denominator: IBIS Population Estimates 2011

HEALTH STATUS INDICATOR #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 124.6 | 116.9 | 5,850.0 | 5,958.0 | 5,958.0 |
| Numerator | 918 | 876 | 43,404 | 44,665 | 44,665 |
| Denominator | 736,615 | 749,214 | 741,951 | 749,662 | 749,662 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. Section Number: Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2013

Field Note:

* Data based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined to report for this measure.

Numerator: Hospital Discharge Database Injury Query Module, 2011

Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 119.4 per 100,000 (N=955, D=749662) for 2012.

2. Section Number: Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2012

Field Note:

* Data based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined to report for this measure.

Numerator: Hospital Discharge Database Injury Query Module, 2011

Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 119.4 per 100,000 (N=955, D=749662) for 2012.

3. Section Number: Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2011

Field Note:

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010

Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 119.7 per 100,000 (N=888, D=741951) for 2010.

HEALTH STATUS INDICATOR #04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

| | Annual Indicator Data | | | | |
|------------------|-----------------------|---------|---------|---------|---------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 19.4 | 14.8 | 244.2 | 240.5 | 240.5 |
| Numerator | 143 | 111 | 1,812 | 1,803 | 1,803 |
| Denominator | 736,615 | 749,214 | 741,951 | 749,662 | 749,662 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #04B**Field Name:** HSI04B**Row Name:****Column Name:****Year:** 2013**Field Note:**

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011

Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 10.4 per 100,000 (N=96, D=749662) for 2011.

2. Section Number: Form20_Health Status Indicator #04B**Field Name:** HSI04B**Row Name:****Column Name:****Year:** 2012**Field Note:**

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011

Denominator: IBIS Population Estimates 2011

** If only Hospital Discharge data are used then the rate will be 10.4 per 100,000 (N=96, D=749662) for 2011.

3. Section Number: Form20_Health Status Indicator #04B**Field Name:** HSI04B**Row Name:****Column Name:****Year:** 2011**Field Note:**

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010

Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 15.4 per 100,000 (N=114, D=741951) for 2010.

HEALTH STATUS INDICATOR #04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

| | Annual Indicator Data | | | | |
|------------------|-----------------------|---------|---------|---------|---------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Indicator | 70.9 | 62.5 | 1,037.8 | 1,051.0 | 1,051.0 |
| Numerator | 320 | 287 | 4,689 | 4,749 | 4,749 |
| Denominator | 451,656 | 459,367 | 451,817 | 451,836 | 451,836 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #04C**Field Name:** HSI04C**Row Name:****Column Name:****Year:** 2013**Field Note:**

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011

Denominator: IBIS Population Estimates 2011

** If Hospital Discharge data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

2. Section Number: Form20_Health Status Indicator #04C**Field Name:** HSI04C**Row Name:****Column Name:****Year:** 2012**Field Note:**

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2011

Denominator: IBIS Population Estimates 2011

** If Hospital Discharge data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

3. Section Number: Form20_Health Status Indicator #04C**Field Name:** HSI04C**Row Name:****Column Name:****Year:** 2011**Field Note:**

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010

Denominator: IBIS Population Estimates 2010

** If Hospital Discharge data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

HEALTH STATUS INDICATOR #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 13.4 | 14.0 | 14.6 | 15.9 | 15.1 |
| Numerator | 1,451 | 1,543 | 1,620 | 1,772 | 1,647 |
| Denominator | 108,205 | 110,053 | 110,810 | 111,682 | 109,126 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #05A**Field Name:** HSI05A**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2013 (preliminary)

Denominator: IBIS Population Estimates 2013 (preliminary)

2. Section Number: Form20_Health Status Indicator #05A**Field Name:** HSI05A**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2012 preliminary

Denominator: IBIS Population Estimates 2012 preliminary

3. Section Number: Form20_Health Status Indicator #05A**Field Name:** HSI05A**Row Name:****Column Name:****Year:** 2011**Field Note:**

Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2011

Denominator: IBIS Population Estimates 2011

HEALTH STATUS INDICATOR #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Annual Indicator Data

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|------------------|---------|---------|---------|---------|---------|
| Annual Indicator | 4.9 | 5.5 | 6.2 | 6.6 | 6.3 |
| Numerator | 2,493 | 2,847 | 3,113 | 3,342 | 3,270 |
| Denominator | 510,434 | 519,153 | 502,558 | 509,257 | 521,020 |

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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #05B**Field Name:** HSI05B**Row Name:****Column Name:****Year:** 2013**Field Note:**

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2013 (Preliminary)

Denominator: IBIS Population Estimates 2013 (Preliminary)

2. Section Number: Form20_Health Status Indicator #05B**Field Name:** HSI05B**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2012 (Preliminary)

Denominator: IBIS Population Estimates 2012 (Preliminary)

3. Section Number: Form20_Health Status Indicator #05B**Field Name:** HSI05B**Row Name:****Column Name:****Year:** 2011**Field Note:**

Numerator: Bureau of Epidemiology, Utah Department of Health, 2011

Denominator: IBIS Population Estimates 2011

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

| 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 | 51,439 | 42,950 | 577 | 670 | 1,253 | 673 | 0 | 5,316 |
| Children 1 through 4 | 206,409 | 187,319 | 3,370 | 3,597 | 3,353 | 2,234 | 6,536 | 0 |
| Children 5 through 9 | 257,951 | 232,742 | 3,819 | 3,815 | 4,247 | 3,072 | 10,256 | 0 |
| Children 10 through 14 | 238,557 | 215,534 | 3,602 | 3,750 | 4,112 | 2,776 | 8,783 | 0 |
| Children 15 through 19 | 218,983 | 197,120 | 3,427 | 3,922 | 4,452 | 2,600 | 7,462 | 0 |
| Children 20 through 24 | 243,620 | 217,737 | 5,842 | 4,156 | 6,747 | 2,896 | 6,242 | 0 |
| Children 0 through 24 | 1,216,959 | 1,093,402 | 20,637 | 19,910 | 24,164 | 14,251 | 39,279 | 5,316 |

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

| CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported |
|------------------------------------------------------------|-------------------------------------|---------------------------------|-------------------------------|
| Infants 0 to 1 | 42,555 | 7,586 | 1,298 |
| Children 1 through 4 | 169,157 | 37,252 | 0 |
| Children 5 through 9 | 214,500 | 43,451 | 0 |
| Children 10 through 14 | 199,505 | 39,052 | 0 |
| Children 15 through 19 | 183,933 | 35,050 | 0 |
| Children 20 through 24 | 207,611 | 34,009 | 0 |
| Children 0 through 24 | 1,017,261 | 196,400 | 1,298 |

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

| CATEGORY TOTAL LIVE BIRTHS 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 |
|---------------------------------------------------|------------------------|--------------|------------------------------------------|----------------------------------------------|--------------|----------------------------------------------------------|----------------------------------------|------------------------------|
| Women < 15 | 13 | 7 | 1 | 2 | 0 | 0 | 0 | 3 |
| Women 15 through 17 | 668 | 398 | 18 | 32 | 9 | 3 | 0 | 208 |
| Women 18 through 19 | 1,825 | 1,264 | 46 | 60 | 22 | 27 | 0 | 406 |
| Women 20 through 34 | 42,851 | 36,396 | 445 | 511 | 982 | 555 | 0 | 3,962 |
| Women 35 or older | 6,082 | 4,885 | 67 | 65 | 240 | 88 | 0 | 737 |
| Women of all ages | 51,439 | 42,950 | 577 | 670 | 1,253 | 673 | 0 | 5,316 |

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

| CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported |
|-------------------------------------------------------------|-------------------------------------|---------------------------------|-------------------------------|
| Women < 15 | 10 | 3 | 0 |
| Women 15 through 17 | 350 | 301 | 15 |
| Women 18 through 19 | 1,195 | 586 | 37 |
| Women 20 through 34 | 36,083 | 5,716 | 1,085 |
| Women 35 or older | 4,917 | 980 | 161 |
| Women of all ages | 42,555 | 7,586 | 1,298 |

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #08A - Demographics (Total deaths) Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

| CATEGORY TOTAL DEATHS 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 | 282 | 235 | 9 | 3 | 3 | 3 | 0 | 29 |
| Children 1 through 4 | 52 | 45 | 0 | 1 | 0 | 3 | 0 | 3 |
| Children 5 through 9 | 23 | 22 | 0 | 0 | 0 | 0 | 0 | 1 |
| Children 10 through 14 | 45 | 38 | 0 | 1 | 2 | 1 | 0 | 3 |
| Children 15 through 19 | 105 | 84 | 3 | 8 | 1 | 3 | 0 | 6 |
| Children 20 through 24 | 191 | 170 | 4 | 6 | 4 | 1 | 0 | 6 |
| Children 0 through 24 | 698 | 594 | 16 | 19 | 10 | 11 | 0 | 48 |

HSI #08B - Demographics (Total deaths) Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)

| CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported |
|------------------------------------------------|------------------------------|--------------------------|------------------------|
| Infants 0 to 1 | 216 | 50 | 16 |
| Children 1 through 4 | 43 | 9 | 0 |
| Children 5 through 9 | 16 | 7 | 0 |
| Children 10 through 14 | 34 | 11 | 0 |
| Children 15 through 19 | 87 | 17 | 1 |
| Children 20 through 24 | 163 | 28 | 0 |
| Children 0 through 24 | 559 | 122 | 17 |

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Final

| CATEGORY Miscellaneous 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 | 973,339 | 875,665 | 14,795 | 15,754 | 17,417 | 11,355 | 38,353 | 0 | 2012 |
| Percent in household headed by single parent | 21.6 | 14.3 | 46.0 | 39.7 | 15.1 | 15.3 | 25.7 | 0.0 | 2010 |
| Percent in TANF (Grant) families | 1.0 | 63.6 | 4.9 | 3.6 | 1.3 | 1.2 | 4.4 | 0.8 | 2010 |
| Number enrolled in Medicaid | 251,665 | 164,915 | 6,430 | 6,770 | 3,850 | 3,649 | 0 | 66,051 | 2013 |
| Number enrolled in SCHIP | 55,564 | 44,947 | 757 | 897 | 946 | 599 | 0 | 7,418 | 2013 |
| Number living in foster home care | 2,775 | 2,421 | 180 | 118 | 16 | 25 | 10 | 5 | 2013 |
| Number enrolled in food stamp program | 239,157 | 134,091 | 6,270 | 7,251 | 4,077 | 3,010 | 827 | 83,631 | 2013 |
| Number enrolled in WIC | 123,139 | 110,892 | 3,405 | 2,486 | 2,840 | 3,516 | 0 | 0 | 2013 |
| Rate (per 100,000) of juvenile crime arrests | 2,020.7 | 1,956.6 | 5,839.8 | 1,885.2 | 2,081.9 | 2,081.9 | 0.0 | 0.0 | 2012 |
| Percentage of high school drop-outs (grade 9 through 12) | 16.0 | 13.0 | 28.0 | 31.0 | 20.0 | 21.0 | 0.0 | 0.0 | 2013 |

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity. (Demographics)*

| CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY | Total NOT Hispanic or Latino | Total Hispanic or Latino | Ethnicity Not Reported | Specific Reporting Year |
|----------------------------------------------------------|------------------------------|--------------------------|------------------------|-------------------------|
| All children 0 through 19 | 809,650 | 163,689 | 0 | 2012 |
| Percent in household headed by single parent | 14.2 | 27.0 | 0.0 | 2010 |
| Percent in TANF (Grant) families | 79.3 | 20.7 | 0.0 | 2010 |
| Number enrolled in Medicaid | 194,995 | 56,671 | 0 | 2013 |
| Number enrolled in SCHIP | 41,899 | 13,665 | 0 | 2013 |
| Number living in foster home care | 1,870 | 550 | 1 | 2013 |
| Number enrolled in food stamp program | 199,725 | 39,196 | 0 | 2013 |
| Number enrolled in WIC | 75,859 | 43,798 | 0 | 2013 |
| Rate (per 100,000) of juvenile crime arrests | 1,872.5 | 2,747.7 | 0.0 | 2012 |
| Percentage of high school drop-outs (grade 9 through 12) | 13.0 | 29.0 | 0.0 | 2013 |

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*
Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

| GEOGRAPHIC LIVING AREAS | TOTAL |
|------------------------------------------|----------------|
| Living in metropolitan areas | 735,676 |
| Living in urban areas | 879,459 |
| Living in rural areas | 46,795 |
| Living in frontier areas | 47,085 |
| Total - all children 0 through 19 | 973,339 |

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

| POVERTY LEVELS | TOTAL |
|-------------------------------|-----------|
| Total Population | 2,855,287 |
| Percent Below: 50% of poverty | 4.3 |
| 100% of poverty | 15.3 |
| 200% of poverty | 37.6 |

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: UT

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*
Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

| POVERTY LEVELS | TOTAL |
|---------------------------------|---------|
| Children 0 through 19 years old | 973,339 |
| Percent Below: 50% of poverty | 4.7 |
| 100% of poverty | 16.4 |
| 200% of poverty | 39.5 |

FORM NOTES FOR FORM 21

None

FIELD LEVEL NOTES

1. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2015
Field Note:
Utah Birth Certificate Data, 2012
2. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2015
Field Note:
Children 1-24.
2012 data from IBIS Race / ethnicity Query Module.
3. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2015
Field Note:
Children 1-24.
2012 data from IBIS Race / ethnicity Query Module.
4. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15
Row Name: Women < 15
Column Name:
Year: 2015
Field Note:
Utah Birth Certificate Data, 2012
5. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2015
Field Note:
Utah Birth Certificate Data, 2012
6. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2015
Field Note:
Office of Vital Records and Statistics, Infant Mortality database. UDOH, 2012.
7. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2015
Field Note:
Office of Vital Records and Statistics, Death Certificate database. UDOH, 2012.
8. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_Children
Row Name: All children 0 through 19
Column Name:
Year: 2015
Field Note:
2012 population estimate from IBIS Race / ethnicity Query Module.
9. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2015
Field Note:
Percent in household headed by single parent.
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 2010 form DP02. IBIS population data for 0-19, 2011. Numerator is derived by adding Male / Female householder, no spouse present, with children under 18.
The denominator is IBIS population data for 0-19, 2011.
10. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2015
Field Note:
Percent in TANF (Grant) families.
1.0% represents 6,643 Families or 10,689 Children. Race and ethnicity distribution is based on 6,643 families.

Data source: http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/caseload_current.htm
TANF race and ethnicity from most recent FY2010 Report to Congress at: <http://www.acf.hhs.gov/programs/ofa/character/FY2010/indexfy10.htm>

11. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2015
Field Note:
Number Enrolled in Medicaid.
2013 data from UDOH Medicaid Eligibility file, special run from Medicaid, 0-19 years of age.
12. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2015
Field Note:
2013 data from UDOH CHIP, FFY2012.
13. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2015
Field Note:
2013 data from DHS, Current Count Data.
14. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2015
Field Note:
2012 data from UDOH WIC Program REPORT 1003.
15. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2015
Field Note:
2012 data from UBCI.
16. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2015
Field Note:
2013 Cohort dropout rates data from USOE (Data Assessment and Accountability).
17. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2015
Field Note:
IBIS Population Estimates Query, 2012 data (based on US Census)
18. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2015
Field Note:
Population estimate, 2012 (IBIS based on US Census).
19. **Section Number:** Form21_Indicator 11
Field Name: S11_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2015
Field Note:
Based on BRFSS, 2012 (OPHA special analysis)
20. **Section Number:** Form21_Indicator 11
Field Name: S11_100percent
Row Name: 100% of poverty
Column Name:
Year: 2015
Field Note:
Based on BRFSS, 2012 (OPHA special analysis)
21. **Section Number:** Form21_Indicator 11
Field Name: S11_200percent
Row Name: 200% of poverty
Column Name:
Year: 2015
Field Note:
Based on BRFSS, 2012 (OPHA special analysis)
22. **Section Number:** Form21_Indicator 12

Field Name: S12_Children

Row Name: Children 0 through 19 years old

Column Name:

Year: 2015

Field Note:

IBIS Population estimates, 0 - 19 yrs old, 2012

23. **Section Number:** Form21_Indicator 12

Field Name: S12_50percent

Row Name: Percent Below: 50% of poverty

Column Name:

Year: 2015

Field Note:

Based on BRFSS, 2012 (OPHA special analysis)

24. **Section Number:** Form21_Indicator 09A

Field Name: HSI Race_FosterCare

Row Name: Number living in foster home care

Column Name:

Year: 2015

Field Note:

2013 data from DCFS.