Maternal and Child Health Services Title V Block Grant

State Narrative for Utah

Application for 2013 Annual Report for 2011

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

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

C. Assurances and Certifications

The Utah Department of Health has submitted the Assurances and Certifications to the authorized signatory and has on file the signed Assurances and Certifications dated July, 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 FY2013

Public input is a valued part of the annual MCH Block Grant application process. In April 2012, 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 FY13 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. 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 2013 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 FY2013 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.

This year (2013 Application) a number of modifications were made to the web application to enhance system usability. Database functionality was added to collect input for performance measures identified during the 2010 MCH Needs Assessment as well as to archive the comments from previous years. The online comments were accepted between April 19 and May 21, 2012. We received valuable feedback on needs and emerging issues as well as reaffirmation of the importance of current program activities. Last year we used an online Webtrends reporting tool, and this year we used a slightly more accurate reporting tool called Google Analytics to report our web trends. We had 297 visits, 195 unique visitors, and 647 page views.

UBID

This year a majority of the block grant information was collected using an on-line system developed in-house, called the Utah Block Grant Information Database (UBID). This customized system was developed by the Data Resources Program web developer 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. Users were able to add, save, and edit their data and narratives during the grant writing process. The system checked 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, we additionally requested the Office of Health Disparities Reduction (formerly known as the Center for Multicultural Health) staff to add the public comment announcement in their on-line newsletter, Connections. 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 2013 Annual Plan. Comments were incorporated into the plan as appropriate.

In May 2012, CSHCN sponsored a meeting with its stakeholders to discuss all the performance measures related to programs in CSHCN to gather suggestions and strategies to advance progress on these measures. The feedback received from that meeting was incorporated as appropriate into the FY2013 plans.

In addition, in June, 2012, MCH sponsored a meeting 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 in FY2011 and asked for input on strategies we could use to advance the measure in the right direction. The group was divided into 2 groups, one for mothers and infants, and the second for children and youth. Each group discussed the related performance measures and suggested strategies that would assist the state in moving the indicator in the right direction. The two groups also discussed the Performance measures that we did attain to provide additional strategies to keep those measures moving in the right direction even further. The comments and suggestions were shared with staff responsible for the measures to incorporate as appropriate into the Annual Plan for FY2013.

We 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 2013, 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 of 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. The 2010 Census results were released indicating that Utah's population is more diverse than originally thought at the time of the FY2011 Grant submission. Every population group grew during the ten year period of 2000- 2010. For example the Hispanic population grew almost 78%, Black populations grew almost 66%, the Native Hawaiian/Pacific Islander population grew 62%, Asian by 49%, and Native American/Alaskan Native population grew by almost 11%. The total population in Utah is 2,763,885 representing a 23.8% growth approximately a half million people in growth.
b. During the 2011 Legislative Session, the Department lost additional funding, though not at the drastic levels experienced in the previous three or so years. The economy seems to be picking up slowly and revenue projections indicate an expected increase. The Title V programs did not

sustain any additional state funding cuts, allowing us to stabilize our clinics for CSHCN. We are currently in the process of cutting back on some services, such as pediatric neurology in some of the outlying areas.
c. We have continued to review data and to discuss ways to address the State Performance Measures. We are currently engaged in a process with local health department leadership to review the Block Grant, its requirements, funding allocations, and services provided. The group is the result of legislation that went into effect in July 2010 that mandates review of all federal (and other sources) grants to determine if there is a role for local health departments and if so, to define that role and then to provide funding to support the local health departments' work. We are currently in the middle stages of the review process, having covered the grant requirements, the work to produce the grant, staff paid by the grant and responsibilities of the staff. We have also reviewed contracts and reporting requirements. Next steps include a further review of the role of LHDs and the budget, leading to recommendations to forward to the Governance Committee for consideration.
d. Several actions that we have taken to operationalize the plans: we now have a position that is dedicated to training on the use of the Ages and Stages tool for child care providers. As we make inroads there, we want to expand the training and use of the tool to health care providers and others. To better address the health of school age children, we created a position for a school health consultant to address health issues such as medication administration in schools, school nursing, health promotion, etc. We believe that this position is critical in enabling us to identify and address the health needs of the school age population, especially given how few school nurses we have.

In the FY2011 grant federal review, comment was made about why certain measures were dropped and others added. The area that came into question, youth suicide, is covered in two 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 that it is covered, though not identified as a state priority. We clearly stated that if an issue was covered with a national PM, we would not declare it a priority since we know we have to work on it as a required national PM

From the FY2011 Grant Application:
"The Leadership Team decided not to include in the list of priority issues any issue that was already addressed in a National Performance Measure so that we could specifically focus on other areas of need."
Additional comments on the changes in state Performance Measures - Some State Performance Measures in the 2006 Needs Assessment were dropped because of health care reform, higher priorities to address, feeling as though we had gotten the message out about some health issues, such as healthy weight before and weight gain during pregnancy and/or difficulty in measuring a state Performance Measure. We decided to put emphasis on late preterm births, most of which are preventable, health concerns for children and adolescents, and coverage and services for children with special health care needs. As we continue the work needed to address the ten priority areas, we are engaging our key partners, such as representatives of local health departments, advocacy organizations, existing advisory committees, and parents. //2012//

/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. The Governance Committee delegated a detailed review to six local staff and we had a corresponding number of staff. Through numerous meetings, the committee reviewed the guidance requirements, the grant and needs assessment documents, the budget allocation, contracts with LHDs, etc. The workgroup consensus was that 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 local health departments, suggesting that funding for a state level position could go to local health departments for direct services. The challenge is explaining the pyramid of services and expectation that states invest in the infrastructure and population based services. When one looks at the broad impact of a state level staff member on the "system" compared to a very limited impact of local health department direct services, it seems logical that the greater impact would be a higher priority. We will continue to work on this 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 more in the planning process than in previous years. The local health officers indicated that they wanted more involvement in the grant, so when the new guidance was released, a notice was posted so that local staff could indicate interest in participation on the planning process. The Department with the locals developed a "collaboration plan" for writing of grants. The MCH grant has been a "pilot" for this process.

d. Each year as we work on the block grant application and report, 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 to impact the issues. 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/

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

III. State Overview

A. Overview

Utah is largely a rural and frontier state, with the majority of the state's population residing along the Wasatch Front, a 75-mile strip running from Ogden (north) to Provo (south) with Salt Lake City, the state's Capitol, in between. The Wasatch Front comprises only 4% of the state's landmass, but 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.

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%.

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 challenges 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 un-employment 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//

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//***

The American Community Survey Summary indicated that for many years Utahns have had larger households compared to the nation. Latest data (2008) indicate that Utah's household size was 3.15 people compared to the national average of 2.62. Utah's average family size was 3.67 people compared to the national average of 3.22. ***/2013/Utah's household size is smaller than previously at 3.1 but still ranked as highest in the country.//2013//*** The percent of Utah family households with children is 21.5% higher than the rest of 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's median household income was somewhat higher than that of the U.S., $56,484 compared to $52,029. However, Utahns have a significantly lower per capita income in Utah than in the U.S., $23,198 compared to $27,589. ***/2013/Utah's 2010 average per capita personal income was $32,473, a 1.8% change from 2009.//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%).

/2012/The recently released 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. The Department has made a commitment to Utahns being the healthiest including healthiest babies. This focus will give MCH an opportunity to focus on healthy pregnancies and healthy outcomes.//2013//

Utah ranks 1st for child dependency ratio at 51.8 vs 37.7 nationally. 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. The high school dropout rate in Utah is lower than the U.S. at 3.1% of youth aged 16 to 19 years old 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%. 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. ***/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//***

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

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 early 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//***

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

Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger with a significantly lower per capita income in Utah than in the U.S. overall. Based on the 2008 American Community Survey Summary, Utah's median household income of $65,226 was slightly higher than the U.S. average of $63,366, ranking Utah 20th nationwide. Due to larger families in Utah, the per capita income ranked the state 45th lowest in the nation at $18,905. ***/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//***.

/2013/In 2011, the Governor 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. The Governor is planning another health summit for fall 2012.//2013//

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//***

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

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

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

/2012/Legislation passed in 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//***

Maternal and child health services, including services for children and youth with special health care needs, are provided in various settings: through medical homes/private providers; local health departments, community health centers, a clinic for the homeless, migrant health clinics, and several free clinics; itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty centers, such as the University of Utah Health Sciences Center, Primary Children's Medical Center, and Shriners Hospital for Children, and several tertiary centers for high risk perinatal and neonatal care. These centers of excellence provide centralized specialty and subspecialty services to pregnant women, infants and children with high-risk pregnancies, neonatal intensive care, and numerous disabling conditions, such as asthma, hemophilia, cystic fibrosis, diabetes, Down syndrome, cancer and orthopedic disorders. Although this allows for better coordination of care because there are fewer providers, it also presents a problem of service delivery to high-risk mothers and infants, and special needs children in rural Utah. CSHCN provides direct services in their Salt Lake City office for three specific populations: follow-up of premature infants, developmentally delayed preschool aged children and developmentally/behaviorally disorder school aged children and youth.

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

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

/2012/In a 2010 survey of local health department nursing directors about 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// ***/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//

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

Since 1995 Medicaid participants living in Utah's urban counties have been required to enroll in a managed health plan. This requirement is the Choice of Health Care Delivery Program, which is allowed under a federally approved freedom-of-choice waiver. In FY05 the Utah Department of Health's Division of Health Care Financing (HCF), Utah's Medicaid agency, contracted with two managed health plans and one PPO to provide services to Medicaid participants, including children with special health care needs, in Utah's urban counties. In the past, HCF had contracts with four managed care organizations, but health plans struggled financially to continue delivering services to the Medicaid population. One health plan continues to expand into rural areas of the state providing an option for Medicaid participants in most areas of the state. At the present time enrollment for rural Medicaid participants is voluntary, allowing them the option of choosing either fee-for-service, a primary care provider or a health plan if available in their area. Medicaid participants in all but three rural counties are enrolled in a Prepaid Mental Health Plan for behavioral health services. ***/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//***

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

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

Utah, not unlike other areas of the country, suffers from a shortage of certain types of health care providers in different geographic areas, including nurses, neonatologists, dentists, mental health professionals, etc. Provider shortages exist throughout the state. Utah's 2007 physician-to resident ratio was eighth lowest in the nation at 208 physicians per 100,000 resident population

compared to a national rate of 271. The Health Professional Shortage Area (HPSA) maps detail areas of the state with provider shortages for medical, dental and mental health providers. Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. The University of Utah Health Sciences Center is currently working on a proposal for a dental school; however, local dentists by and large do not support the efforts. Mental health providers, especially those specializing in children's mental health, are limited, in part due to the mental health system in the state which is a Medicaid carve out serving primarily the chronically mentally ill, but not necessarily those with acute conditions. ***/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 their dental school in 2013.//2013//***

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

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

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

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

/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//

Presumptive eligibility for prenatal Medicaid had been problematic in some areas of the state for a number of years, especially in the urban areas with limited Presumptive Eligibility (PE) sites. In 2001 Baby Your Baby by Phone was instituted enabling women annually to apply more easily than in person. For pregnant women ineligible for PE or Medicaid and unable to afford private care are referred to one of two University of Utah Health Sciences Center prenatal clinics located in local health departments or to a community health center located along the Wasatch Front offering sliding fee schedules. In 2008, the Department of Health eligibility workers were moved to the Department of Workforce Services to consolidate all eligibility workers. Though initially concerned that the move would impact customer service, it seems to be working /2012/ adequately for some populations. However, special populations, such as children with disabilities or children in Utah foster care or kinship placements are having a difficulties accessing 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// ***/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//***

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

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

Most specialty and sub-specialty pediatric providers are located along the Wasatch Front, including the state's tertiary pediatric care centers, Primary Children's Medical Center and Shriners Hospital for Children. The location of most pediatric specialists and sub-specialists in the most populous area of the state presents a problem for provider access for special needs children in rural Utah. In several counties of Utah, there are no pediatricians or sub-specialists, necessitating families to drive long distances to access care for their children. In most cases,

there is only limited additional itinerant coverage from the private sector for this large geographic area. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers. /2012/ St. George, in the southwestern part of Utah, is the most promising of the remote areas of the state to begin to build pediatric subspecialty infrastructure. Intermountain Healthcare, a large Utah health system, has opened a St. George based Women and Children's Health Center, serving the five county area. This area is also home for approximately 45 physicians who are both family practice and pediatricians. There is now onemetabolic geneticist. Additionally, the Intermountain hospital has a Neonatal Intensive Care Unit. //2012//

/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. 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//

Title V programs across the nation are working toward the six CSHCN core components of: 1) family and professional partnership at all levels of decision-making; 2) access to comprehensive evaluation and diagnosis; 4) adequate public and/or private financing of needed services; 5) organization of community services so that families can use them easily; and 6) successful transition to all aspects of adult heath 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//

/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//

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 Network and has a small contract with the Utah Parent Center to help support information and referral for families of children with autism.//2012//

The CSHCN Bureau is addressing these issues through the many initiatives, some of which include the Medical Home Initiative and MedHome Portal website, Telehealth, traveling

multidisciplinary clinics, the Fostering Healthy Children Program, community based case management teams, Baby Watch/Early Intervention and collaboration with Family Voices and the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) grant. These initiatives are described in greater detail elsewhere in this document. ***/2013/CSHCN collaborated with the Medicaid Infrastructure Grant to provide training on transition to adulthood to Medical Homes throughout Utah. All CSHCN clinics are implementing a new electronic billing and health record system.//2013//***

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

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

As the Title V block grant is reduced by establishment of categorical funding streams, additional financial obstacles particularly when the required outcome has been legislatively mandated by the state, such as the State Dental Director, newborn hearing screening, and so on. While Utah is not suffering the degree of economic 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.

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

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

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

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

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

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

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

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

/2012/Several statutes regulate pre-abortion education of women seeking abortions in Utah. New legislation passed in the 2010 Utah legislative session mandated that women seeking abortions be offered a description of the fetus during an ultrasound if they so desired. The requirements of these statutes are funded with state general funds; however Title V staff has responsibility to assure that they are adhered to. In addition, a law passed in the 2011 Legislative Session required the Utah Department of Health to "license" all clinics, including private physician offices that perform abortions. The law also requires the Department to inspect the clinics twice a year, with one inspection being unannounced. //2012// ***/2013/The 2012 Legislature passed a bill requiring a 72 hour wait (previously 24) before the procedure.//2013//***

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

In 1965, statute (Section 26-10-6) was passed requiring that every newborn in Utah be tested for the presence of phenylketonuria (PKU) and other metabolic diseases, which may result in mental retardation or brain damage. In 2006, newborn screening was expanded to include 32 new tests; therefore the rule for this statute will be updated. The Newborn Screening Program provides tracking and follow-up of abnormal screens and diagnostic testing, and provides education to institutions of birth, medical home (providers), and families. In January 2009, the Newborn Screening Program started screening for Cystic Fibrosis leading to 37 disorders being tested currently. ***/2013/The Newborn Screening Advisory Committee established a workgroup to develop a process for implementation of Severe Combined Immune Deficiency Syndrome (SCIDS) screening. The workgroup has developed an algorithm, a budget, timeline and obtained outside funding for implementation in July 2013. Approval for the screening will be needed by the Department, advisory committees, the Utah Hospital Association and the Legislature prior to implementation.//2013//***

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

adolescent mothers.//2012//

During the 2001 Legislative Session, Utah legislators passed a bill prohibiting the state from applying for CDC funding related to HIV/AIDS Education due to misunderstanding of CDC requirements for use of the funding. This legislation limits the state's ability to promote reduced risk for HIV/AIDS among its student populations. The impact of this mandate has resulted in the loss of YRBS funding as well. The political climate regarding CDC funding is unfortunately so controversial that the State Office of Education had not sought federal funding to continue YRBS Surveillance. /2012/ The State Office of Education has applied for and received funding for the YRBSS.//2012// The Utah Department of Health coordinates this survey in collaboration with the State Office of Education and with support for data analysis by CDC.

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

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

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

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

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

Each program that addresses the health of mothers and children has a specific program plan that identifies goals, objectives and activities. The process of strategic planning for each program varies from program to program. The Maternal and Infant Health Program, (formerly the Reproductive Health Program) has developed a plan based on the National and State Performance Measures and the one state Outcome Measure. /2012/ now 2 state outcome measures //2012// Each staff member is assigned responsibility for one or more measures. For other programs, each is assigned responsibility for the related National and State Performance Measures in their program plans. Additional goals and objectives are developed by each program

as issues arise, such as the need for dental services for pregnant women is incorporated in the Oral Health Program plan. Generally each program holds 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.

/2013/The Utah Department of Health signed the commitment agreement with ASTHO and the March of Dimes to work to reduce prematurity rates in the state. In addition, the Department is in process of developing a strategic plan which includes healthy babies. Folded into these two efforts will be a collaborative effort to focus on preterm birth and ways we can reduce the rates in the state. 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. In November 2012, March of Dimes with its partners will sponsor a Prematurity Symposium to discuss the impact of prematurity and develop an action plan to address the problem.//2013//
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.

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

/2013/The Department signed the ASTHO and March of Dimes' challenge to reduce prematurity. 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.//2013//

Budget shortfalls have impacted both MCH and CSHCN programs. The Governor has imposed a hiring freeze at least until July 1, 2010. As a result, we have 26 vacant positions. CSHCN programs have been impacted significantly with state cuts of $1 million due to its large portion of state funds. In 2009 $1 million was cut in the CSHCN budget, but restored for one year. In 2010, the funding was not restored, resulting in a shift of Title V funds, loss of staff, or discontinuation or reduction of clinic services. Some staff members have been reassigned to other work.
/2013/Utah's economy has improved creating a budget surplus, we did not receive any replacement funds for those cut in CSHCN clinics.//2013//

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.

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, Head Start State Collaboration Office, Early Intervention and the Office of Home Visiting. Plans are underway to hire a child development specialist to train providers on the ASQ and ASQ/SE tools to increase developmental screening in children. We will also recreate a lost position, the Child Health Nurse Consultant, to cover overall children's health not addressed by other programs. ***/2013/Rather than filling this position, we hired a School Health Consultant to work with other programs focused on school aged children and with school nurses. Instead of funding the developmental screening position, the funding will expand Help Me Grow.//2013//***

The Child Adolescent and School Health Program was dissolved in 2009 due to budget cuts. Two staff members were moved to the Child Development Bureau while the Adolescent Health Coordinator, whose work has a strong reproductive health focus, was moved to the Maternal and Infant Health Program (MIHP), formerly the Reproductive Health Program. These moves are a better fit in that early childhood and reproductive health efforts are better aligned allowing improved collaboration.

CSHCN Bureau
The CSHCN Bureau oversees 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 a newborn critical congenital heart disease grant.//2013//***

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.

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

Utah Medical Home Program trained and supports 22 medical home and 5 dental home teams statewide for children with special health care needs in primary care settings, building capacity for comprehensive, family-centered, coordinated, culturally competent health care. Medical Home teams include a parent partner, a care coordinator and office staff trained in the Medical Home model of care. For the past 2 years, staff has collaborated with the ASD MCH Grant to recruit and train 26 new practices and six additional dental practices with emphasis on rural Utah and family medicine physicians. The University Department of Pediatrics hosts a website developed through this collaboration that contains information on diagnosis, special education, transition, family, coding and resources for providers and families. The website is being adapted for six other states. www.medicalhomeportal.org

Neonatal Follow-up Program tracks very low birth weight babies less than 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 is shared with the Medical Home or primary care provider and respective newborn ICU.

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

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

Specialty Services 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.

The Maternal and Child Health Bureau oversees five programs, three of which are primarily funded with Title V funding: Data Resources, Maternal and Infant Health, Oral Health and Pregnancy RiskLine. The MCH Bureau oversees local health department contracts for services to mothers, children and youth, and P-5 home visiting. The Bureau also oversees the MCH Block grant application and needs assessment with input from CSHCN and other Department programs.

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.

Maternal and Infant Health Program (MIHP) is comprised of five components. Prenatal and family planning focus on access to care, Presumptive Eligibility, and enhanced Medicaid services. The Perinatal Mortality Review program reviews infant deaths and pregnancy related maternal deaths to identify trends and issues that, with change, might prevent future deaths. The adolescent health component works closely with stakeholders to analyze, prioritize and address critical adolescent issues. MIHP also includes PRAMS (Pregnancy Risk Assessment Monitoring System) funded with CDC and state funds and the state-funded WeeCare Program, nurse case management for high risk pregnant women enrolled in the state Public Employees' Health Plan. ***/2013/In December 2011, PEHP terminated the WeeCare contract to bring the program in house.//2013//***

Oral Health Program promotes prevention to reduce dental decay and other oral diseases and increase access to services. The program provides technical assistance to local health departments and others in the community. The State Dental Director heads the program.

Violence and Injury Prevention Program, now 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.

Other programs that serve mothers and children
Baby Watch/Early Intervention (EI) contracts with local entities to provide EI services for young children birth to age three. Local programs are available statewide.

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. Nurses work with DCFS caseworkers to ensure that children get required and follow-up health services. Nurses provide training to biological and foster parents so they can care for the child's health needs. Health care requirements for children in foster care were mandated by federal court settlement agreement.

Head Start State Collaboration Office (HSSCO) works with state agencies and others to promote better collaboration between agencies that provide services for young children. The HSSCO Director negotiates MOAs with state agencies for data sharing and other services. For example, the state WIC program shares data such as hematocrits, saving unnecessary repeat testing. ***/2013/State match funding was cut by the 2011 Legislature, preventing the Department from continuing the grant. The Office of Child Care, Department of Workforce Services now administers the grant. Department staff continues to work with the HSSCO on early childhood issues.//2013//***

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 hospitals and providers to improve the quality and timeliness of samples.

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.

Travis C. Waiver for Technology Dependent Children, Medicaid's Waiver for Technology

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

WIC 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.

State program collaboration
The Division collaborates with many programs and agencies within and outside the Department of Health to improve services for mothers, children and children and youth with special health care needs. The Division participates in coalitions, task forces, advisory committees sponsored by other programs, other state agencies or community-based organizations. CSHCN and MCH programs work with the Department of Workforce Services on the Child Care Board, early childhood efforts, home visitation, and Head Start. The DHS Child and Family Services contracts with the Fostering Healthy Children Program. The Department works with the Division of Mental Health and Substance Abuse (DMHSA) on a variety of efforts, such as the Early Childhood Systems grant and UDOH's Adolescent Health Network.

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

/2013/The Neonatal Follow Up Program is collaborating with the Uof U to offer counseling to mothers on risk for future preterm births so that they can plan future pregnancies accordingly. A small percentage of mothers were aware of increased risk. NFP provides clinical experiences for UofU Neonatology Fellows.//2013//

The University of Utah (UofU), Department of Psychiatry has served as a medical consultant for youth suicide prevention efforts. Utah State University (USU), especially the Early Intervention Research Institute (EIRI), has worked closely with the CSHCN Bureau on grant projects. This year CSHCN worked with Champions for Healthy Communities to begin a 5 year needs assessment of community based systems of care for CSHCN. USU, UofU and CSHCN work together on the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) project for advanced degree health care providers who work with children with special health care needs and families. In 2009, URLEND received two supplemental grants for mini projects focused on autism and hearing follow up. ***/2013/The URLEND project was awarded a new 5 year continuation for training. The Champions for Healthy Community project concluded.//2013//***

State statutes relevant to Title V program authority
In 1965, statute (Section 26-10-6) was passed requiring that every newborn in Utah be tested for PKU and other metabolic diseases. Newborn screening has since expanded to 39 disorders. The statute also includes mandatory hearing screening for all babies born in Utah. The Department is given statutory authority over certain records and data with provisions for privacy and confidentiality. For example, the Perinatal Mortality Review program is able to obtain prenatal and

hospital medical records in review of infant or maternal deaths.

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

In 2009 SB 21 requires the Department to establish a committee of Department and LHD representatives (Governance Committee) to review any federal grant to determine if there is a role for local health departments, defining that role and allocating funding to carry out their role to ensure that funding allocation to the LHDs is "fair". The law requires that federal grant funds may not be disbursed or encumbered by the Department before committee approval. Committee members review grant guidance to determine if the funding allocation is appropriate. The law went into effect July 2010. The Committee was formed early and has focused on 7 federal grants including Immunizations, STD, Cancer, PANO, Tobacco, Diabetes, and the Preventive Block grant. After these, the Committee will review other federal grants.

Numerous statutes regulate abortion with one that particularly impacts Title V. Utah State Code 76-7- regulates informed consent for abortions, mandating that the Department publish print material and a video that: provides medically accurate information on all abortion procedures; describes the gestational stages of an unborn child; and includes information on public/private services and agencies to assist a woman through pregnancy, at childbirth, and while the child is dependent, including adoption. The law requires that the materials be provided to any woman seeking an abortion. In 2010, the slight changes were made to the law, allowing the materials to be posted on the Department website, and that any woman
considering an abortion who opts to have a free ultrasound prior to her decision may request information about the fetus during the ultrasound. Numerous other statutes govern public health, but they are too many to elaborate on. ***/2013/State legislators passed a bill requiring women to wait 72 hours, not 24, before having an abortion.//2013//***

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

Preventive and primary care services for pregnant women, mothers, and infants
The MCH Bureau contracts for MCH/CSHCN services with the 12 autonomous local health departments (LHD). LHDs provide a range of services for mothers, women of childbearing ages and for children including those with special health care needs. Services may include family planning, well child care, immunizations, dental care, home visiting; Medicaid targeted case management; depression screening in pregnant and postpartum women; car seats and helmets; and, contacting families to ensure children receive Medicaid medical and dental preventive visits; WIC, and referrals to other services as needed. Some LHDs have co-located services, such as immunizations in WIC clinics.

Reproductive health services, in some degree, are offered by the twelve LHDs with 11 providing Presumptive Eligibility (PE) screening and 10 performing prenatal risk assessment. LHDs assist the mother in finding a provider and other resources. Only 2 urban LHDs (Salt Lake Valley and

Weber/Morgan) support prenatal services but which are provided by University of Utah physicians and the Midtown CHC Family Practice Residency Program. A small amount of MCH funding for the Salt Lake Community Health Centers, Inc. supports some prenatal services to uninsured women in Salt Lake City. ***/2013/We currently are working with Medicaid to improve the oversight of the PE eligibility process.//2013//***

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

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

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

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

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

In 2009, the Office of Home Visiting was created with federal grant funds to support evidence based home visiting programs. Salt Lake Valley Health Department started a Nurse Family Partnership Program with local funding. Community-based organizations have implemented Healthy Families America programs in four communities. The Department of Workforce Services has given the Office $1M over two years to support local programs. Other LHDs are interested, but lack funding. We are very interested in expanding home visiting programs in the state.

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

UDOH had been integrally involved in a state-level coalition for early childhood systems development, the Early Childhood Council (ECC). The Council included heads of state agencies

that provide services to young children, service providers, and advocates. However, the ECC has not met since the change in governors. Until after the November election, we won't have a sense of the Governor's commitment to early childhood. The Governor's Deputy of Education is leading an effort to apply for ARRA funding for the Early Childhood Advisory Council as part of the Head Start reauthorization.

Staff works with Medicaid and CHIP staff to promote better access to health care for young children and youth.
The state MCH/CSCHN Medical Director and the State Dental Director sit on the Medicaid and CHIP committee to authorize services for children. The Oral Health Program supports fluoride rinse and sealant activities in schools. In fall 2010 the program will survey children ages 6 -- 8 years for dental caries experience. We will compare 2010 results with 2005 data to identify trends and areas of need. Since two large counties have added fluoride to water supplies since 2005, the survey may provide data to measure the impact of water fluoridation.

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

Many children, youths, and adults with special health care needs are Medicaid recipients and low provider reimbursement rates are a barrier to finding providers. Routine preventive dental care for children, youth and adults with special health care needs is especially difficult to access because many dentists are reluctant and/or not trained to treat individuals with disabilities. The CSHCN Transition and SSI work in the Specialty Services Program addresses some of these issues through information, referral and Transition to Adulthood training for Utah Medical Homes. CSHCN staff has been instrumental in developing transition modules on the utahmedicalhome.org website. CSHCN staff collaborates in the Utah State University's Center for People with Disabilities project "Becoming Leaders for Tomorrow". The CSHCN Bureau Director chairs the State Rehabilitation Council, which guides provision of rehabilitation services to youth and adults throughout Utah. The CSHCN Bureau collaborates closely with the Utah Developmental Disabilities Council and the CMS Medicaid Infrastructure Grant, "Workability". ***/2013/The CSHCN Director completed her term as chair for the State Rehabilitation Council. CSHCN collaborates with the eight major agencies serving adults and children with disabilities through the state mandated Coordinating Council for People with Disabilities.//2013//***

CSHCN oversees direct clinical services, statewide consultation, education on several disorders, including communicative disorders, information about particular birth defects, exposures to medications, infections, chemicals, etc. for the public. The Bureau provides direct clinical services through multidisciplinary diagnostic evaluation and care coordination in CSHCN clinics in Salt Lake City and 9 other locations.

Staff works with families in a consultative model, identifying community resources to support health needs. Transition services focus on community infrastructure building, training for families and providers, and informational materials. In Salt Lake, developmental clinics will be held jointly with the University of Utah (UofU) with the University billing for pediatric services provided. CSHCN satellite clinics have been reduced: the Provo CSHCN, Ogden neurology and the Cedar City hearing clinics were eliminated and neurology clinics are being reduced. ***/2013/Telehealth Auditory Brainstem Testing is being pilot tested by the Hearing Screening Program in Cache County to improve access to hearing loss follow up.//2013//***

Since Utah rates of autism exceed national estimates, the CSHCN Bureau provides state leadership to bring together agency representatives and advocates who influence services for

children with autism spectrum disorder (ASD) and their families. CSHCN hosts the Utah Autism Initiative Committee, a multi-agency workgroup, and actively participates on the Autism Council of Utah. The Utah Registry for Autism and Developmental Disabilities (URADD) collects and manages prevalence data on Utah children with ASD and other developmental disabilities. UDOH and the UofU Department of Psychiatry jointly and successfully applied for additional CDC funds to expand surveillance activities. The Bureau received a 3 year award for the HRSA Autism Spectrum Disorder and Developmental Disability (ASD/DD) grant to focus on expanding state service infrastructure for children with ASD/DD and promoting early screening, diagnosis and treatment. New medical home practices will be recruited and trained on providing a Medical Home to children with ASD/DD and their families with emphasis on rural Utah and family medicine physicians. Dental practices will be trained to become "dental homes" for children with special needs. The program includes a "Learn the Signs Act Early" project in a pilot Early Intervention site to be adapted throughout Utah if successful. The medical home website contains information on diagnosis, special education, transition, family and other resources for providers and families. ***/2013/CSHCN oversees the Utah Autism Initiative bringing together agencies and advocacy groups serving those with autism to coordinate and implement the State Autism Strategic Plan. The 2012 Legislative Session passed, a bill that funded the Autism Treatment Fund with $1M and required Medicaid to submit a waiver for autism treatment for children and also a pilot with PEHP. CSHCN oversees the Autism Treatment Fund and works with the other two agencies to coordinate efforts.//2013//***

Culturally competent care that is appropriate to the State's MCH populations
The Department's Center for Multicultural Health (CMH) was created in 2004 through legislation (Utah State Code 26-7-2) that mandates the Center to:
• Reduce health disparities and improve health outcomes of multicultural populations.
• Improve access to healthcare for multicultural populations.
• Promote cultural competence.
• Improve translation and interpretation services at health agencies.
• Coordinate research, education, health promotion and screening activities related to multicultural and minority health issues.
• Share information about multicultural and minority health issues.
• Facilitate the Ethnic Health Advisory Committee.
• Help public/private organizations and advisory committees with minority health issues.
• Seek federal funding and other resources to accomplish its mission.

The Center hosts a monthly Ethnic Health Advisory Committee that involves community leaders to discuss issues for different populations in the state on health and works closely with Department programs and community based organizations to promote cultural awareness. The Center has spearheaded a committee to address issues of workforce diversity.

The CMH works with Department programs and the minority and ethnic community on health issues of specific populations in the state. The Center compiled a study on health issues for different ethnic groups. Utah health indicators by race and ethnicity for many health conditions, such as overall health, access to care, health behaviors, infant health, reproductive health, infectious disease, chronic disease and injuries and violence are posted on the Department's website and are easily accessible to the public. The CMH published a report on "Public Health Messages from Utah's Racial and Ethnic Minority Populations" in 2008 presenting qualitative data from focus groups held with 17 ethnic community populations on their experiences with health care in the state.

The CMH website is full of information on many topics and in many languages. The CMH provides health education materials in many languages to assist health professionals in communicating with people who don't speak English or have a low English proficiency. In addition, on the website is Yahoo! Babel fish which allows anyone to enter words for a rough translation into twelve different languages. The Center offers trainings to Department staff as well as local public health workers who are interested. Also, the Connection Newsletter is widely

distributed which includes grants, jobs, training opportunities, upcoming events and articles about health, cultural competence and health disparities. Every month the Center sponsors a "Brown Bag" on an issue related to disparities or information about different ethnic and racial groups that make up Utah's population. An example is in February 2010, the Brown Bag focused on cardiovascular health disparities including obesity, tobacco use, diabetes, high blood pressure, etc. Website: http://www.health.utah.gov/cmh/

/2012 /One of our MCH staff members worked with a leader of a Somali refugee group in Salt Lake City, who was interested in education on "pregnancy spacing." He said that "The women have a baby, go home, and next you know they are pregnant again." The leader was clear about the types of family planning that are acceptable in their culture, i.e. Cycle beads and Depo Provera injections. He didn't want to talk about "birth control" or "family planning," but specifically pregnancy spacing. In meetings with the leader and several members of the Somali Bantu community, they wanted to know more about the Cycle beads and asked us to train some of the female members in the use of Cycle Beads so they could train other members in their community. Subsequent meetings were held, however, translation is a problem since Somalian women do not speak English and are illiterate in their own language. These women are mostly home with their children, dependent on their husbands for transportation as they do not drive and do not "work". They have no formal way to learn English. Simple pictorial handouts of the female reproductive system were distributed and women given paper calendars for tracking of menstrual cycles. Using this simple method facilitates education on fertility. We have approached the leader about discussing pregnancy spacing with the men in the community and the leader is receptive. Our experience allows us to develop successful strategies to support this community in pregnancy spacing education.//2012//

/2013/In March 2012, the Department released Utah's HP2010 Final Report to determine if we met HP2010 Objectives. Utah did not meet targets for prenatal care, infant mortality, low birth weight and maternal mortality. Utah did achieve initiation of breastfeeding. Decreasing rates of dental caries and untreated dental decay in children through the decade and reached the target for untreated dental decay The report compares hospitals in Utah to one another, and regional and national averages. For example, from 2008 to 2010, 9.6% of deliveries were 1st time Cesarean deliveries with hospital charges less than the national averages.//2013//
An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

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

/2013/ Governor Herbert is running for a second term in the November 2012 election.//2013//

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

/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 Prevention and Control'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 MCH/CSHCN/CD 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 residents. CVs for senior management are attached. The Bureau of Child Development is headed by Teresa Whiting. Teresa has background in child development, child care, Head Start, the State Office of Child Care and child care licensing. She has headed the Department's Bureau of Child Care Licensing, and now has expanded her responsibility to include other programs related to children. The CSHCN Bureau includes eight programs and the state Part C program, Baby Watch/Early Intervention. ***/2013/ With Holly Williams' retirement, on July 1, 2012, the new CSHCN Bureau Director is Richard Harward, Au.D. who has 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//*** The MCH Bureau includes 4 programs that specifically focus on mothers and children. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse, who brings more than forty years of experience to this position.

Organizational charts are attached.
The Utah Department of Health is responsible for administration of programs that are carried out with Title V funding by housing the majority of Title V funded programs in the same Division, Family Health and Preparedness distributed among the three bureaus described above.

The Department of Health's organizational structure provides for oversight of programs and budgets by program managers, bureau directors and the Division Director. The Department has a number of programs that address the needs of women, mothers, children and adolescents including those with special health care needs, and families. Some programs are fully funded with Title V dollars, some with partial Title V funding and some that are funded with other sources of monies. In addition, each Bureau oversees contracts that allocate Title V funds to LHDs, CBOs and academic institutions. Local health department funding supports services for mothers and children, P-5 home visiting and injury prevention. With the five year needs assessment, we will review the funding allocations to determine if we are adequately addressing identified priorities with the funding available.

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

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

Programs that focus on mothers and children
The programs are described in more detail in Section B.

Child Development
The Bureau includes the child development specialist and the child health consultant, both vacant positions. It also oversees the Early Childhood Systems grant. It also includes BabyWatch/Early Intervention, Child Care Licensing, the Office of Home Visiting, and the Head Start State Collaboration Office. /2012/ The 2010 Legislative Session cut the state funds that were used as match for the federal Head Start State Collaboration Office grant which will result in the

Department having to forego future applications for funding beginning July 1, 2011. It is unfortunate that the funding was cut because the purpose of the Bureau of Child Development was to bring together all the early childhood programs to integrate work and activities. It is unknown at this time where the grant will go after June 30, 2011. The Governor is responsible for designating the grantee agency for the state. //2012//

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

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

Other programs that reach mothers and children:
Violence and Injury Prevention Program (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.

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

D. Other MCH Capacity

Number and location of Title V program staff
Division staff members are primarily housed at the main 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 system 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 outstationed staff in the southeast area (Moab) the east

(Price) and in Ogden including an occupational therapist, audiologist, a speech pathologist and one support staff. The CSHCN pediatric clinics have 3 outstationed staff in Ogden, 2 in St. George, a growing community in southern Utah, and contract staff in 7 rural LHD satellite sites to support the CSHCN itinerant clinics.

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

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

Three Bureau Directors oversee the Department's MCH/CSHCN programs. Teresa Whiting, with the Department for 4 plus years, oversees the Bureau of Child Development. Teresa has a degree in child and family development and extensive experience in child care, Head Start and program administration. Holly Williams, who oversees the Bureau of Children with Special Health Care Needs, has worked in the Department for 30 years. ***/2013/Holly is retiring on June 30, 2012.//2013//*** Harper Randall, MD, Medical Director of Maternal and Child Health/Children with Special Health Care Needs/Child Development, with extensive experience in community pediatrics, has been with the Department for 6 years. She works with a number of programs, such as autism, newborn blood screening, child death review, perinatal death review etc. The Deputy Director of DFHP, Nan Streeter, is also the state Title V Director and oversees the bureaus of Child Development and CSHCN. She is also responsible for administration of the maternal and Child Health Bureau programs. Ms. Streeter has been with the Department for 20 years.

Division program managers are all well experienced skilled health professionals with significant experience in their field and in program administration, planning and evaluation. Staff that provides planning, evaluation, and data analysis capabilities. ***/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//***

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 UNS-cHIE grant, and other Department data projects. CHARM (Child Health Advanced Record Management), housed in CSHCN, links newborn hearing screening with newborn blood screening, vital records and immunizations. CHARM will enable providers to look up a child's records to determine immunization status, newborn screening results, etc. Eventually CHARM will be incorporated into the cHIE system to link multiple data sets. Division staff is part of the oversight committee for several grants awarded to the Office of Public Health Informatics. CHD oversees the legislatively mandated Health Data Committee which is responsible for publication

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

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

Division planning and evaluation occur primarily at the program level with support from Division and Department data resources. The MCH Epidemiologist ensures that data linking and data related to mothers and children are available to staff. The MCH Epidemiologist, also the Manager of the Data Resources Program, is very skilled and adept for the work and has extensive experience in survey development. The program is an invaluable resource to programs. MCH staff continues to partner with Medicaid to link birth and Medicaid eligibility data to assess birth outcomes among Medicaid women. With the Medicaid Data Warehouse, we have been able to access eligibility and claims data easily. Data Resources staff are skilled in data linkages which is very helpful in comparing the general population to CHIP and or Medicaid. The MCH Epidemiologist hosts regular meetings of the MCH Epi Network to share data issues related to mothers and children. The MCH Epi Network is well attended by Title V staff and Department staff including the CHD and its offices. The Network addresses critical issues related to MCH and CSHCN to share results or to problem solve an issue. Feedback from Network members has been invaluable for presentations, policy setting and review of data analyses. The Division has successfully submitted abstracts to national meetings for presentation and staff participated in the development of the national preconception health indicators.

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

Number and role of parents of special needs children and youth on staff
The CSHCN Bureau hired the Director for the Utah Chapter of Family Voices (UFV) as the Bureau family 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 Family to Family grant was awarded to Utah Family Voices (UFV) in 2008. Services for families continue through the Utah Parent Center, UFV and the Family to Family Health (F2F) Information grant. Although funding for the F2F Information Center has been uncertain, it is probable that HRSA will fund centers through the health reform legislation. CSHCN has provided funds to the Utah Parent Center to support their Autism Hotline. This year, CSHCN reallocated some ASD/DD carryover funding to support the F2F Center because CMS funding ends. CSHCN has dedicated MCH funding to enhance family-to-family activities and support development of a

family database. Through this grant two Family Health Partners have been hired and trained to assist in family-to-family health information and education. The funding will reimburse families for their consultation and involvement in development of materials for various projects, such as the F2F project, the Utah Collaborative Medical Home project, the URLEND project and medical residency training. This funding also helped to establish a toll free information and referral line staffed by trained parents. ***/2013/CSHCN will contract with the Family to Family project to provide consultation and family support to CSHCN clinics and programs.//2013//***

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 MaternalChild 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//***

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

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

in the MCH workforce at present. ***/2013/We have experienced a number of retirements of staff who have worked for the Department for 20+ years. 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. //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. WIC Directors have various backgrounds with some being Registered Dietitians.

/2013/We have experienced a number of retirements in key staff, such as our Newborn Blood Screening Program Manager, Division Financial Manager and recently the CSHCN Bureau Director. 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//

E. State Agency Coordination

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

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

The Division has developed a strong collaborative working relationship with the Division of Children and Family Services (DCFS) and Child Protective Services in a number of efforts, including providing services for children in foster care through a contract with the UDOH's Fostering Healthy Children Program (FHC). FHC is an exceptional program that ensures these children and youth receive needed services. CSHCN staff participates on the Health Care Consortium Council for the Division of Child and Family Services (DCFS), which advises the DCFS Board on health issues for children in their system. UDOH Division representatives sit on the DCFS Child Abuse and Neglect Council, and an inter-agency group, Utah Prevention, to address substance use and other issues among youth. Division representatives are part of an inter-agency group to address youth transition issues.

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

developmental delay.

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

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

CSHCN Bureau and SARS have worked together on the Utah Registry for Autism and Developmental Delays (URADD) grant. /2012/UDOH has a School Health Consultant to address health issues in schools and work with the Office of Education and school nurses.//2012//

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

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

The Maternal and Infant Health Program has worked with Medicaid to certify smoking cessation interventions for pregnant Medicaid participants; provide case management to a subset of high

risk pregnant Medicaid women in Salt Lake County; and to ensure information for, outreach to, and access for Medicaid eligible children and youth with special health care needs and their families. Two Medicaid eligibility workers at the CSHCN clinics work with the Travis C. Waiver Program, CSHCN clinics and other Medicaid staff at two adjacent tertiary care facilities.

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

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

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

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

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

Governance Committee.//2012//

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

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

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

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

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

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

Tertiary care facilities
The Division has effective relationships with many of the tertiary facilities in the state, seven perinatal centers and two children's centers. The Newborn Follow-up Program provides outcome data to the newborn intensive care units in the state. The University of Utah Health Sciences Center, a tertiary perinatal center, works closely with MCH Bureau staff on various grant projects. Our staff often provides linked datasets to the University for studies or grant applications. /2012/The Maternal and Infant Health Program queried all delivering hospitals on neonatal care and capacity related to provider types, availability, and support services. Ten facilities self-designate as Level III, but only three met the AAP criteria. The Program met with hospital representatives to discuss survey results and to discuss criteria for Level III designation. The definition of "continuously available" is the sticking point in defining Level III.//2012//

/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, the Medicaid ACOs, Medicaid and MCH to identify women at high risk for preterm birth. //2013//

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

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

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

Pediatricians from the UofU Department of Pediatrics are contracted to provide developmental pediatric assessments at CSHCN Salt Lake City and satellite clinics. Neurologists and geneticists from the UofU are contracted to provide sub-specialty evaluations at CSHCN satellite clinics. Intermountain Healthcare, the state's largest health system, owns four perinatal centers and one pediatric tertiary care center. Department staff works with providers in these centers on a number of initiatives, including induction policies, appropriate delivery site for very low birth weight infants, electronic medical records, Perinatal Task Force, etc.

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

Title V staff members have been involved with the Rocky Mountain Public Health Education Consortium which provides a number of educational offerings through on-site educational opportunities, such as the MCH Summer Institute, a MCH PH Certificate Program through the University of Arizona and distance learning opportunities, such as on-line modular courses. The Consortium is a collaboration of academic and state, local and tribal MCH leaders working to provide workforce development opportunities for public health professionals working in areas with a dearth of educational programs. The Division has sponsored several staff members to participate in the MCH PH Certificate Program and several have gone on to obtain their MPH degrees. However, with budget cuts, we are not able to sponsor staff participation. MCH and CSHCN staff has been involved with several colleges and Universities in the state as well as out of state providing internships for students in these programs and others, such as nursing, pharmacy, pediatric medicine, social work, dental hygiene, and health education. CSHCN provides internship sites for University of Utah audiologists, social workers and clinical experiences for students and trainees through its multi-disciplinary clinics and through the Pregnancy RiskLine. /2012/We no longer are able to support this.//2012//

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

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

Utah CSHCN is in its third /2012/tenth//2012// year of the MCHB-funded Utah /2012/Regional//2012// Leadership Education in Neurodevelopmental Disabilities (ULEND) program. CSHCN collaborates with USU Center for Persons with Disabilities and University of Utah, Department of Pediatrics, in an MCHB Leadership Grant. 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 CDC, USDA, HRSA, etc., including Early Intervention (Part C), WIC, PRAMS, Autism, Hearing, IT, oral health, and others as they become available.

WIC
The state WIC Program which is in the MCH Bureau greatly enhances opportunities for coordination of efforts. WIC has a strong collaboration with other programs focused on the health

needs of mothers and children. Other programs have enthusiastically welcomed the collaboration opportunities with WIC. WIC staff members participate on various committees related to maternal and child health, including the Perinatal Task Force, MCH Epidemiology, nutrition, and data integration efforts.

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

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

Family Leadership and Support Programs
CSHCN employs the Utah Family Voices Director to /2012/ lead the Family Leadership and Support programs which //2012// provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. /2012/ Family Voices was awarded the next three years of funding to continue the Family to Family Health Information project, under the Utah Parent and Information Center. Through the Family to Family Project information and referral is provided to families through a toll free information phone bank. Both the Utah Parent Center and Utah Family Voices provide resource information and support to families of children and youth with special health care needs, as well as leadership training and mentoring for parent leaders.//2012// CSHCN includes families in the Part C interagency coordinating council. ***/2013/ We are very concerned about the ending of funding for the F2F program. We have greatly benefited from family involvement in our programs and had hoped to expand our efforts so that more programs had family support to better address the needs of families with CYSHCN.//2013//***

F. Health Systems Capacity Indicators

a. What has influenced the program's ability to maintain and/or improve the HSCI?
b. What efforts are being made by the program in developing new strategies for meeting the HSCI?
c. Interpretation of what the data indicate

HSCI #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.

a.
The Asthma Program through CDC funding has conducted several activities to help children under five manage asthma. During the past three years, trainings were given to child care providers to encourage asthma-friendly child care environments and to teach care givers to recognize and manage asthma symptoms. Several members of the Utah Asthma Task Force, comprised of various community and professional partners, conducted focus groups for mothers of children under five and developed asthma educational materials based on the results. Materials were distributed through various partners including the Baby Your Baby Program to help young mothers recognize and manage their children's asthma symptoms. The Asthma Program has 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 staff by training staff members and educating parents at monthly meetings. Two more local health departments were funded to help spread asthma programs, education, and resources.

b.
The Asthma Program develops strategies according to its Utah Asthma Plan, which was just updated for 2012-2016. The plan was prepared with partners, such as the American Lung Association, the Asthma Task Force and others. The State plan is written to address several levels of Utah'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, such as a health care provider manual and guidelines to manage pediatric and adult asthma and a guide to asthma and medications. The Asthma Program also recently began conducting a quarterly Telehealth session for health care providers across the state, to educate them on various asthma-related health issues. Guidelines were developed about mold and its dangers and how to safely eradicate it. Online tutorials for the public on air quality and asthma were published on the website. The Utah Asthma Program website includes resources from a variety of sources and those the Program has developed. The website address is http://www.health.utah.gov/asthma/

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

c.
Between 2009 and 2010, the asthma hospitalization rate for children less than five years of age decreased from 17.2 to 14.3 hospitalizations per 10,000 population. The 2010 rate was the lowest asthma hospitalization rate for children in this age group within the past ten years. These data indicate that interventions and asthma education around the state may have had a positive impact on asthma hospitalizations for children.

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

HSCI #02
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

a.
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 the level of care children receive.

b.
Medicaid contracts with local health departments for CHEC (Utah's EPSDT) outreach to assist families in accessing health care services.

The local health departments also provide targeted case management services for Medicaid 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 Medicaid reimbursement rate for health care providers is low and thus, fewer providers are willing to accept low Medicaid reimbursement rates has decreased.

Title V will continue to work closely with Medicaid to develop better strategies to improve access to health care for infants.

c.
The percent of Medicaid enrollees under age one receiving at least one initial periodic screen has been increasing since 2002 from 81.4% to 88.9% in 2011. The increases may be indicative of a positive impact 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. The calculation of this measure has been revised for more accurate reporting.

HSCI #03
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

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

c.
This Health System Capacity Indicator has shown dramatic improvement. In 2002 only 53.5% of infants had received a periodic screen and in 2008, 99.3% received a service. The increases may be due to better reporting of information. The rate remained relatively stable for the last two years (97% - 98%). The rate dropped to 97.8% in 2011.

HSCI #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.

a.
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 this, many working poor women who may be eligible in other states across the country are not eligible 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 funding is woefully inadequate to cover the need. Due to contractual issues, the Baby Your Baby media campaign that encourages women to get early and continuous prenatal care was suspended and no ads were run in 2011.

b.
We continue to promoting safety net providers that cover uninsured women. The Utah Clicks online enrollment application system provides easy access for pregnant women to begin their presumptive eligibility process to enroll in prenatal Medicaid. The MIHP prints and disseminates Utah Clicks promotional flyers to partners that are in touch with pregnant women throughout the state. It is anticipated that in FY13, a new contract will be in place for the Baby Your Baby media campaign. When the contract is in place, Baby Your Baby is planning to have a strategic planning retreat in FY2013. Remarketing of Baby Your Baby will include presences on Twitter, Pinterist and a Baby Your Baby Blog.

c.
In 2010, 84.5% of Utah women delivering a live birth received adequate prenatal care based on the Kotelchuck Index.

Among Hispanic women, only 73.2% 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 their immigration status. While Hispanic mothers receive some prenatal care, because they are uninsured and paying out of pocket, they may be much more likely to skip visits. The 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. Higher rates are also are noted among women who have had 3 or more previous live births. Among women with 3 or more previous live births, 80.7% received adequate prenatal care compared to 85.5% of women with fewer than 3. This disparity may be due to lack of time, day care for children and/or a feeling that they're experienced with pregnancy and do not need as many visits.

HSCI #05A
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State -- Percent of low birth weight (<2,500 grams).

a.
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.
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 substance use, elective inductions, and so forth. Staff from Medicaid and the Maternal and the Infant Health Program are working together to educate women who enroll in Medicaid about the potential of preventing recurrent singleton preterm births with the early and continuous use of 17 alpha hydroxyprogesterone (17P).

c.
Data indicate that women enrolled in Medicaid fare far worse than their non-Medicaid counterparts. The percentage of low birth weight births among Medicaid women was 8.2% in 2010 compared to the state rate of 7.0%. Utah's Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that women enrolled in prenatal Medicaid are more likely to have numerous risk factors which make them more likely to have a LBW infant, for example they are more likely to be younger, 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.

HSCI #05B
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State -- Infant deaths per 1,000 live births

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

b.
The Department continued the "Power Your Life" social marketing campaign in 2011 to encourage women of reproductive age to reach optimal health by using novel and established social marketing approaches to: increase awareness of the importance of being at optimal health prior to pregnancy, increase awareness of existing preconception/interconception, prenatal and parenting services and programs, and to address the relationship between such services and health/birth outcomes and a healthy first year of life. The target populations of the media campaign are low income women and women of racial and ethnic minorities who have higher rates of infant mortality.

The MCH Bureau convened 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 babies born statewide. The consortium is also working towards the goal of sharing clinical data on these vulnerable infants.

c.
The rate of infant mortality for the nation as a whole was 6.4 infant deaths per 1,000 live births (2009). Utah compares favorably with a rate of 4.6 infant deaths per 1,000 live births (2010), one of the lowest infant mortality rates in the country. However, women enrolled in Medicaid have a higher rate of infant mortality than the state as a whole (5.1/1000 live births, 2010). Again, we know that women enrolled in prenatal Medicaid have numerous risk factors which make them more likely to experience an infant death, for example they are more likely to be younger, unmarried, have less than a high school education, or be of a racial or ethnic minority group. These factors may be contributing to higher rates of infant mortality among our prenatal Medicaid population.

HSCI #05C
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State -- Percent of pregnant women entering care in the first trimester

a.
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 this, 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 citizenship status, which interferes with early prenatal care. Due to contractual issues, the Baby Your Baby media campaign that encourages women to get early and continuous prenatal care was suspended and no ads were run in 2011.

b.
The Maternal and Infant Health Program maintains a web-based application system for presumptive eligibility for prenatal Medicaid, called UtahClicks. We continue to add Qualified Providers who receive prenatal presumptive eligibility applications around the state to expedite a pregnant woman's ability to enroll in the program and begin prenatal care before the end of the first trimester.

c.
The overall entry into first trimester prenatal care for Utah pregnant women was 73.1%, however for Medicaid women, the rate was 62.5%. 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.

HSCI #05D
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State -- Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]).

a.
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. Due to contractual issues, the Baby Your Baby media campaign that encourages women to get early and continuous prenatal care was suspended and no ads were run in 2011.

b.
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. We support enrollment of women in presumptive eligibility to facilitate a pregnant woman's ability to access prenatal care while her Medicaid application is processed.

c.
Women enrolled in prenatal Medicaid (76.8%) 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 is likely the reason for a lower percentage of Medicaid enrolled pregnant women to have adequate prenatal care.

HSCI #06A
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)
See attachment: HSCI06A_06C_attachmentTVIS.docx

HSCI #06B
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children
See attachment: HSCI06A_06C_attachmentTVIS.docx

HSCI #06C
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women
See attachment: HSCI06A_06C_attachmentTVIS.docx

HSCI #07A
The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

a.
The 2011 data shows that 69.1% of medicaid children received services. Obviously we need to increase our efforts to ensure that Utah children enrolled in Medicaid are receiving health care services. Calculation for this measure has been revised for more accurate reporting. Previously the rate was reported for 1-18 years, but now the rate is reported for birth to 20 years.

b.
This is an area for Medicaid and the Department of Workforce Services (they do Medicaid enrollment) to addressed 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.
We are not sure what the data mean other than the obvious fact 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.

HSCI #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

a.
There has been a slight increase in the percentage of children receiving dental services. The rate increased from 52.6% (2009) to 54.8% (2011). This is in part, due to the emphasis that the Oral Health Program (OHP) has placed on early childhood dental caries prevention and education as well as the need for early and regular dental visits. The OHP has collaborated with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits for children.

b.
The OHP collaborated with staff in the UDOH Division of Medicaid and Health Financing to expand current CHEC (Utah's EPSDT) outreach programs. 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, child care, language, etc.; 4) serving as liaisons with dental offices to recruit and encourage dentists to become Medicaid providers. In addition, Division of Medicaid and Health Financing staff has worked with dental office staff on billing and other issues to reduce identified barriers to providing care. The State Dental Director has been working with the Utah Dental Association to encourage dentists to see Medicaid eligible children. The Dental Director meets with members of local dental districts around the state to promote increased access for children to dental services.

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

HSCI #08
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

a.
Insufficient information about possible SSI eligibility may be lacking thus limiting application for eligibility and receipt of services. Data from DDS (Disability Determination Services) to CSHCN (Children with Special Health Care Needs) are processed by two staff now for completeness enabling them to process the information faster. We have stability in the same staff working on this system database for several years. CSHCN has transitioned to a new electronic health record system which will allow data to be housed in one database.

b.
CSHCN has implemented an electronic health record system. SSI information is collected on all children at clinics.

We have received some returned notification envelopes due to address changes. Some notification letters have been returned for address issues. Some of the returns have an address change listed but many do not. From the time we receive the information from DDS we will send our informational page in a timely manner.

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 broad array of services beyond those provided by CSHCN clinics.

The CSHCN Bureau employs an SSI Specialist who works with the Office of Disability Determination Services (DDS). DDS sends referrals for all potential recipients up to age 18 years, to the Specialist for outreach and information about potential Medicaid eligibility, CSHCN services and other community resources.

c.
Numerator data for this indicator come from the number of referrals from Utah's Office of DDS added to the unduplicated number of children receiving direct CSHCN clinic services/case management. These data indicate that for 2011, the percent of identified SSI beneficiaries who received rehabilitative evaluation services decreased.

Fewer children are seen at CSHCN clinics due to significant state budget cuts, in addition to children aging out of the program eligibility, and/or families have moved with no forwarding address. We have noticed a sharp decrease in the number of 831 forms sent to us from DDS reflecting the overall decrease noted.

HSCI #09A
The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

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

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

c.
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.

HSCI #09B
The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

a.
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 and 2011 YRBS because the funding requirements were changed to allow health departments to apply. Weighted results for the 2009 and the 2011 YRBS are available on the

web-based Utah Department of Health Indicator-Based Information System for Public Health (IBIS).

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

c.
Utah continues to have low rates of tobacco use among high school students. The 2011 rate of 7.8% is the lowest high school smoking rate recorded by the YRBS. Youth smoking has declined significantly since 1999 which was 14.5%.
An attachment is included in this section. IIIF - Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

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

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

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

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

/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//

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 Births" 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 Births" (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//

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	479	463	423	417	417
Denominator	479	463	423	417	417
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Data reported are the most recent data available.
Utah Newborn Screening Program Database 2010 Data

Notes - 2010
Data reported are the most recent data available.
Utah Newborn Screening Program Database 2010 Data

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

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 100% and the Annual Indicator was 100%.

The Newborn Screening Program (NSP) continued surveillance and identification of children with 37 different disorders including : congenital hypothyroidism, galactosemia, biotinidase, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders, fatty acid disorders, hemoglobinopathies and cystic fibrosis .

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

were sent and receipt tracked. A case was closed only upon receipt of the form.

A new process for reporting TSH levels was implemented. On the first screen if the TSH is =40 and the T4 is normal, the results are now reported as 'elevated' and a note is added with explanation and a request for collection of the second screen to confirm normalization of values. If TSH is >230, it is called out as a critical value. These changes have reduced false positive rates, decreased program and provider workload, and reduced the need for additional testing.

Newborn screening education was provided to hospitals, medical homes, other health care providers, families and the general public. Additionally, the Bureau of CSHCN continues to provide financial assistance for medical food for families and individuals with PKU.

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. Reporting levels for TSH were changed to reduce false positive rates.			X	
4. Education was provided to hospitals, medical homes, other health care providers, families and the general public.		X		
5. Financial assistance for medical food was provided to families and individuals with PKU.	X			
6.				
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. Care coordination and data tracking is ongoing. Collaboration continues with the University of Utah Metabolic Clinic, ARUP Laboratories, Ambry Genetics and the UDOH State Lab to provide testing for disorders and follow up.

The Newborn Screening Advisory Committee continues to meet on a quarterly basis and has recommended the addition of Severe Combined Immunodeficiency (SCID) to Utah's newborn screening panel. NSP is working with the UDOH State Lab and ARUP to implement SCID newborn screening.

NSP and the Birth Defects Network (BDN) submitted a grant proposal to evaluate the efficacy of Critical Congenital Heart disease pulse oximetry screening as part of newborn screening which was funded.

Monthly quality assurance report cards are sent to hospitals. NSP continues involvement with the cHIE and CHARM project to integrate data for newborn screening, newborn hearing, immunization and vital records. NSP is working with the BDN on its National Birth Defects Prevention Study project. Newborn hearing program and NSP are collaborating to provide

education and assistance with other UDOH programs such as the Office of Home Visiting and Long-Term 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 and acylcarnitine disorders. Care coordination and data tracking will be ongoing. Collaboration will continue with the University of Utah Metabolic Clinic, ARUP Laboratories and the UDOH State Laboratory to provide testing for disorders and follow-up.

The NSP will participate in discussions with the Genetic Advisory Newborn Screening subcommittee to review the recommendation of including CCHD on the state newborn screening panel. NSP will implement newborn screening for SCID. In addition to requesting a kit fee increase, NSP will research alternatives to offset the increased costs of screening for SCID.

NSP plans to utilize CSHCN's updated telehealth facilities to improve access to heelstick training for birth hospital staff and medical homes throughout Utah, with an emphasis on rural areas.

NSP will work with the UDOH State Laboratory which will be upgrading their Laboratory Information Management Software.

The QA Report Card for hospitals will continue with the emphasis on decreasing unsatisfactory specimens, incomplete 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.

Newborn screening kits will be sold to all institutions of birth and to direct entry midwives. Consultations with all providers will be available by phone or site visit. Consultations and education of families and the general public will continue. The NSP will work with its lab partners to review the screening processes and test results to reduce the false positive rates and improve the overall quality of our services.

Collaborative and financial support to the University of Utah 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:	**53395**			
Reporting Year:	**2010**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that**

					Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	52939	99.1	5	3	3	100.0
Congenital Hypothyroidism (Classical)	52939	99.1	495	23	23	100.0
Galactosemia (Classical)	52939	99.1	13	1	1	100.0
Sickle Cell Disease	52939	99.1	265	2	2	100.0
Biotinidase Deficiency	52939	99.1	32	6	6	100.0
Congenital Adrenal Hyperplasia	52939	99.1	53	6	6	100.0
Cystic Fibrosis	52939	99.1	1075	22	22	100.0
Acylcarnitine Disorders*	52939	99.1	267	16	16	100.0
Amino Acid Disorders**	52939	99.1	162	5	5	100.0
Galactosemia (non-classical)	52939	99.1	13	10	10	100.0
Hemoglobinopathies (non-sickle cell disease)	52939	99.1	265	243	243	100.0
Hearing Screening***	52641	98.6	341	68	54	79.4
Diet Monitoring Pregnant Women	65		4	4	4	100.0
Diet Monitoring, 0-18y	635		120	120	120	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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	65	52	55.1	55.1	55.1
Annual Indicator	55.1	55.1	55.1	55.1	71.5
Numerator					
Denominator					
Data Source		See footnote for source	See footnote for source	See footnote for source	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	71.5	71.5	71.5	71.5	71.5

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Data are pre-populated from the National Survey of CSHCN. The same questions were used to generate the NPM02 indicator in 2001 and 2005-2006 survey.

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 55.1% and the indicator was 71.5%.

Funding for the Family Involvement and Leadership program continues to make progress with a part-time position for the Utah Family Voices Director to coordinate the program in collaboration with Utah's Family to Family Health Information Center. This funding has expanded limited resources to continue the valued family and consumer participation within many MCH programs and activities and respond to contacts from families wanting and needing information in a timely and systematic way.

Family involvement and leadership are key in the CHIPRA grant administered by the Utah Department of Health and the University of Utah, Department of Pediatrics Medical Home demonstration project. The project has 22 additional family leaders involved in partnering with professionals in making positive change and a family "voice" within individual practices and clinics. The family leaders were provided a stipend for their involvement and expertise.

Families have been a vital training experience for LEND trainees, medical students and residents. Individual parents are presenting to nurse and medical residents at the Primary Children's Medical Center. One parent has been nominated and accepted as the first parent representative of the hospital's board of trustees. Identified parents with Utah Family Voices continue providing information about family centered care and the day in the life of a family of a child with special health care needs to the 2nd year pediatric medical residents at the University of Utah.

Utah Family Voices' staff and parent leaders presented, "The ABCs of Autism", a full day program which consists of six modules for families of children diagnosed with an ASD. The trainings were provided in rural areas of the state as well as on the Wasatch Ffront. Both families of children with ASD and professional partners attended the trainings. Evaluations from the trainings resulted in 90% of the participants being very satisfied or satisfied and the other 10% being neutral with

comments of needing more in depth information to meet the needs and challenges of their individual situations.

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

The families and staff involved with Family Voices and the Family Involvement and Leadership program were instrumental in providing various trainings and one on one consultation to families of children, youth and young adults with special health care needs. Trainings provided throughout the state have included: "Healthy Transition to Adulthood", "Medical Home 101", "Families involved in Systems Change", "Emergency Preparedness", "The Affordable Care Act", "Partnering with Providers", "Special Needs Funding Resources", and "The Sibling Experience" to name a few. The annual Family Links conferences and trainings that are provided by a coalition of family, advocacy and disability groups continued to provide training and information in new innovative mechanisms such as mini topical conferences and webinars.

Many of the accomplishments are sustaining the important components of Family involvement and satisfaction and building on successful projects and activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Employed paid “parent” staff.				X
2. Increased family voices in medical professional training and curriculum.				X
3. Increased the partnerships of parent leaders, family and disability groups, advocacy organizations with state agencies and policy makers.				X
4. Supported Utah’s Family to Family Health Information Center to provide information, referral and support to families.		X		
5. Partnered with Family Links conferences and trainings.				X
6. Increased family directed training throughout the state.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN Bureau with Utah Family Voices, Family to Family Health Information Center are providing the ABCs of Autism training into 8 additional communities throughout the state with the collaboration and funding of Utah State University, Center for Persons with Disabilities. Development and planning of enhanced efforts to have additional staff in the CSHCN clinics are being implemented to provide a mechanism for family partners and consultants to work directly with parents and family organizations in providing them with resource, advocacy information and peer emotional support.

Family leadership trainings are provided to new and existing Parent Partners in the Medical Home. Parent Partners were provided training on HIPAA, Boundaries and Care of the Care-Giver. New partnerships with the Division of Substance Abuse and Mental Health have begun to integrate medical and mental health family involvement initiatives. Partnerships with agencies and organization creative mechanism to compensate families for their expertise continues to develop and be enhanced across service systems.

Family experts continue providing input for grants and projects developed including the MCH Block grant. The collaboration will enable additional family leaders and parent partners to provide credible and time-sensitive information, training, and guidance regarding the needs of CSHCN.

c. Plan for the Coming Year

Families are the core of the health care system and should systematically be involved in providing credible experience and expertise to program and policy development, implementation and evaluation. Family leaders are equal partners and new innovative mechanisms to continually compensate for their knowledge and involvement will be explored.

Parents involved in Medical Homes will become more formalized and a network will be developed for families to connect and share their expertise and resources. Grants from various sources will be explored to develop a model of payment and sustainability for parents providing support and care coordination services in a Medical Home. Formal job descriptions and Medical Home commitment will be developed and proposed to health care partners.

The caregiver educational series that was developed for families of children diagnosed with an ASD will be expanded for families of children with other diagnosis. The curriculum has been condensed as a result of evaluation and input from families.

Presentations provided by family leaders to health care professionals, medical and allied professional training programs will expand to impact systems. Compensation for family involvement in the Utah Regional LEND program will be sustained throughout the next year and remain a priority. Families serving on state level committees will be improved with new opportunities sought including those in Accountable Care Organizations and sister agencies such as the Division of Substance Abuse and Mental Health.

The state's Parent Training and Information Center (Utah Parent Center) will continue to receive a small contract to help provide an autism information toll-free line and provide up to date resources and fact sheet for families of children with an Autism Spectrum Disorder especially in light of the new prevalence with Utah having the highest rate in the nation.

Outreach, training, and information dissemination on the Affordable Care Act, health care funding and resources, family-centered care, family/professional partnerships in the Medical Home and Medicaid eligibility information will be provided to families, health care professional and policy makers in efforts of positively impacting more families. The program director will be involved in a leadership position on Medicaid Reform providing a consumer and special health care need voice.

The Family Involvement and Leadership Program and Family Voices staff will provide peer support in the CSHCN rural clinics as well as the Child Development Clinic and Newborn Follow-up Program with funding from the CSHCN Bureau.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	49	52.2	52.2	52.2
Annual Indicator	52.2	52.2	52.2	52.2	46.2
Numerator					

Denominator					
Data Source		See footnote for source	See footnote for source	See footnote for source	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	46.2	46.2	46.2	46.2	46.2

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The Performance Measure was not achieved. The performance objective was 52.2% and the Annual Indicator was 46.2%.

The 2009/10 National Survey of Children with Special Health Care Needs indicated a 6% decrease from the 2005/06 Survey in the percentage CSHCN who receive care within a Medical Home. The Survey also indicated a nearly 2% increase in CSHCN without insurance, a nearly 4% increase in CSHCN with inadequate insurance, and a nearly 7% increase in CSHCN 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 increasing the number of CSHCN without a Medical Home. It is possible that NPM-3 will not see a significant increase until Utah has seen a significant, sustained economic recovery.

The Medical Home Program and CSHCN utilized the CSHCN Executive Group (CEG) and its

consultant group to gather feedback from stakeholders at the quarterly meetings. The CEG consists of CSHCN administration and CSHCN program managers. The CEG consultants consist of 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.

Year three of the State Implementation Grant involved training medical homes using a peer mentoring model by physicians from the initial project to improve screening and referral for autism and developmental delays.

The video series for parents of children newly diagnosed with autism, "The ABC's of Autism," was presented throughout the state. Trained family navigators accompanied the presentations to answer questions and assist in locating community resources.

In an effort to promote a coordinated services system, CSHCN partnered with various groups. CSHCN and the Medical Home Portal, at the University of Utah, partnered 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. The Medical Home Portal team continued negotiations to include other states' lists of community services.

In other efforts to improve the system of services, CSHCN Medical Home Program staff served on the Board of the Utah Parent Center. The Utah Parent Center provided training for professionals and families on a variety of topics including school, transition, and advocacy issues. The Medical Home Program staff also served on the Steering Committee of the Interagency Outreach Training Initiative (IOTI). The IOTI provided state-funded grants for training to increase the capacity of organizations to serve people with disabilities and their families. The Medical Home Program staff also collaborated with the CSHCN Transition Specialist to improve transition services provided by Medical Homes and provide families and young adults with resources to facilitate the transition to adulthood.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN completed year three of the State Implementation Grant to improve autism screening in Medical Homes.				X
2. CSHCN partnered with the Medical Home Portal to provide quarterly articles for the Utah Chapter of the American Academy of Pediatrics' newsletter.				X
3. CSHCN 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. Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) trained medical, nursing, and allied health students.				X

6. The CSHCN Executive Group (CEG) and its consultant group gathered feedback from stakeholders.				X
7.				
8.				
9.				
10.				

b. Current Activities
The video series, "The ABC's of Autism" for parents of newly diagnosed children with autism is being presented throughout the state through a partnership between Utah Family Voices and the Center for Persons with Disabilities at Utah State University. Trained family navigators are accompanying the presentations to answer questions and assist in locating community resources. Additional funding for the training is being provided by the Interagency Outreach Training Initiative (IOTI).

Outreach plans include dissemination of medical home topic-oriented newsletters to pediatricians and family practitioners and posting on the Medical Home Portal, www.medicalhomeportal.org. The Portal team continues to develop new content and add new resources to the website. The Portal team is in negotiations with the Information and Referral (211) organization in Idaho to include their state's lists of community services.

The Medical Home concept is being reinforced through the "Learn the Signs. Act Early." campaign, http://health.utah.gov/utahactearly, by reminding parents to talk to their Medical Home about developmental milestones and screening. The campaign, with funding from the CDC through HRSA, is targeting families with children from birth to age four in the fastest growing areas of Salt Lake County.

c. Plan for the Coming Year
The final year of supplemental funding through the State Implementation Grant for the "Learn the Signs. Act Early" (LTSAE) campaign from the Centers for Disease Control and Prevention will continue with the evaluation in the first two months of FY13. The campaign is a partnership between CSHCN and Utah State University's Center for Persons with Disabilities. The random telephone survey in Salt Lake County will evaluate penetration of the campaign and the understanding of parents regarding what actions to take if they suspect a missed developmental milestone in their young children, ages birth to four. Medical Homes will be contacted to promote the campaign and developmental screening. Families will be reminded to contact their medical home for an appointment if they have concerns about their child's development or potentially missed milestones.

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

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

CSHCN will be represented on committees and boards to improve the coordination of services and the provision of family-centered care. Staff will serve on the Coordinating Council for People with Disabilities, the Utah Parent Center Board, the Interagency Outreach Training Initiative Committee, and other interagency committees. Collaborative efforts to support improved transition services in Medical Homes and to provide resources for young adults as they transition to adulthood will continue between the Medical Home Program and the CSHCN Transition

Specialist.

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

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

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	59	59	59.5	59.5	59.5
Annual Indicator	59.5	59.5	59.5	59.5	55.9
Numerator					
Denominator					
Data Source		See footnote for source	See footnote for source	See footnote for source	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	55.9	55.9	55.9	55.9	60

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Data are pre-populated from the National Survey of CSHCN. The same questions were used to generate the NPM04 indicator in 2001 and 2005-2006 survey.

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 59.5% and the Annual Indicator was 55.9% (data from 2009/10 National CSHCN survey).

The financing of health care services for children and youth with special health care needs continued to be a vital function during FY11. Statewide outreach efforts were conducted to identify children and families who may be eligible for public funding of health services through Utah Medicaid or CHIP. Educating families on available programs, eligibility requirements and application processes were included in these outreach efforts during itinerant clinics and through the Medical Home web-portal and Bureau website. During the first half of FY 11, an on-site Medicaid eligibility worker efficiently processed Medicaid and CHIP applications received in person during clinics and from staff referring children throughout the state. Open enrollment for CHIP continued throughout this year. A database, updated and maintained by CSHCN, was used to identify SSI eligible children who were not yet enrolled in Medicaid. Once families were identified, a letter was sent in English and Spanish to inform identified families of their potential Medicaid and CSHCN program eligibility.

Case managers and clinical staff assisted families in working with their private insurances, Medicaid and Medicaid contracted HMO providers to access needed health related services. CSHCN worked collaboratively with Utah's Family-to-Family Health Information Center to respond to the needs of families through direct family-to-family support and information on public and private health insurance. Primary Children's Medical Center continued its agreement to write-off service charges for children who qualify for CSHCN (up to 133% of poverty).

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. The Division's pediatric 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.

Case managers performed the day-to-day administrative activities for Medicaid's Technology Dependent Waiver program. The waiver program provides access to Medicaid based on the child's income and assets, not the parents as in traditional Medicaid. Eligibility determination, service authorization and care coordination activities were performed statewide. The waiver program assists families in coordinating medical benefits between their private health insurance plans and Medicaid and referring families to the Medicaid Buy-out Unit for evaluation of cost savings to Medicaid by paying the child's private insurance premium.

Table 4a, National Performance Measures Summary Sheet

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

7.				
8.				
9.				
10.				

b. Current Activities
Outreach activities are being conducted statewide to identify children who may qualify for public funding of health care. Strategies being implemented to reach potentially eligible children and families include evaluating eligibility requirements during itinerant clinics, on-line information and application systems and identifying SSI eligible children who are not yet enrolled in Medicaid and informing families of their child's potential eligibility.

Case managers and clinical staff assist families to navigate the health care payer system including working with private health insurance plans and Medicaid to access needed services. Primary Children's Medical Center is writing-off their services for eligible children (up to 133% of poverty) who are referred there by CSHCN clinics.

CSHCN refers families to Utah's Family-to-Family Health Information Center to respond to the needs of families with information on public and private health insurance including the changes that have occurred as a result of the Affordable Care Act.

Case managers provide the administration for Medicaid's Technology Dependent Waiver. The waiver program provides access to Medicaid for the technology dependent child based on his/her income. CSHCN staff assists Medicaid in reviewing documentation and providing recommendations on service coverage for their EPSDT Expanded Services and Prior Auth Committee.

c. Plan for the Coming Year
Financing health services will continue to be a priority in meeting the needs of children and families with special health care needs, especially in light of significant budget cuts over the past several years. Outreach efforts to identify children, especially minority populations, who may be eligible for public funding of health care will be a component of each CSHCN program. Educating families by providing culturally relevant and linguistically appropriate information on available programs, eligibility requirements and application processes will occur during statewide clinics and through the Med Home web-portal, Bureau web-site and Utah's Family-to-Family Health Information and Education Center. 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 help families work with private health insurances, Medicaid and Medicaid HMOs to access needed health related services. Staff will conduct 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. Case managers will provide the day-to-day administration for Medicaid's Technology Dependent Waiver program which provides access to Medicaid for 120 technology dependent children based on the child's income and assets. CSHCN will continue membership on the EPSDT Expanded Services and Prior Authorization Committee for Medicaid reviewing documentation and providing recommendations on service coverage.

CSHCN will work with partners to create a legislatively mandated pilot program for autism spectrum services. Aspects of the autism programs will include: working with Medicaid as they develop a Medicaid waiver to provide proven and effective services for children between the ages of two and six; working with the Public Employees Health Program to assist them in establishing a pilot program for autism treatment services for children of government employees and,

management of the Autism Treatment Account which will focus on identification of providers, payment of services. The three entities will develop common evaluation plans to validate the effectiveness of evidence-based treatments.

Program staff will refer families to Utah's Family-to-Family Health Information Center to respond to the needs of families through direct family-to-family support and information on public and private health insurance including implementation of the Affordable Care Act. CSHCN will monitor other forthcoming initiatives that affect health care coverage and provide input and education to families as applicable.

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

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82	82	86.2	86.2	86.2
Annual Indicator	86.2	86.2	86.2	86.2	62.2
Numerator					
Denominator					
Data Source		See footnote for source	See footnote for source	See footnote for source	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	62.2	62.2	62.2	62.2	62.2

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 86.2% and the Annual Indicator was 62.2%*.

*(From the 2009/2010 CSHCN Survey, note- wording and parameters for this performance measure were changed on the 09-10 survey and are not comparable to the previous 05-06 data. Newly worded Performance Measure: The percent of children with special health care needs who can easily access community based services.)

The Bureau of Children with Special Health Care Needs (CSHCN) faced major funding cuts due to State budget shortfalls and flat Federal funding. Even so, CSHCN staff worked closely with the Utah Medical Home Program, University of Utah health care providers and Utah Family Voices on efforts to enhance access, collaboration, and efficient and effective clinical services and care coordination among community agencies, health care providers and families. CSHCN and U of U Pediatrics continued a more comprehensive collaboration during this reporting period , to increase the availability of their specialty consultations. Continued use of our online/hard-copy referral form and process, to gain input and information from primary and community providers on service access and communications efficiencies, was maintained on a statewide basis.

CSHCN continued to provide access to community-based specialty care through statewide satellite case management and traveling clinics. Specialists traveled 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, cranio-facial 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 4500 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 1800 children meeting certain criteria after leaving Utah newborn intensive care units. CSHCN worked with the Department's Multicultural Health Center and Indian Health Service to improve access and collaboration with community providers of health, education, vocational rehabilitation, and health care coverage for populations served by those agencies.

Increased CSHCN collaboration with the Utah Health Information Network (UHIN), a not for profit organization, 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. CSHCN completed the selection of an electronic health records and prepared for implementation of the new system in order to meet future Federal mandates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN collaborated with Utah Medical Home Program and University of Utah health care systems to enhance access and coordination of services.				X
2. CSHCN continued use of referral forms and processes initiated statewide to enhance access to and coordination of services, along with complete updates and maintenance of the Bureau website for ease of use.		X		
3. Utah's Family Voices and the Family-to-Family Health Information and Education Center provided parent-to-parent support and information on community resources and services.		X		
4. CSHCN provided access to community-based specialty care through statewide satellite case management and traveling clinics.	X			
5. CSHCN provided case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC).	X	X		
6. Bureau programs augmented community clinical services, case management and capacity building efforts to enhance a coordinated system of care, including coordination with the Multicultural Health Center and Indian Health Service.				X
7. Neonatal Follow-up Program continued provision of clinical diagnostic, assessment and follow-up for NICU graduates meeting their eligibility criteria.	X			
8. CSHCN collaborated with CHARM, CHIE, UHIN, and other like entities.				X
9. CSHCN completed selection of a new EHR system, CaduRx, and prepared for implementation statewide at all clinics over the next year.				X
10.				

b. Current Activities

Due to flat Federal funding and State budget reductions, Children with Special Health Care Needs has responded by reorganizing staff to meet the needs of the Special Needs community in the State. CSHCN, in collaboration with University of Utah pediatric specialists, continues to provide access to community-based specialty care, transition services and coordination through statewide satellite case management and traveling clinics. CSHCN continues to provide case management 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). Bureau programs will continue to evaluate systems to increase efficiency, and assess for needed changes in case management and clinical services.

The Newborn Follow-up Program (NFP) continues to provide multidisciplinary clinics to NICU graduates. They will complete the first version of a new clinical database. NFP is currently working with the developer of their database and CaduRx staff to set up an initial version of an interface that will allow both systems to "talk" and share info with each other, avoiding the need for double data entry.

c. Plan for the Coming Year

On-going flat State and Federal funding for CSHCN clinics, will serve as the impetus for the Bureau to closely evaluate the clinic service delivery system, to increase efficiency, possibly combining or eliminating clinics as needed. The Bureau will also submit a funding request for the FY13 Legislative Session to try to recoup the funding that was cut several years ago. Ongoing collaboration 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 the Utah Medical Home Program, Family Voices and the clinics will augment community clinical services, case management and capacity building efforts to enhance a coordinated, community system of care. Utah's Family Voices/Family-to-Family Health Information and Education Center will provide parent-to-parent support and information on community resources and services, implementing on-site access with parent advocates. During this next year, the center will continue its focus on collaboration and sustainability by developing new family advocacy and interagency relationships with community-based organizations at the local, state and national level.

CSHCN programs will collaborate with the Multicultural Health Center, Indian Health Service and other community cultural agencies to improve access and partner with community providers of health, education, vocational rehabilitation, and health care coverage.

The Newborn Follow-up Program (NFP) will continue to partner with the University of Utah and other agencies to provide multidisciplinary clinics to NICU graduates. The Program will investigate ways to enroll more eligible children into the program and provide data on outcomes to the NICUs.

Continued collaboration among CSHCN clinical entities, CHARM, UHIN and CHIE will focus on implementing and expanding data sharing via CaduRx, the new electronic health records system, that meet "Meaningful Use" certification, for records management and billing services.

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

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective		36	42.5	42.5	42.5
Annual Indicator	42.5	42.5	42.5	42.5	49.3
Numerator					
Denominator					
Data Source		See footnote for source	See footnote for source	See footnote for source	See footnote
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	49.3	49.3	49.3	49.3	49.3

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Data are pre-populated from the National Survey of CSHCN. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 42.5% and the Annual Indicator was 49.3%.

In FY2011, the Bureau of Children with Special Health Care Needs (CSHCN) promoted and supported transition services for young adults, their families and health care providers. CSHCN employed a transition specialist who provided transition planning to young adults with disabilities and their families in rural sites at Blanding, Moab, Price, Richfield and Vernal clinics. These services are especially important, as rural Utah presents significant challenges for families in successful transition into adult services for their young adults. The transition specialist also provided services to young adults with disabilities and their families at CSHCN Bureau clinics based in Salt Lake City. In both rural sites and Salt Lake City the transition specialist coordinated with local health department staff, health and mental health providers, and other state and local agencies.

In addition to the onsite consultations, phone consultations and email correspondence were

available to young adults, their families and their health care providers. The transition specialist was also available to community agencies for needs assessment and transition planning.

A Memorandum of Agreement with Work Ability Utah (WAU) facilitated transition training opportunities in rural communities for health care providers. Trainings were held twice in St. George in private medical practices. Pre and post surveys were done to understand and address the specific needs of each group. While in St. George, office visits were made to other local providers and approximately 12-15 additional providers were reached through this effort. Bureau staff training for CSHCN was conducted in Salt Lake City to increase the staff's understanding of the nature of the trainings for health care providers. Additional trainings were scheduled for rural communities throughout the state.

The transition specialist maintained current resource information critical for young adults, their families and their health care providers for transition from pediatric services and programs to adult services and programs. This information was available through onsite visits, phone consultation, email and written correspondence as well as the Medical Home Portal. The transition specialist also attended information fairs hosted by schools and community agencies to disseminate transition information to young adults, parents, educators, and other community agencies.

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

Each of our transition brochures have been translated to Spanish and are posted on the transition page of the CSHCN website and available in hard copy to young adults, parents and health care providers.

A concerted effort to enhance outreach to health care providers was initiated implemented by the transition specialist networking by participation on committees in different programs of the Department of Health including The Employment Partnership, Adolescent Health Network, and Utah Oral Health Coalition. For The Employment Partnership the transition specialist developed a follow up Work Sheet newsletter that summarized the meeting for all members of the Partnership and was also made available to the public at http://blt.cpd.usu.edu/News/html. The transition specialist contributed to writing and editing a column for the quarterly publication of the Utah Chapter of the American Academy of Pediatrics.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN's Transition Specialist presented training sessions in St. George and Salt Lake City for health care providers and CSHCN staff members.				X
2. Telephone consultation, written correspondence and email communication were available to providers and community agencies for needs assessment and transition planning throughout the state.		X		

3. CSHCN maintained current resource information for adult services and programs.		X		
4. CSHCN Transiton Specialist attended school and community information fairs to provide transition information to young adults, parents, educators and other community agencies.				X
5. CSHCN expanded networks through committee participation both in and outside of the Department of Health including developing work sheets and newsletter quarterly columns.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Children with Special Health Care Needs (CSHCN) employs a transition specialist who provides onsite services to young adults with disabilities and their families both in rural Utah locations and locally based CSHCN programs.

The transition specialist and Medical Home Program (MHP) Representative provides transition training to Special Educators at the Utah State Office of Education Transition Round Table.
The transition specialist continued developing a Work Sheet that provides a synopsis of meetings for The Employment Partnership and editing and writing a column for a quarterly publication of the Utah Chapter of the American Academy of Pediatrics.

The transition specialist and MHP representative are attending transition fairs to disseminate resources and information in the community setting.

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

c. Plan for the Coming Year
In FY2013, the transition specialist will continue to travel to rural sites to provide transition planning for young adults and their families. Rural sites include Price, Blanding, Moab, Montezuma Creek, Ogden, Richfield and Vernal. The young adults and families in Salt Lake City based CSHCN Bureau clinics will also continue to be served. The specialist will collaborate with local health departments, other state agencies, health and mental health providers, and community programs. Onsite consultations, telephone consultations, written and email correspondence, and other support s will continue.

The transition specialist will continue to speak at conferences and attend information fairs hosted by community agencies and school districts. Additional educational opportunities for young adults, their families, community agencies and health care providers will be offered by the transition specialist and the Medical Home Program (MHP) representative both locally and in rural areasly (when possible through taping or telehealth for rural locations).

The end of the Medicaid Infrastructure Grant (MIG) 12/31/11 brings to a close the formal opportunity to provide educational transition training opportunities to medical providers in rural locations. Pre and post surveys were conducted to better understand and address transition issues and specific concerns identified by each community. The findings from the surveys will help us as we bring transition information to the young adults, their families and providers within the communities. By bringing this information to health care providers, through them, we have the

ability to reach more young adults and families in communities.

The transition team will update information and resources for the transition section of the CSHCN website and partner websites encompassing the spectrum of transition to adult services and programs.

The transition team will continue to develop new relationships and work collaboratively with federal, state and local agencies and organizations to provide transition services and information to young adults, families, providers and other agencies. This effort will include continuing to write and edit articles and columns as requested.

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

The CSHCN Bureau Director will work with the Office of Health Disparities Reduction to develop a comprehensive plan for recruitment and retention of DOH employees from varied cultural, ethnic and linguistic backgrounds, including adults with disabilities.

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

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	85	82.5	80	75.8
Annual Indicator	78.5	78.1	75.8	70.6	70.6
Numerator					
Denominator					
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70.6	70.6	70.7	70.7	70.8

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.

Notes - 2010
Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 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.

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

a. Last Year's Accomplishments
The performance measure was not achieved. The performance objective was 75.8% and annual indicator was 70.6%.

In response to a Measles outbreaks and requests for information, the Immunization Program (UIP)created the Utah School and Child Care Employee Immunization Recommendations, a list of recommended vaccines for teachers and staff following recommendations of the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices. The list was also reviewed and recommended by the Utah Scientific Vaccine Advisory Committee. The recommendation was sent out to schools statewide with recommendations for employees in schools to be up to date on their vaccinations. Many schools are working on employee immunization requirements or recommendations as the result of this program effort.

UIP worked closely with VFC providers to help improve pre-teen and teen immunization coverage levels in Utah. The program promoted some quality improvement strategies such as participation in the Utah Statewide Immunization Information System (USIIS); promoted HPV, Meningococcal Conjugate, and Tdap vaccines; encouraged providers to think about school requirements for children k-12, not just for kindergarten entry. The program staff worked with providers in reminding them of the new 7th grade immunization entry requirement, Tdap. Adolescent Immunization was promoted during the statewide coalition workshop/conferences. All adolescent promotional materials were updated to reflect the new changes to the adolescent schedule.

The program promoted the immunization requirements for Early Childhood Programs, kindergarten entry and also 7th grade entry by working closely with Head Start Programs to ensure their students are up to date with the Head Start required vaccines. The program also promoted the recommended vaccines for students, collaborated closely with the Utah State Office of Education and the state Bureau of Child Development, Child Care Licensing program to ensure all schools and child care facilities are in compliance with the state immunization law for children in these facilities.

The program worked closely with organizations representing minority populations and promoted our culturally and linguistically designed materials to these organizations and promoted the Vaccine For Children (VFC) Program.

UIP developed a poster and flyer specifically for Native American Tribes in Utah to promote Tdap vaccine as part of our "cocooning" project to promote vaccination of family members surrounding the new born to protect against pertussis disease.

Program staff worked with Native American Title VII Coordinators and the Utah State Office of Education's American Indian Education Specialist and promoted the program's educational materials that were created specifically with the advice of the Utah Indian Health Advisory Board for Utah American Indian tribes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. UIP has 380 provider groups enrolled in VFC.				X
2. Almost 100% (96.6%) of VFC providers received a VFC site visit during 2011.				X
3. Almost three-quarters (72%) of VFC providers received an AFIX quality improvement visit in 2011.				X
4. An additional 519 provider groups enrolled in USIIS, including pediatrics, family practice, internal medicine providers, hospitals, and pharmacies.				X
5. More than 800 (81)6 schools, daycare centers, and Head Start programs enrolled in USIIS.				X
6. 34 VFC Providers received a face to face AFIX Feedback session.				X
7. Using USIIS, 80% of assessments were completed.				X
8.				
9.				
10.				

b. Current Activities

The AFIX Program feedback sessions have been successfully implemented by the provider relations staff; a display and brochures were created to promote the program.

The Utah Immunization Program (UIP) and USIIS are continuing to develop a method to use USIIS to assess immunization coverage (general population, race/ethnicity and Medicaid) levels statewide and regionally. USIIS records have resulted in an increased number of children birth to five years that have at least two vaccinations.

USIIS enrollment has increased by 6%. USIIS now automatically accepts race/ethnicity data from vital records when USIIS is updated weekly with birth certificate data.

Provider representatives have completed approximately 50 assessments (50% of goal) at VFC provider offices.

The electronic Immunization Reminder Service continues as an ongoing service to remind parents of timely immunizations.

UIP works closely with VFC providers to help improve pre-teen and teen immunization coverage levels in Utah. The program promoted some quality improvement strategies such as participation in the Utah Statewide Immunization Information System (USIIS), promoted HPV, Meningococcal Conjugate, and Tdap vaccines; encourages providers to think about school requirements for children k-12, not just for kindergarten entry.

UIP worked with providers in reminding them of the new 7th grade immunization entry requirement, Tdap. Adolescent Immunization is promoted during the statewide coalition workshop/conferences.

c. Plan for the Coming Year

Provider relations staff will continue to assist VFC providers with understanding immunization best practices and conduct 200 CASA/AFIX assessments and determine coverage levels at 120 clinics.

The Utah Immunization Program (UIP) Provider Relations sStaff will continue to implement the

quality improvement program, AFIX. They will work towards the goal of 20% of providers receiving face to face feedback on their 4:3:1:3:3:1 immunization rates every year. AFIX will be promoted to providers through VFC site visits, brochures, and participating in local conferences with the new AFIX display.

The Utah Pediatric Partnership to Improve Quality of care (UPIQ) project will continue recruiting providers to participate in quality improvement activities. UIP will collaborate on the Adolescent 101 project with Select Health to gather data on 4:3:1:3:3:1 as well as adolescent data that are comparable and reportable by UIP to the CDC.

Data will be queried from the USIIS data base to determine coverage levels based on race/ethnicity, Medicaid status and local health departments. The annual coverage report will be disseminated to UIP partners/ stakeholders and posted online.

The UIP will continue collaboration with the regional immunization coalitions to support early childhood immunization efforts. The UIP will continue to provide support to local health departments, community health centers and Indian Health centers for NIIW, National Immunization Awareness Month.

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

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15.7	16.5	18.5	18.5	16.5
Annual Indicator	18.6	18.5	16.5	14.3	14.3
Numerator	1133	1122	995	876	876
Denominator	61060	60796	60127	61154	61154
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	14.3	14.2	14.2	14.1	14.1

Notes - 2011
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: IBIS Population estimates for 2010

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: IBIS Population estimates for 2010

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

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 16.5 and the Annual Indicator was 14.3.

The Utah Department of Health (UDOH), Maternal and Child Health Bureau, Maternal and Infant Health Program (MIHP) applied for and received 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. MIHP received $319,037 for Abstinence Education programming and $525,624 for PREP programming. Funds for PREP were used to implement programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS, and other adulthood preparation subjects.

MIHP sub-contracted most of the PREP funds out to local organizations through a competitive grant process. Those organizations who 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. Between 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, current teen moms, and youth residing in areas with birth rates higher than Utah's state rate. The first project year is estimated to run from 8/1/11 to 9/30/12. The PREP funding will be renewable each year for up to 3 additional years depending on availability of federal funds and project performance.

MIHP also sub-contracted the Abstinence Education funds out to local organizations through a competitive grant process. Those organizations who received funding were: National Tongan American Society, 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. Between the six 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 birth rates higher than Utah's state rate. The 2011 project year is ran from 4/4/11 - 9/30/11. The Abstinence Education funding will be renewable each year for up to 3 additional years depending on availability of federal funds and project performance.

The Adolescent Health Coordinator continued to oversee the Utah Adolescent Health Network, a group of diverse stakeholders of adolescent health from government, academic, non-profit, and community organizations. The Network took a different direction this year. Instead of focusing on Teen Pregnancy and Sexually Transmitted Infection Prevention, the Network decided to serve as

a venue for overall adolescent health professional development. Quarterly network meetings were held and included presentations by experts in general adolescent health topics, presentation discussions, and member networking and project sharing.

The Adolescent Health Coordinator monitored, analyzed, and released Utah teen pregnancy, birth and STD data. This data was distributed among the Adolescent Health Network, various media and legislative entities, and maintained on the State of Utah's, Department of Health, Indicator-Based Information System for Public Health (IBIS-PH).

MIHP worked with the Utah State Office of Education and the Utah Parent Teacher Association (PTA) to continue to distribute the information booklet entitled: Life Planning for Teens, among Utah Adolescents. This booklet discusses a reproductive life plan and why it is important to develop one. No new tools were developed educating students, teachers, and policy makers on the importance of scientifically based sex education due to time restraints. The Adolescent Health Coordinator represented the UDOH on the Utah PTA, Health Commission, and Sex Education Committee. MIHP was not able provide a training of presenters for the U.S. Health & Human Services "Parents Speak Up" program, since the program has been discontinued at the federal level.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MIHP applied for and received PREP and AB ED funding from the U.S. Department of Health and Human Services.				X
2. MIHP subcontracted PREP and AB ED funding to 12 local Utah agencies.				X
3. MIHP monitored, analyzed, and released Utah teen pregnancy, birth and STD data.				X
4. MIHP provided oversight of the Utah Adolescent Health Network.				X
5. MIHP distributed the “Plan Your Health: Live Your Life” teen life plan booklet.				X
6. The Adolescent Health Coordinator served on the Utah PTA, Health Commission, Sex Education Committee.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal and Child Health Bureau continues 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 provides project oversight and technical assistance to 12 funded community-based projects. A part-time Research Analyst, within the Maternal and Infant Health Program (MIHP) was hired in October 2011 to assist with the PREP program evaluation needs.

The Adolescent Health Coordinator continues to oversee the Utah Adolescent Health Network. Two Network meetings have been held thus far this year. Both meetings included a presentation or training by an expert in a general adolescent health topic, time for discussing the topic, and time allotted for member networking and project sharing. The two presentations provided were: 1) Disordered Eating Among Adolescents and, 2) Dating Violence and Domestic Violence among Utah Teens.

MIHP continues to work on reaching the UDOH Teen Pregnancy Goal. The goal was set for year 2015 to reach the rate of 31.7 per 1,000 females (ages 15-19). The current rate based on 2010 birth data is 27.6 per 1000. The Adolescent Health Coordinator continues to monitor and share 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 carry out oversight and technical assistance to funded community-based projects. The abstinence education projects target Utah youth ages 10-16 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, and youth residing in areas with birth rates higher than Utah's state rate. All funded abstinence programs must ensure that abstinence from sexual activity is the expected outcome as outlined in the federal requirements. PREP projects will focus on programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. PREP will target Utah youth ages 14-19 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, current teen moms, and youth residing in areas with birth rates higher than Utah's state rate.

The Maternal and Infant Health Program will update the Adolescent Health section of the program website. Additional components will be added specifically for the Abstinence Education and PREP sub-awardees.

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

The Maternal and Infant Health Program will continue to work on reaching the Utah Teen Pregnancy Goal: By the year 2015, the Utah pregnancy rate among girls between the ages of 15-19 will be 31.7 per 1,000 females. The Adolescent Health Coordinator will continue to monitor and share state birth and pregnancy data pertaining to this goal. The 2010 Utah Adolescent Reproductive Health Report will be updated to include the most recent data. This updated report will be released in the Spring or Summer of 2013.

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

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	45.1	45.1	45.1	45.1	41.9
Annual Indicator	45.1	45.1	45.1	41.9	41.9

Numerator	155	155	155	392	392
Denominator	344	344	344	935	935
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	41.9	41.9	41.9	41.9	50

Notes - 2011
Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
Unweighted=40.2%, weighted=41.9%

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

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

Notes - 2009
Data reported are the most recent data available.
Oral Health Survey 2005, Oral Health Program, UDOH

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 this year. During FY11, Oral Health Program (OHP) promoted sealants through screenings 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 screenings 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. In spite of decreased funding "Sealant for Smiles" program provided education and direct services to schools in Davis, Tooele, Summit and Salt Lake Counties. Nearly 6,000 children were screened and nearly 16,000 sealants placed on low-income uninsured and Medicaid/CHIP insured children.

The OHP also supported and provided technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene Programs at Weber State University, Utah Valley State College, Utah College of Dental Hygiene and Dixie College. Sealant Projects in the Weber-Morgan Health Department, Utah

County Health Department and Southwest Utah Health Department included local health department staff, 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. Oral Health Program provided technical assistance for local health department to form local Oral Health Task Forces and emphasize placement of dental sealants.				X
2. Oral Health Program used data from the statewide survey of 6-9 year old children to develop strategies for direction of efforts to reduce the percentage of children with untreated dental decay and increase the number of children with dental sealants.			X	X
3. Oral Health Program supported and provided technical assistance to Sealants for Smiles for free sealants to low-income and underinsured first through sixth grade children in Salt Lake, Davis, and Tooele Counties.	X			X
4. Oral Health Program supported the prevention and education activities of the Utah Oral Health Coalition in the promotion of dental sealants.				X
5. Oral Health Program worked with Sealant for Smiles in modifying the program developed by the American Association of Community Dental Programs called “Seal America” and used as a guide to promote dental sealant programs at the community level.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY12, DFHP Oral Health Program (OHP) is promoting dental screening, sealants, fluoride varnish, and referral activities. A statewide survey of 6-9 year old children was performed during FY10 and a report was published in FY12. Results of the survey indicate 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 department level, and promoting education/awareness programs among dental professionals, pediatricians and the public.

The OHP is collaborating, supporting and providing technical assistance to "Sealant for Smiles" school-based preventive dental program. More than 7,000 low-income uninsured and Medicaid/CHIP insured children will be screened and have sealants placed.

The OHP is supporting and providing technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children statewide and making presentations and

providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers.
The Program is engaged in multiple outreach activities to Head Start Programs, health care provider trainings on fluoride varnish and early dental visits in promoting the importance of oral health and overall health for children and adults.

c. Plan for the Coming Year
During FY13, Oral Health Program (OHP) will promote sealants through screening and referral activities. A statewide survey of 6-9 year old children was performed in 2010 and results will help direct OHP activities in the future. The OHP will support direct delivery of sealants at the local health department level and promote education/awareness programs among dental professionals, pediatric providers and the public. The OHP will concentrate on training local health departments on screening and referring procedures for children attending high risk elementary schools in their communities.

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

The OHP will also support and provide technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene Programs at Weber State University, Utah Valley State College, Utah College of Dental Hygiene and Dixie College.

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.

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.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.1	4.5	3.4	4.3	2.2
Annual Indicator	3.2	4.6	2.2	2.0	2.0
Numerator	23	33	16	15	15
Denominator	708557	723026	736615	749214	749214
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2	2	1.9	1.9	1.8

Notes - 2011
Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2010
Denominator: IBIS Population estimates for 2010

Notes - 2010
Data reported are the most recent data available.

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

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

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 2.2 and the Annual Indicator was 2.0.

The Violence and Injury Prevention Program (VIPP) collaborated with many partners to implement interventions for reducing motor vehicle crash (MVC) deaths among children in Utah. Funding and assistance to each local health department (LHD) was provided to conduct local injury prevention programs on bicycle, pedestrian, and motor vehicle safety. Over 149,473 people were reached through 2,131 events promoting motor vehicle safety. In addition, there were 65 media events promoting motor vehicle safety.

VIPP worked with LHDs to promote use of child safety seats through: Boost Til'8 Campaign which promoted car seat use to over 19,575 individuals with 662 activities at day care centers, schools, doctor offices, and businesses; distribution of more than 1,553 child safety seats; inspection of almost 1,878 child safety seats; conducting 45 car seat checkpoints; and educating the public through 30 media activities.

The pedestrian safety interventions included: promoting pedestrian safety to 81,799 individuals through 473 events; coordinating with local law enforcement and the public through media activities. VIPP also funded LHDs to distribute 1,078 bicycle helmets in their communities.

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

The Utah Teen Driving Task Force continued to coordinate the efforts of several state, local, and private agencies working together on the issue of reducing teen motor vehicle crashes. Since teens are the role models for their younger siblings, impacting the teens' behavior will impact the siblings'. VIPP also coordinated a statewide campaign with all LHDs in Utah to reduce deaths to teens from motor vehicle crashes. This campaign targeted 15-19 year olds since they are

involved in 21% of all MVC, but only represent 8% of licensed drivers in Utah. At least 465 events were conducted reaching over 48,099 teens with 18 media events promoting teen motor vehicle safety. In addition, 116 additional events were held, reaching 16,026 parents or family members of teen drivers at football games, back-to-school nights, and other activities that draw the whole family. VIPP and the Task Force developed the fourth annual teen memorial book "All They Left Were Memories" on teen motor vehicle-related deaths in 2010. Other LHD interventions included: education, mobilization of local partners to identify and solve traffic safety problems, strengthening law enforcement partnerships, and permanent seatbelt reminders installed in targeted communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Violence and Injury Prevention Program and local health departments reached over 149,473 people through 2,131 events promoting motor vehicle safety. In addition, there were 65 media events promoting motor vehicle safety.			X	
2. The Violence and Injury Prevention Program and local health departments promoted child safety seat use to over 19,575 individuals through conducting awareness activities at day care centers, schools, churches, doctors' offices, and businesses.			X	
3. The Violence and Injury Prevention Program and local health departments distributed over 1,078 bicycle helmets and 1,553 car seats and inspected 1,878 child safety seats.			X	
4. VIPP coordinated with LHDs, local law enforcement, and local pedestrian safety enforcement to reach 81,799 people with pedestrian safety messages at 473 events.			X	
5. The Violence and Injury Prevention Program remained the lead agency for Safe Kids Utah.				X
6. The funding and training provided to local health departments for a statewide campaign to promote teen motor vehicle safety resulted in 581 events and 25 media events reaching over 48,099 teens and 16,026 parents and family members.			X	
7.				
8.				
9.				
10.				

b. Current Activities

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

Funding and technical assistance are provided to each local health department (LHD) to address traffic safety issues.

VIPP is coordinating a statewide campaign with LHDs and other partners to reduce teen MVC deaths. VIPP is contacting families of teens who died in 2011 to determine their willingness to participate in the fifth Teen Memorial Book (The 2007 memorial book is recognized on the AMCHP website as a best practice and received several national awards). A bill to ban cell phone use for teen drivers was introduced and VIPP provided a fact sheet with data from a VIPP survey showing 85% of Utahns supported a law. The bill passed the House, but was not read in the Senate. VIPP conducted a survey to determine attitudes and barriers about booster seats, cell

phone use while driving, etc.

Car seat efforts include partnering with LHDs to promote proper use, conducting inspections, distributing low cost seats, working with media; and, providing UDOH and partners website information.

VIPP, the lead agency for Safe Kids Utah (SKU), oversees coalitions/chapters statewide that coordinate interventions in their communities. SKU participates in car seat checkpoints and PSAs to educate the public.

c. Plan for the Coming Year

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

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

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

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

VIPP will continue pedestrian safety efforts by funding LHDs to promote pedestrian safety events (Green Ribbon Month, Safe Routes to School and Walk to School), partnering with community organizations, distributing educational materials, working with the media, and coordinating with enforcement agencies.

VIPP will continue to coordinate a campaign with all LHDs aimed at reducing deaths to teens, 15-19 years of age, from MVC. Multifaceted interventions will include: education; mobilizing partnerships to solve traffic safety problems; partnering with law enforcement; partnering with drivers education classes to teach a parent class about GDL laws, and installing seatbelt reminder signs in communities. 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 2011 Teen Memorial Book will be produced and distributed statewide through Drivers Education classes.

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

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	50	56	60.5	69.6	58.5
Annual Indicator	55.6	60.4	69.5	61.5	61.5
Numerator					
Denominator					
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	61.5	61.5	62	62	62

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.

Notes - 2010
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.

Notes - 2009
Data reported are the most recent data available.
The data reported are from the National Immunization Survey, 2006. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 58.5% and the Annual Indicator was 61.5%. The U.S. national average for Breastfeeding at 6 months was 44.3%. Utah was among only five that met the HP2020 objective (MICH 21.2).

CDC 2008 data and NIS indicated that Utah's breastfeeding rates were above the national average in all five measures. Ever Breastfed for the nation was 74.6; Utah was 84.5%. The HP2020 Objective is 81.9% which Utah has exceeded. Utah was among 12 states that met this objective. Breastfeeding at 6 months for the nation was 44.3%; Utah was 61.5% and was one of only 5 states meeting the HP2020 Objective of 60.5%. Breastfeeding at 12 months for the nation was 23.8%; Utah was 29.3%. Utah is above the national average but did not meet the HP2020 Objective of 34.1%. Exclusively breastfeeding at 3 months for the nation was 35%; Utah was 44.1%. The HP2020 Objective was 44.3%. Utah is ahead of the nation and was only 0.2% below meeting the HP2020 Objective. Exclusively breastfeeding at 6 months for the nation was 14.8%; Utah was 17%. The HP2020 Objective was 23.7%. Utah is ahead of the nation but did not reach the HP2020 objective.

The CDC Breastfeeding Report Card shows Utah had increased to 6.2 state health department

FTEs dedicated to breastfeeding; this was more than most states. The percent of live births occurring at Baby Friendly Facilities for the nation was 4.53; Utah reported 6.44 and was above the national average. Utah has 1.69 International Board Certified Lactation Consultants (IBCLC) per 1,000 live births; the national average is 2.67. There is no state legislation mandating employer lactation support and no state child care center regulation that supports lactation.

The Utah Breastfeeding Coalition (UBC) held annual Breastfeeding Cafe's for World Breastfeeding Week. Over 20 businesses that were followed using the Business Case for Breastfeeeding. Plans to obtain a 501(c)3 status are now pending due to lack of funding and expertise. The UBC held a promotional event "Latch on America". A certified nurse midwife midwife volunteer provided breastfeeding prenatal classes, and group support meetings. The UBC has an expanded membership and local coalition involvement. Outreach was extended to the public with improved website and materials. There was representation from the UBC at state conferences.

The WIC Program continued to implement the new food rule. Statewide training was provided on a national breastfeeding curriculum "Glow and Grow". Self-paced training programs were developed. All agencies provided prenatal and postpartum breastfeeding classes to all women participants. The number of IBCLCs increased from 9 to 19 statewide. The Peer Counselor Program expanded services with four supervisors and an increase in service hours of 52 counselors. Two statewide training events were provided to train newly hired Peer Counselors.

Utah worked on the development of a new computer system, VISION, incorporating USDA's system requirements.

The Physical Activity Nutrition and Obesity program, in another division of the Department, educated hospital staff and promoted worksite lactation support. They developed and piloted a Healthy Child Care Initiative for child care providers with breastfeeding best practices.

The WeeCare pregnancy program provided prenatal and postpartum education to over 1,000 women. They maintained a breastfeeding blog with 4,490 page visits. The Pregnancy Risk Assessment Monitoring System survey included breastfeeding questions on its survey. These data are forthcoming. The Maternal and Infant Health Program has breastfeeding information on its website.

The Pregnancy Risk Line (PRL) provided information and support on the potential impact of medications to 3,766 breastfeeding women. The staff made 34 presentations. Staff attended several health fairs and disseminated information on breastfeeding issues.

The Baby Your Baby Program provides resource and referrals for pregnant and postpartum women for breastfeeding and lactation support. They provide a newsletter and a Health Keepsake booklet that contains breastfeeding content in English, Spanish and one specifically for Native Americans.

The Neonatal Follow-up Program's Registered Dietitian encouraged use of breast milk through twelve months adjusted age for the premature babies seen in their clinics. Due to lack of funding a resource guide was not developed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The WeeCare program provided breastfeeding education, telephonic support, and a blog for over 1,000 clients.	X	X		
2. The Pregnancy Risk Line (PRL) provided information to 3,766 callers on questions about the safety of taking medications and	X			

breastfeeding.				
3. The PRL provided 34 presentations to health care providers regarding the importance of continuing breastfeeding while taking medications.				X
4. The Utah Breastfeeding Coalition held Breastfeeding Café s across the state.			X	
5. The Utah WIC Program and the Utah Breastfeeding Coalition organized the hosting of a promotional event “Latch on America” as one of 33 participating cities in the U.S. in celebration of World Breastfeeding Week.			X	
6. The Utah WIC Program trained all staff on a national breastfeeding curriculum.				X
7. The Utah Breastfeeding Coalition promoted Baby Friendly Businesses and the establishment of worksite lactation programs.				X
8. The WIC program piloted a new state-wide computer system with extensive breastfeeding components.				X
9. The WIC Breastfeeding Peer Counselor Program expanded throughout the state.		X		
10.				

b. Current Activities
The Utah WIC Program continues to offer statewide training and conferences, is planning for World Breastfeeding Week, and leading the formation of a Utah Donor Human Milk Bank.

The Pregnancy Risk Line (PRL) is presenting results of a CDC collaborative study on breast fed infants at the 25th Annual the Organization of Teratology Information Specialists OTIS meeting and will be published in "Reproductive Toxicology" in 2012. Staff are piloting a follow-up QA survey with breastfeeding callers. Results of a study on teratology education relating to breastfeeding women are being compiled.

The Baby Your Baby Program continues to operate a resources and referrals hotline for pregnant and postpartum women. The Neonatal Follow-up Program follows newborn intensive care graduates after their discharge from a NICU and encourages use of breast milk.

The Physical Activity Nutrition and Obesity Program contracted with local health departments and 48 child care facilities to implement breastfeeding best practices. They provided information and resources to a State Representative who developed and introduced the Joint Resolution on Breastfeeding (HJR4) encouraging employers to make accommodations to meet the breastfeeding needs of their employees, which was passed by the 2012 Utah legislature. The Utah PANO health care work group, in partnership with the Utah Medical Association, published an article in the Utah Medical Association newsletter on "Breastfeeding for Pediatricians".

c. Plan for the Coming Year
Breastfeeding will continue to be promoted and supported in Utah through a variety of programs and activities.

The Utah Breastfeeding Coalition (UBC) will hold Breastfeeding Cafés. Worksite breastfeeding support will continue to be promoted with the dissemination of the Business Case for Breastfeeding. UBC will expand their use of university interns to help accomplish projects and move the Utah Donor Human Milk Bank project forward.

The WIC Program will provide breastfeeding support, education and services and will offer staff training opportunities including comprehensive lactation courses to increase the number of

IBCLCs. The Breastfeeding Peer Counselor Program will provide training statewide. WIC continues to implement the new food rules that limit formula issuance, provide a variety of manual and electric breast pumps, prenatal and postpartum breastfeeding classes, and offer breastfeeding assessment and counseling. The state WIC office will collaborate closely with many organizations in the community. WIC will work on enhancements for the new computer system, regarding infrastructure and interface components, and data reporting features related to breastfeeding.

The Physical Activity Nutrition and Obesity Program will provide education to hospitals and physicians to increase the awareness of the need for Baby Friendly Hospitals in Utah. The program staff will promote worksite lactation support. They will contract with 5 local health departments to work with child care providers to implement best practices for nutrition and physical activity, including breastfeeding.

The Pregnancy Risk Line will concentrate outreach efforts to low-income risk groups. Exhibits for health fairs will be created and attended during the Native American Summit, Indian Walk-In Center, Pacific Island Health Summit, Migrant Seasonal Farmworker Coalition and the Mexican Consulate.

The Neonatal Follow-up Program will continue to support the use of breast milk by counseling and encouraging mothers of newborn intensive care unit graduates in breastfeeding and/or expressing breast milk. Referral resources will be available regarding lactation educators and consultants as well as breast pump rental and purchase information.

A short article for the Utah Health Status Update will be written on reasons that Utah women have given for discontinuing breastfeeding from the 2009-2010 Utah PRAMS survey. New questions on breastfeeding practices at delivering hospitals will be added to the 2012 Utah PRAMS survey to determine the focus of education efforts.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	97.9	97.5	97.9	98.1	98.3
Annual Indicator	97.9	98.1	98.3	98.6	98.6
Numerator	55113	55705	54225	52624	52624
Denominator	56320	56788	55143	53395	53395
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	98.6	98.7	98.7	98.8	98.8

Notes - 2011
Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2010

Notes - 2010
Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2010

Notes - 2009
Data reported are the most recent data available.
Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2009

a. Last Year's Accomplishments
Performance measure was achieved. Performance Objective was 98.3%; Annual Indicator 98.6%.

Universal newborn hearing screening is done at all 45 Utah birthing facilities and the pediatric specialty hospital. Utah had 53,395 births in 2010. Over ninety-eight percent (98.5%) of live births were screened for hearing loss. Pass rate for those screened was 98.7%, with 50,850 (97.8%) passing by one month of age. Homebirth screening rates increased from 41.8% in 2009 to 69% for 2010 births. Three hundred forty-two (342) newborns were referred for diagnostic evaluation. Sixty-eight (68) infants were identified with permanent hearing loss. Approximately 1.7% of Utah's 2010 newborns have not returned for outpatient/diagnostic testing, have no screening results reported, or missed newborn hearing screening (improvement from 2009). Targeted efforts are increasing to meet national 1-3-6 EHDI goals.

Utah EHDI's focus was to decrease the number of infants lost to follow-up or documentation and improve program success. Program Summaries for each birthing facility were updated in May 2011. All were reviewed and details were reported to the Newborn Hearing Screening Advisory Committee. Hospitals not detailing referral and follow-up protocols were contacted and encouraged to work with their supervising audiologist to ensure that all babies are screened, referred for diagnosis and enrolled in intervention when necessary. Six midwife programs were added to the Homebirth Hearing Project (through June 2011), increasing rural and non-hospital screenings. A Utah EHDI presentation was made on our midwife collaboration at the 2011 National EHDI Conference. Through participation in the Utah Regional LEND Program, and contacts following the conference presentation, Montana and Wyoming are implementing homebirth hearing projects.

All hospitals upgraded to HiTrack 4.5.3 data tracking system, allowing additional advanced grouping and sorting of data, editable Transfer History records, improved data transfer speed, improvements to the Hearing Loss and EI Services reports. Monthly distribution of State HiTrack reports enabled timely data corrections and earlier tracking. Reports were utilized to assess hospital issues. Action plans were initiated to address individual program needs. Annual regional meetings (5) in the spring of 2011focused on using HiTrack to achieve performance standards.

The Annual Utah EHDI conference in Oct, 2010, focused on 1-3 guidelines for screening and evaluation, and the supervising audiologist's role in referral and completion of diagnosis. EHDI audiologists were assigned to mentor and train hospital audiologists. An Infant and Pediatric

Audiology workshop in May 2011 provided training on ABRtesting, Best Practice models for Pediatric Hearing Aid Fitting, Family Centered Counseling, and Medical Aspects of Cochlear Implants to 46 local audiologists. Two audiologists were enrolled to beta test direct reporting into State HiTrack through a secure web portal.

Two staff attended the national Investing in Family Support Conference in October, 2010. The Hands and Voices Guide-By-Your-Side was reviewed for possible inclusion for family support activities. A parent survey was conducted in collaboration with NCHAM to evaluate content and usefulness of Utah Parent Notebook information. The updated Notebook was integrated into the diagnostic/early intervention referral process when a hearing loss is confirmed. A newborn hearing module was updated in July 2010 for the Utah Medical Home Portal.

One-time funding from Part C Early Intervention was used to build a hearing aid bank of new digital hearing aids. Families of newly-identified children, 0-3, may apply for this "Early Fit Project". Eligibility is based on financial need or special hardship. When eligible, State EHDI sends hearing aid(s) to a community audiologist who has agreed to fit the aids and follow all Utah Recommended Infant Audiological Amplification Protocols. This project has provided 21 hearing aids through June 2011.

The Birth Certificate (BC) Alert project was postponed due to data development issues in the VR Office. This project, when complete, will provide an alert message to families when a BC application data link generates a "missed screening" or "needs follow-up" message. Progress is ongoing to complete development of electronic link with the Utah School for the Deaf Parent Infant Program data.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Program updated hospital NBHS Program Summaries statewide.	X		X	
2. The Program hosted a statewide infant/pediatric audiology workshop.				X
3. The Program hosted an Annual Utah EHDI Conference.				X
4. The Program increased the overall number of homebirth screenings statewide.	X			
5. The Program updated the HiTrack (hearing) data management and tracking system.				X
6. Program staff attended the National EHDI and Family Support Conferences.				X
7. The Program initiated the “Early Fit” hearing aid project with one-time funding from Baby-Watch Early Intervention.	X	X		
8. The Program continued activities to address uniform standards in screening, diagnostic testing, training, and development of pediatric standards and protocols.				X
9.				
10.				

b. Current Activities

Focused activities are planned to reduce the number of infants lost to follow-up after failed hearing screening, provide access to hearing screening for families who have limited access and resources and increase tracking and reporting capabilities for these infants. The Loss to Follow-up Coordinator has initiated direct outreach, assists families through follow-up, diagnostics and intervention referral. Parent support will be increased to ensure family awareness of services and support organizations. The Homebirth Hearing project/lay midwife screening coverage will be

expanded to promote more screenings of babies born outside of hospitals. HiTrack 4 data system enhancements will improve EHDI data quality to ensure better tracking and follow-up. A pediatric audiology workshop is planned for professionals to increase capacity to provide age appropriate diagnostic services. Integration of the EHDI tracking system with other state screening, tracking, surveillance, and health information systems that serve children will be expanded. Evaluation of hospital programs and quality improvement activities are on-going. Results and recommendations are being reported to the Newborn Hearing Screening Advisory Committee and findings will be used to implement future activities.

c. Plan for the Coming Year

During FY13, we will continue to focus on decreasing loss to follow-up after failed newborn hearing screening and increasing support for the national 1-3-6 EHDI goals. We will provide access to hearing screening for families who have limited access or resources and increase the tracking and reporting capabilities for these infants. The Follow-up Coordinator will initiate additional strategies to decrease the number of infants missed and/or lost to follow-up (or lost to documentation. Fax back forms -- from screening program to provider - will be re-introduced to increase the numbers of infants returning for follow-up. Program audiologists will initiate a process to monitor failed screenings/evaluations, and decrease the number of infants who go beyond three months - between failed hearing screening and diagnosis - due to unresolved middle ear disease. A Self-Assessment tool will be developed for use by hearing health professionals to help reduce loss to follow-up. A plan will be developed to assure that all children who are not screened at birth or who pass the screening but have risk factors for late onset or progressive hearing loss receive on-going monitoring and follow-up in a medical home.

The Homebirth Hearing Project will be expanded and additional referral strategies will be developed. Development of a midwife screener consortium and a Utah EHDI conference for midwives will be explored. Greater partnership will be developed with the Newborn Screening (heel stick) Program for quality improvement. A Memorandum of Understanding (MOU) will be drafted for each state bordering Utah, and those who transport critical care newborns to Primary Children's Medical Center.

Staff will attend national EHDI and Family Support conferences to develop program improvements activities. An annual Utah EHDI conference and a pediatric audiology conference will be provided. Regional workshops and hospital site visits will target individual program needs and challenges.

Continued data integration projects through the Clinical Health Information Exchange, Utah Health Information Network, CHARM, and Baby Watch Early Intervention (BTOTS) will increase avenues to link health information systems and decrease infants lost to tracking/documentation. Newborn screening results (heel stick and hearing) will be available to electronic medical records (EMR) system in an HL7 messaging format using standard LOINC and SNOMED coding.

Exploration of "teleaudiology" and use of video conferencing strategies will continue with the goal of providing better and timelier follow-up and consultative audiological services to rural and remote areas of the state.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10.3	9.1	9.1	8.3	5.9
Annual Indicator	9.2	8.4	6.9	5.9	5.9

Numerator	76734	71700	59700	51367	51367
Denominator	834070	857680	860368	870623	870623
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5.9	5.9	5.8	5.8	5.8

Notes - 2011
Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2010
Denominator: IBIS Population estimates 2010

Notes - 2010
Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2010
Denominator: IBIS Population estimates 2010

Notes - 2009
Utah Healthcare Access Survey is now combined with BRFSS.

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

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 5.9% and the Annual Indicator was 5.9%.

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Division monitored insurance rates among children in the state.			X	
2. The Division monitored the number of children enrolled in			X	

Medicaid and CHIP.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The creation of a new position for school health has allowed us to focus on school age children. The person hired will be able to address insurance among school age children through Telehealth conferences across the state. Families seeking health insurance for their children were higher in the previous year, but are dropping off compared to last year's enrollment numbers. Current Medicaid numbers for children enrolled were 167,759 for February 2012 compared to October 2011 at 165,931. The numbers of children enrolled in Medicaid have increased more than 900 children in Four months. In February 2012, 37,061 children were enrolled in CHIP compared to 37,563 in October 2011. The lowered number of children enrolled in CHIP can be attributed to the overall Utah economic recovery and corresponding employment expansion. In March 2012, the current unemployment rate was 5.7% compared to the unemployment rate in 2011 of 6.7%.

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

WIC promotes referrals to Medicaid and CHIP so that those who might be eligible can apply for benefits. The UDOH leadership has determined that health care reform and Medicaid reform are top priorities for the Department.

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

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

We also need to be aware that the changes in weighting and modes of data collection may affect the uninsured rate. Previously health insurance coverage estimates were derived from the Utah Health Status Phone Survey or Healthcare Access Survey (UHAS). After 2008, the UHAS was discontinued and the health insurance coverage and health care access questions were added to the Behavioral Risk Factor Surveillance System Survey (BRFSS) as state-added questions. The "no insurance coverage (children aged 0-17)" estimates for 2009 (6.7%) and 2010 (5.9%) were based on BRFSS data. These estimates were significantly lower to UHAS 2008 rate (8.4%). The Office of Public Health Assessment (OPHA), who produces the official health insurance coverage estimates, has notified that the uninsured rate may have been underestimated. The weighting process for BRFSS data have now changed from Post-Stratification to Raking (or iterative proportional fitting). This method (Raking) will allow incorporating cell phone survey data with

landline data. Evaluations conducted by CDC using 2010-2011 BRFSS data indicate that the addition of cellular phone -- only household will improve survey coverage for certain population groups. So, OPHA have used raking as the only source of weighting for BRFSS with 2011 data. Raking adjusts the data so that groups which are underrepresented in the sample can be accurately represented in the final dataset. The preliminary results for 2011 data now estimates 368,200 Utahns between the ages of 18-64, or 21.5 percent of this population, did not have health insurance in 2010. Under the old methodology, the estimate for this same population was 247,100 uninsured 18- to 64-year-olds, or 14.4 percent of that population. In the coming months, the UDOH will be evaluating the effects of these changes on other public health indicators as well as child uninsured rates.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	21.6	21.6	21.8	21.8	20.7
Annual Indicator	21.8	21.8	21.8	20.7	20.7
Numerator	6558	6558	6558	7083	7083
Denominator	30083	30083	30083	34217	34217
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	20.7	20.7	20.7	20.6	20.6

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).

Notes - 2010
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).

Notes - 2009
The data are from the 2005 Pediatric Nutrition Surveillance. Table 8C combining the 85th-<95th and greater than or equal to 95th BMI categories.

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

a. Last Year's Accomplishments

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

The Utah WIC Program continued its strong collaboration with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) also called SNAPEd and the Food Stamp Nutrition Education Program (FSNE) known as the Food Sense Program. Parents and caretakers of WIC children at risk of overweight or overweight were referred to these nutrition programs for Healthy Lifestyle classes. During FY11, it was determined that 123 of these Healthy Lifestyle classes, for 8,252 WIC participants, were taught at Utah WIC clinics or at EFNEP or FSNE locations. The updated Help Me Be Healthy brochures and physical activity series "Baby Play, Toddler Play and Child Play" were distributed to all WIC participants. Almost 30,000 Sesame Street kits "Food for Thought- Eating Well on a Budget" purchased by the Utah WIC Program were given to WIC families. The kits contained valuable information in 5 different areas including, 1) "Family Food Talk" which offers ways for families to talk together about food and related concerns that families and children may have, 2) "Healthy Foods on a Budget" contains ideas for families on how to plan, shop, and save money, 3) "Healthy Choices Anytime" provides tips for children to make healthy choices anytime and anywhere, 4) "Making Connections" contains ways to reach out for help and support, and 5) "Sesame Street" Recipe Cards provide healthy recipes.

The results of the 2010 Utah WIC Participant Satisfaction Survey were used to plan an updating of the Authorized WIC Foods List which emphasizes healthy foods such as whole grains, fresh fruits and fresh vegetables. Emphasizing healthy foods is also a component of the USDA Fit WIC Program which was to prevent childhood overweight in WIC communities. The program consists of 10 chapters that provide information on the epidemic of overweight among children, the role of prevention and how WIC can help to prevent childhood overweight. Reducing the prevalence of at risk of overweight and overweight among WIC children requires monitoring and documentation of weight and growth trends.

The USDA Nutrition Risk Revision 10 was fully incorporated into the new VISION computer system and the Utah WIC Policy and Procedure Manual by October 1, 2010. This revision updated risk factors related to weight gain during pregnancy and inappropriate nutrition practices for infants, children and women. Training resources on Nutrition Risk Revision 10, the logic model approach to program planning and WIC data reports from CDC were offered to all local WIC staff in the fall of 2010. The new VISION system also included a more comprehensive nutrition needs assessment process, as well as a referral sources list and the ability to track follow up on referrals that were made in the local WIC clinics.

Since breastfeeding has been associated with reduced risk for pediatric overweight, a more comprehensive breastfeeding assessment function was integrated into the new VISION computer system. Breastfeeding also appears to have an inverse dose-response association with pediatric overweight (longer duration, less overweight). Thus, the USDA "Grow and Glow" training, which promotes and supports breastfeeding, was offered and completed by all WIC staff during the months of July, August, September and October of 2010. The overall evaluations of these training sessions were either excellent or good.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 8,252 WIC participants completed SNAPEd or Food Sense and EFNEP classes.		X		
2. “Help Me Be Healthy” educational series was distributed.		X		X
3. Baby Play/Toddler Play/Child Play activity series was distributed.		X		X
4. Sesame Street “Food for Thought- Eating Well on a Budget”		X		X

kits were distributed.				
5. 2010 WIC Participant Satisfaction Survey results were used to update Foods List.				X
6. USDA “Fit WIC” Program was determined to be applicable for implementation.		X		
7. Nutrition Risk Revision 10 was incorporated into the VISION computer system.				X
8. “Grow and Glow” breastfeeding training was completed by all WIC staff.				X
9.				
10.				

b. Current Activities
Parents and caretakers of WIC children who are at risk of overweight or overweight continue to be referred to the "Healthy Lifestyle" classes offered by Utah State University Expanded Food and Nutrition Education Program (EFNEP) also called SNAPEd and the Food Stamp Nutrition Education Program (FSNE).

The Utah WIC Program Authorized WIC Foods List which emphasizes healthy foods became effective in November 2011. The new USDA MyPlate icon and related materials are being reviewed and considered as additional education resources. The results of the 2010 Utah WIC Participant Satisfaction Survey and the 2010 Dietary Guidelines are being used to update 18 nutrition lessons and 13 educational handouts on healthy eating.

The remaining Sesame Street kits entitled "Food for Thought- Eating Well on a Budget" continue to be distributed. The USDA "Fit WIC" Program, applicable for implementation in all local WIC clinics, is now resulting in positive outcomes in the Utah County's WIC Program and is currently being implemented in the Tooele County's WIC Program.

The new WIC computer system entitled, VISION is functional in all 49 WIC clinics. Implementing this new VISION computer system allows for a more comprehensive nutrition assessment process, while ensuring the retention of valuable anthropometric data such as height, weight and body mass index (BMI).

c. Plan for the Coming Year
The Utah WIC Program will continue to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) and the Food Stamp Nutrition Education Program (FSNE). Parents and caretakers of WIC children who are at risk of overweight or overweight will be referred to these nutrition programs for "Healthy Lifestyle" classes. Utah WIC will integrate the new USDA icon, MyPlate, into all applicable nutrition education materials. This MyPlate visual asks the question, What's on your plate? and emphasizes plating out half your plate as fruits and vegetables.

Articles on the USDA Fit WIC Program, which is designed to reduce the prevalence of childhood overweight, will be published in the monthly Utah WIC newsletter, WIC Wire, to be distributed to all local WIC staff. The articles will provide strategies on how to implement "Fit WIC" in the local clinics. The 2006 WHO growth charts for birth to 24 months will be implemented by October 1, 2012. These new growth charts show "how children should grow" and establish breastfeeding as the biological "norm" for measuring healthy growth. These charts will allow standardized Body Mass Index (BMI) values to be used in the assessment of healthy weights for infants and children up to 24 months of age.

The Utah WIC Program will offer the Washington University training module entitled, "Life Course Nutrition: Maternal and Child Health Strategies in Public Health" (http://www.nwcphp.org/training/courses/nutrition) to all WIC staff. This training module is based

on a life course framework which is designed to help public health nutrition professionals understand the role of maternal and child nutrition in population level public health programs. After completing this module, participants will be able to describe the role of maternal and child health (MCH) nutrition in the lifelong health of the population, access resources for assessment, assurance, and policy development for MCH nutrition, identify ways to integrate MCH nutrition within state and local public health agency programs, and apply the principles of the life course framework for population-based public health actions and initiatives.

The Utah WIC Program will collaborate with the developers of WICHealth.org, an internet based application of nutrition education lessons, to pilot and implement a Virtual Peer Counselor (VPC) program. Utah WIC participants will be able to access a secure VPC program through the WICHealth.org 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4.2	4.2	4	3.8	3.5
Annual Indicator	4.1	3.9	3.6	3.2	3.2
Numerator	2285	2188	1936	1666	1666
Denominator	55063	55605	53894	52164	52164
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3.2	3.2	3.1	3.1	3.1

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

Notes - 2010
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

Notes - 2009

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

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 3.5% and the Annual Indicator was 3.2%.

During 2011, the Utah Department of Health's Tobacco Prevention and Control Program (TPCP) distributed educational brochures and tobacco cessation tools -- onesies, diaper wipes and changing pads imprinted with smoking cessation messages - via local health departments. This project was a part of the Preconception Health Workgroup of the First Time Motherhood/New Parent Initiative Grant.

The TPCP First Step Program assisted pregnant women in their smoking cessation efforts implemented in local health departments (LHDs). The LHDs found the six session format to be too long to retain attendees and, as a result, most LHDs have discontinued use of the program. However, some local health districts chose to continue the program , or at least distributed program materials to pregnant women who smoke. LHDs also referred pregnant women to the Quit Line (this can be accomplished via fax) and promoted the cessation services available through that intervention.

During 2011, the TPCP 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.

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 FY2011 1,630 Medicaid-insured pregnant women received free counseling and prescriptions for medications to help them quit using tobacco. More than 26% of participants in the TPCP-funded Medicaid program for pregnant women quit using tobacco and 22% reduced their tobacco use.

Due to time constraints, the article on the effects of tobacco use before, during and following pregnancy was not placed on the MIHP website. It will be added during FY2011 along with a link for health care providers to educational materials and resources for professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Tobacco Prevention and Control Program distributed cessation messages imprinted on onesies, changing pads and diaper wipes to local health departments.			X	
2. Some local health departments continued to provide information from the First Step Program to pregnant women		X		

using tobacco. All local health departments referred pregnant women wishing to quit tobacco use to the Tobacco Prevention and Control's Quit				
3. The Tobacco Prevention and Control Program's Quit Line fax referral system provided access to cessation support services for local health departments, WIC Offices and private providers counseling pregnant women on tobacco use.		X		
4. Medicaid provided tobacco cessation support to pregnant women via phone calls from Medicaid Health Program Representatives at six-week intervals during pregnancy.		X		
5. The Tobacco Prevention and Control Program made visits to private providers' offices to assist them in incorporating tobacco cessation messages and materials in their practices.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Tobacco Prevention and Control Program (TPCP) continues to distribute tobacco cessation messages from the First Time Motherhood/New Parent Initiative Grant. The TRUTH Network's Quit Line fax referral system continues. 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 refers pregnant Medicaid applicants to Health Program Representatives for tobacco cessation support via phone calls every six weeks throughout pregnancy. In 2011, the number of Quit Line calls covered by Medicaid for pregnant clients was increased by the addition of a call postpartum to women successful in quitting or reducing tobacco use.

The Maternal and Infant Health Program analyzed 2010 Utah Vital Records birth and PRAMS data which indicate that 3.2% of women smoked during the last trimester of their pregnancies. The highest rates were noted among 15-19 year olds (6.4%) and 20-24 year olds (5.2%). There are also geographical areas of the state that have higher rates than the state average: Tri-County-10%, Southeastern-9.8%, Tooele-7.8% and Central-7.6%. These data were used to update and publish the IBIS indicator on third trimester smoking so that partners and stakeholders are aware of where to focus intervention efforts.

c. Plan for the Coming Year

During 2012 the Tobacco Prevention and Control Program (TPCP) will continue to utilize its TRUTH Network Tobacco Cessation Program's Quit Line as a primary source of education and support to pregnant women in their tobacco cessation efforts. The Quit Line fax referral system will continue to provide ready access for local health departments, WIC Offices and private providers to Quit Line services for their clients needing support in their cessation efforts.

Despite the end of the First Time Motherhood/New Parent Initiative Grant, the distribution by the TPCP of onesies, changing pads and diaper wipes imprinted with tobacco cessation messages will continue as long as supplies remain. The main distribution sites will be via WIC clinics and through Medicaid. If funding is available, Medicaid may purchase additional changing pads and diaper wipes for their pregnant clients using tobacco.

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.

In 2011 the number of calls to the Quit Line covered by Medicaid for pregnant women using tobacco increased through the addition of a postpartum follow-up call to women successful in either quitting their tobacco use or in reducing it. To determine the impact of this addition, the TPCP is conducting a study to determine the effectiveness of this intervention. Analysis of the study results and a report will be available in 2012.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	13.2	13.2	10.6	11	12.1
Annual Indicator	10.6	11.5	12.1	11.4	11.4
Numerator	23	25	26	25	25
Denominator	216313	216682	215470	219146	219146
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11.4	11.3	11.3	11.2	11.2

Notes - 2011
Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2010
Denominator: IBIS Population estimates for 2010 (GOPB).

Notes - 2010
Data reported are the most recent data available.

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

Notes - 2009
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2009
Denominator: IBIS Population estimates for 2009 (UPEC, GOPB).

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 12.1 and the Annual Indicator was 11.4.

The Utah Department of Health Violence and Injury Prevention Program (VIPP) continued to provide data collection and analysis services on Utah suicides (suicide fatalities, suicide emergency room visits, and suicide hospitalizations). VIPP also developed a state plan for injury in which suicide prevention is a priority for ages 15 to 19 years of age. Staff also participated on the state suicide prevention coalition.

VIPP continued to facilitate the state Child Fatality Review Committee in which the Division's Medical Director also attended and participated.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VIPP provided data collection and analysis services.				X
2. VIPP developed a state plan for the prevention of suicide for ages 15 to 19.			X	
3. VIPP facilitated the Child Fatality Review Committee.			X	
4. Utah NAMI continued its Hope For Tomorrow Program.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Violence and Injury Prevention Program (VIPP) continues to provide data collection and analysis services, as well as participating in the development of a plan to prevent suicide among youth ages 15 to 19. VIPP continues to participate on the Utah Suicide Prevention Council. A school health consultant was hired during this fiscal year and serves on the Child Fatality Review Committee and the Utah Suicide Prevention Council.

c. Plan for the Coming Year
VIPP will co-chair the Utah Suicide Prevention Council with the Youth Suicide Specialist 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 Council. The Council will finalize a new state plan for the prevention of suicide. VIPP will continue to provide data collection, analysis and fact sheet publication and dissemination.

VIPP will continue to facilitate the Child Fatality Review Committee (CFRC) and make recommendations on the reviews of youth suicides. Additionally, the Division Medical Director for CSHCN/MCH/CD will attend and participate on the CFRC.

VIPP hopes to continue efforts to reduce youth suicide, but the extent of involvement will be dependent on resources.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	84	81	82	80.5
Annual Indicator	79.9	81.3	78.3	89.8	89.8
Numerator	460	469	440	520	520
Denominator	576	577	562	579	579
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90.1	90.2	90.3	90.4

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.

Notes - 2010
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.

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

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 7 level III hospitals.

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 80.5% and the Annual Indicator was 89.8%.

It must be clarified however that based on ongoing collaboration with Neonatal Intensive Care Unit (NICU) stakeholders, we have revised the number of facilities that qualify as Level III NICUs based on hospital self-designation from 7 to 10.ten). We had previously only acknowledged seven facilities as having the capabilities to provide Level III care for very low birth weight (VLBW) neonates. The Healthy People 2020 Target for this objective is 83.7%. Utah must set a realistic target for this measure since we are currently exceeding this target and believe that there is room for improvement.

Currently, Utah regulations that address Levels of Care for Perinatal Services are imprecise with no authorized oversight of NICU service capacity by the Department. The Utah Administrative Code R432-100-17 on Perinatal Services provides that each hospital shall self -designate its capability to provide perinatal care in accordance with levels described in the "Guidelines for Perinatal Care, Sixth Edition".

Utah had a total of 579 very low birth weight infants (VLBW) born in 2010 (latest year for which data are available) with 520 of these infants being born in one of the ten self-designated Level III facilities. Review of the 59 birth certificates for VLBW infants born outside a Level III facility indicates that the decision to deliver at a lower level facility was appropriate in the majority of cases based on maternal factors such as placenta abruption or previa or infant factors such as fetal distress or lethal congenital anomalies.

The Maternal and Infant Health Program (MIHP) carried out a survey of all delivery hospitals in 2009 to obtain capacity information on which to determine Levels of Care. Based on findings realized that there are several self-designated NICUs that do not meet the proposed guidelines published in the American Academy of Pediatrics (AAP) Policy Statement for Levels of Neonatal Care. As a result, the MIHP convened a group of over 40 Utah stakeholders of neonatal care in May 2011 due to concern about the percentage of VLBW infants not being delivered at facilities appropriate for their care needs. In the stakeholder meeting, the AAP Policy guidelines was presented and discussed, as were data on VLBW deliveries in Utah. This large group of stakeholders agreed that a Workgroup should be formed to review the issues in detail and to make recommendations on Utah specific guidelines.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Program reviewed 59 birth certificates (linked to death certificates where applicable) in which the VLBW infant was not born in a Level III facility and found that the decision to deliver at a lower level facility was appropriate in the majority				X
2. The Program convened a group of over 40 Utah stakeholders of Neonatal Care in May of 2011 due to concern over the percentage of VLBW infants who were being not being delivered at facilities appropriate for their care to present and discuss the AAP Po				X
3. The Program convened a Workgroup of interested individuals, primarily neonatologists from the various health care systems that self-designate as Level III NICUs, to reach agreement on				X

Utah guidelines for Perinatal Services, specifically around Levels				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A Workgroup of interested individuals, primarily neonatologists from the various healthcare systems that self-designate as Level III NICUs has been meeting quarterly since fall of 2011 to reach agreement on Utah guidelines for Perinatal Services, specifically around Levels of NICU care. Several Workgroup participants voiced the need for accurate data from which to assess current care and treatment of VLBW infants in Utah before decisions are made about guidelines for NICU Levels of Care.

Analysis of mortality rates for VLBW infants born in one of the ten self-designated Level III facilities has revealed that there is a wide range of rates. In a non-risk adjusted analysis of infant mortality rates by the ten self-designated NICUs during 2005-2010 that included less than 1500 grams, gestational ages 23-28, and excluded less than 500 grams and selected birth defects the rates ranged between 111.7/1000 to 454.5/1000 among the ten facilities. Rates were highest for the NICUs that delivered the fewest VLBW infants per year. However, due to small numbers it has been agreed that analysis of major morbidities among the ten self-designated NICUs would be a much better gauge of care and treatment.

The Workgroup reviewed ICD-9 codes for neonatal morbidities in the UDOH hospital discharge dataset. It was agreed that UDOH data are less than optimal for clearly depicting morbidities as they are billing data and therefore less precise than hospital collected clinical data.

c. Plan for the Coming Year
A Workgroup of interested individuals, primarily neonatologists from the various health care systems that self-designate as Level III NICUs will continue to meet quarterly to reach agreement on Utah guidelines for Perinatal Services, specifically around Levels of NICU care.

Discussion with the Workgroup regarding compilation and analysis of data to evaluate outcomes of VLBW infants related to facility capacity is ongoing. The majority of Workgroup participants indicate that their units participate in national data collection efforts (Vermont Oxford Network [VON], Pediatric Database [Pedbase], Neonatal Research Network, or Canadian Neonatal Network) and that they would be willing to share pertinent treatment and outcome data with the UDOH and Workgroup. The Workgroup has agreed on a selection of morbidities as defined by the VON data system: Chronic lung disease, Severe IVH (grade 3 or 4) and/or Periventricular Leukomacia, Severe ROP (Per VON: Stage 3, 4 or 5) and ROP treated with laser ablation in at least one eye, NEC, Central Line Associated Bloodstream Infection, and Ventilator Associated Pneumonia for analyses. There is Workgroup consensus that provision of these data to the UDOH by the ten NICU facilities would be an effective means of assessing outcomes for VLBW infants in Utah.

Several Workgroup participants have voiced concern over whether their facilities would allow release of the data to the UDOH. While current Utah Statute and Administrative Rules authorize the UDOH to "promote and protect the health and wellness of the people within the state" and for the "development, strengthening, and improvement of standards and techniques relating to the services and care", the Workgroup agreed that it would be most helpful for the Department to develop and implement a new administrative rule with specific language requiring Utah NICUs to

provide data to the UDOH for analyses of VLBW outcomes and protecting them against liability in doing so.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	79	78.6	79	79.1	71.7
Annual Indicator	79.4	79.1	71.6	73.1	73.1
Numerator	43728	43977	38562	38124	38124
Denominator	55063	55605	53894	52164	52164
Data Source		See footnote for source	See footnote for source	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	73.1	73.2	73.3	73.4	73.5

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

Notes - 2010
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

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

a. Last Year's Accomplishments
The performance measure was achieved. Performance Objective was 71.7% and the Annual Indicator was 73.1% in 2010.

Utah Vital Records implemented the 2003 birth certificate to collect data in 2009. Because timing of prenatal care entry is calculated differently than the previous version, data are only available for 2009 and 2010, making it difficult to analyze trends.

During FY11, BYB applications were submitted via paper applications or Utah Clicks, an online application system that permits women and families to apply for BYB and also for services through Baby Watch, Children with Special Health Care Needs, Early Head Start and Head Start.

In FY11, 5,070 applications were submitted via Utah Clicks, a decrease of almost 1,000 applications from FY10. Due to funding cuts and contracting issues, the BYB Campaign was unable to promote early prenatal care via television or radio ads. About 1,500 copies of the Native American version of the Baby Your Baby Health Keepsake were distributed in FY2011.

The Division continued to provide limited funds to support the efforts of the Salt Lake Community Health Centers, Inc. to provide early and continuous prenatal care for uninsured women seen at their clinics throughout Salt Lake County.

The Maternal and Infant Health Program (MIHP) completed development of classes for women incarcerated at the state prison who are preparing for release back into the community, the YPREP Program (Your Parole Requires Extensive Preparation). The MIHP classes focused on preconception, prenatal and postpartum care. Through collaboration with the Pregnancy RiskLine and Sexually Transmitted Diseases (STD) Programs at UDOH and Planned Parenthood Association of Utah, additional classes on substance use in pregnancy, STDs, normal female reproductive physiology and contraception have been provided and are ongoing.

The MIHP supported "text4baby", a campaign sponsored by the National Healthy Mothers, Healthy/Babies Coalition, by posting a link on the MIHP website to the campaign's website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Baby Your Baby distributed 1,150 Native American versions of the Baby Your Baby Keepsake.			X	
2. Maternal and Infant Health Program completed development of the YPREP classes to be offered to incarcerated women at the Utah state prison. Classes taught were Preconception Health and Substance Use in Pregnancy.		X		
3. Maternal and Infant Health Program continued to provide limited financial assistance to Salt Lake Community Health Centers for prenatal care for uninsured and underinsured women.				X
4. Maternal and Infant Health Program supported “text4baby” by posting a link to the MIHP website.			X	
5. Maternal and Infant Health Program provided support for Presumptive Eligibility Program (Baby Your Baby) to enhance early entry into prenatal care for low income women.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

BYB and radio B98.7 hosted "Operation Baby Bundle" in 2011 to support the March of Dimes Teddy Bear Den, a prenatal health program for low income pregnant women. A second Teddy Bear Den was opened in Cedar City in March 2012. MIHP participated on the Office of Health Disparities Reduction's Birth Outcomes Advisory Board to support development of culturally appropriate preconception and health 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. Funding for under/uninsured women seeking prenatal care from Salt Lake Community Health Centers continues. YPREP classes for women preparing for release from the state prison were presented. Classes on sexual infection, substance use before and

during pregnancy and while breastfeeding, preconception health, pregnancy and postpartum care were taught by the STD Program, MIHP and Pregnancy RiskLine Programs at UDOH. Planned Parenthood Association of Utah presented classes on female reproductive physiology and contraception. MIHP continues to support Utah Clicks in accepting PE applications online. BYB continues to accept applications via phone and online for PE in Salt Lake County. BYB began placing text4baby information in Keepsake mailings, and the MIHP program manager discussed the program on a news segment on KUTV.

c. Plan for the Coming Year

The Maternal and Infant Health Program has reassessed its role in the Presumptive Eligibility (PE) process. We will work to transition the PE oversight to Medicaid since policies and oversight fall under Medicaid's purview. Baby Your Baby will continue to accept applications via phone and online for PE in Salt Lake County.

In an effort to improve reporting of entry into prenatal care on birth certificates, the MIHP will collaborate with the Utah Office of Vital Records and Statistics to promote further training of hospital personnel involved in completion of birth certificates.

The MIHP will continue to educate local health departments, community health centers, hospitals and other appropriate agencies about the national "text4baby" campaign. Through delivery of free text messages delivered three times per week to pregnant women, early and continuous prenatal care is stressed along with other helpful pregnancy and new mother "tips". MIHP will also continue to distribute posters and flyers for this campaign.

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

It is anticipated that in FY13, a new contract will be in place for the Baby Your Baby media campaign. When the contract is in place, Baby Your Baby intends to have a strategic planning retreat. Remarketing of Baby Your Baby will include presences on Twitter, Pinterist and a Baby Your Baby Blog.

The MIHP will continue to track reasons for late prenatal care entry using Utah PRAMS data. Using results, messages will be developed to increase the awareness of the importance of early and continuous prenatal care.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					38
Annual Indicator				37.6	37.6
Numerator				52274	52274
Denominator				138948	138948
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	37.6	37.7	37.7	37.9	38

Notes - 2011
Data based on Utah Behavioral Risk Factor Surveillance System, 2010
Utah BRFSS 2011 data is not yet available

Notes - 2010
This is one of the new SPMs identified during 2010 Needs Assessment . Data based on Utah Behavioral Risk Factor Surveillance System, 2010

Notes - 2009
This is one of the new SPMs identified during 2010 Needs Assessment

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 38.0% and the Annual Indicator was 37.6%.

The Utah Birth Defect Network (UBDN) continued to monitor the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Specifically, neural tube defects (NTDs) are monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

The final six month periods for survey questions for the 2010 BRFSS statewide telephone survey were asked to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid. In August 2011, the UBDN requested that the folic acid questions be included in the 2012 BRFSS survey which was approved.

Activities for Birth Defect Prevention Month and Folic Acid Awareness Week occurred in January 2011. A joint news release with PRL, and information packets were sent to OB/GYN offices with messages about folic acid and preconception health.

The Pregnancy Risk Line (PRL) answered questions about medications and exposures during pregnancy and breastfeeding for over 8,500 callers. More than 36% of the calls were regarding breastfeeding. PRL consulted with 383 non-pregnant callers regarding the importance of taking a multivitamin before conception.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BDN monitored the occurrence of neural tube defects.			X	
2. BDN and PRL promoted Birth Defect Prevention Month and Folic Acid Awareness week.			X	
3. PRL reached more non-pregnant callers who were counseled regarding folic acid.	X			
4. BDN and PRL incorporated use of social media to promote the use of folic acid.			X	
5. BNDN and PRL promoted the use of folic acid at community events.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Utah Birth Defect Network (UBDN) continues to monitor the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Neural tube defects (NTDs) are monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

In January the 2012 BRFSS statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid began. The questions have been placed on one portion of the landline survey (5000 respondents) as well as one portion of the cell phone survey (1250 respondents).

Birth Defect Prevention Month packets were sent to OB/GYN offices with messages about heart defects, folic acid and preconception health with the focus for the campaign being on Congenital Heart Defects.

Non-pregnant, early pregnant, and breastfeeding PRL callers are asked if they take a multivitamin with folic acid. If callers are not consuming a vitamin with folic acid, counselors educate on the importance of the vitamin. As part of the survey breastfeeding questionnaire, non-pregnant callers are asked about their use of multivitamins and are offered a free bottle of multivitamins containing folic acid.

Social media tools Facebook and Twitter are being utilized to educate on the importance of taking folic acid for women of childbearing age.

c. Plan for the Coming Year
The Utah Birth Defect Network (UBDN) will continue to monitor the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Specifically, neural tube defects (NTDs) will be monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

The UBDN will again make the request for the folic acid question to 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.

Activities will be planned around January Birth Defect Prevention Month and Folic Acid Awareness week for 2013.

PRL will disseminate informational brochures to health care providers throughout the state. Brochures on folic acid in multivitamins and having a good diet will be included. PRL will also continue to ask and educate non-pregnant and early pregnant callers of the importance of consuming a multivitamin with folic acid and to follow a good diet.

Non-pregnant and early pregnant callers as well as breastfeeding callers will be asked if they take a multivitamin with folic acid. If callers are not consuming a vitamin with folic acid, counselors educate on the importance of the vitamin. Counselors will also offer to send the caller a free bottle of multivitamins. A survey of breastfeeding mothers will also be piloted. As part of the survey questionnaire, non-pregnant callers are asked about their use of multivitamins and are offered a free bottle of multivitamins containing folic acid.

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	2007	2008	2009	2010	2011
Annual Performance Objective					17
Annual Indicator			17.8	17.6	17.6
Numerator			2695	2566	2566
Denominator			15150	14581	14581
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17	16.5	16	15.5	15

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

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

Notes - 2009
This is one of the new SPMs identified during 2010 Needs Assessment

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

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 17.0% and the Annual Indicator was 17.6%.

This state performance measure was added as a new measure for FY 2011, due to the fact that nearly one-third (31%) of the nation's babies are now born by cesarean delivery, an increase by 50% between 1996-2006. The Maternal and Infant Health Program (MIHP) tracked the number of primary cesarean deliveries to low risk women giving birth for the first time. Since labor induction may contribute to the increase of cesarean deliveries, it was decided to track the indications for and numbers of elective inductions as well.

IBIS-PH is the Utah Department of Health's Indicator-Based Information System for Public Health (IBIS-PH). The website which is updated yearly provides statistical numerical data as well as contextual information on the health status of Utahns and the state's health care system. MIHP maintains several indicators on this website relevant to maternal and infant health including this performance measure. The indicator was updated with current data on the IBIS-PH system during FY2011.

The Maternal and Child Health Bureau (MCHB) in the Dept. of Health worked toward development of an evidence-based set of perinatal performance measures as the groundwork for a statewide perinatal quality improvement collaborative. MIHP tracked rate of primary Cesarean section deliveries among low risk women giving birth for the first time, using Office of Vital Records and Statistics birth certificate data.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MIHP tracked rate of primary Cesarean section deliveries				X

among low risk women giving birth for the first time, using Office of Vital Records and Statistics birth certificate data.				
2. MIHP tracked rate of elective labor inductions to assess any correlation with rate of Cesarean delivery using birth certificate and PRAMS data.				X
3. MCHB worked toward establishment of a statewide perinatal quality improvement collaborative with an agreed-upon set of perinatal performance and quality measures.				X
4. MIHP updated IBIS-PH with current cesarean section delivery rates for low risk women giving birth for the first time.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Birth certificate data are being tracked for rates of Cesarean births among low risk primigravidas. Rates of elective labor induction are being tracked through birth certificate and PRAMS data. Data on reasons for labor induction were presented in Dec. 2011 at the National MCH Epi Conference. A Health Status Update on elective induction of labor is now published on the UDOH website; targeted audiences include the Utah Medical Association, government agencies and the public. A comparison of reasons for labor induction between PRAMS and birth certificate data has not yet been done because of a personnel shortage due to retirements and staff leaving state employment.

Medicaid is in the process of reorganizing its current managed care format which serves the state's urban corridor, into accountable care organizations (ACOs) which will cover the entire state. Once the new structure is in place, it will be possible to explore incorporation of perinatal quality performance measures into the new Medicaid ACOs' quality improvement activities. The IBIS-PH indicator on cesarean birth was updated.

c. Plan for the Coming Year
The MIHP will continue to track numbers of primary Cesarean birth among low risk primigravidas, and the rates of elective induction of labor, and to follow for correlations.

With new staff in place, the MIHP will be able to now evaluate PRAMS and birth certificate sources for consistency of data related to indications for Cesarean delivery.

The MIHP and MCHB will continue involvement in discussions with providers of NICU care to establish clear and consistent delineations of the different levels of NICU care available to the public, and to have NICU data reported to the Utah Department of Health. It is hoped that this work will form the basis for continuing discussions and establishment of voluntary performance measures for maternity and perinatal quality of care.

The IBIS-PH indicator on cesarean births to low risk women giving birth for the first time will be maintained.

Finally, after Medicaid restructuring is complete, the possibility of incorporating some perinatal quality indicators into Medicaid's quality improvement activities will be broached.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					9.7
Annual Indicator			9.8	9.5	9.5
Numerator			5272	4957	4957
Denominator			53894	52164	52164
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	9.7	9.6	9.6	9.5	9.5

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

Notes - 2010
This is one of the new SPMs identified during 2010 Needs Assessment

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

Notes - 2009
This is one of the new SPMs identified during 2010 Needs Assessment.

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

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 9.7% and the Annual Indicator was 9.5%.

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, there are subpopulations in Utah that have higher rates. Utah women of Pacific Islander descent had a preterm birth rate of 13.3% in 2010 and Asian women in Utah had a rate of 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 10.5%. Another common risk factor for preterm birth is maternal age and; in Utah during 2010 teens (15-17 years) had a preterm birth rate of 11.6% as did women who were over 35 years of age (35-39 years-11.8%, 40-44 years-15.4%, 45-49 years-24.6%). 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) focused some activities around progesterone supplementation (17P) for the prevention of recurrent preterm birth. 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.

Because overweight or obesity raises a woman's risk for preterm birth, the MIHP continued to collaborate with Physical Activity and Nutrition staff to increase the number of reproductive aged women who are at a healthy weight through outreach to providers and through policy change.

To provide information on late preterm births in Utah, the MIHP authored a two page "Health Status Report" on the topic. This report was distributed via the Department's web site and through the Utah Medical Association.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MIHP provided public education on the need for 17P to prevent recurrent singleton preterm birth.			X	
2. MIHP provided public education on the Danger Signs of pregnancy.			X	
3. MIHP collaborated with the Physical Activity and Nutrition Program to educate public and providers and promoted policy change around the area of obesity among reproductive age women in Utah.			X	
4. MIHP collaborated with the Physical Activity and Nutrition Program to educate public and providers and promoted policy change around the area of obesity among reproductive age women in Utah.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Because being overweight or obese raises a woman's risk for preterm birth, the MIHP continues to collaborate with the Physical Activity, Nutrition and Obesity (PANO) program to implement strategies developed in the Utah Nutrition and Physical Activity plan. Specifically, MIHP staff continues to participate in the PANO Health Care Work Group, which works to educate providers on calculating a patient's body mass index at visits and counsel those who are not at an optimal weight.

As induction is hypothesized to be contributing to the increases in late preterm birth rates, the MIHP used Utah Pregnancy Risk Assessment Monitoring System (PRAMS) data to analyze reasons for induction and examined outcomes of induced deliveries. According to 2009 data, women with elective inductions were more likely to be married, of White race, non-Hispanic ethnicity, multiparous, and have private insurance at the time of delivery.

The MIHP continues to educate providers and women at risk for recurrent preterm birth on the use of 17 alpha hydroxyprogesterone. We had planned to utilize data from the Utah PRAMS survey to see if women at risk for recurrent preterm birth were offered 17P during their pregnancies and compare outcomes of those who did and did not receive the medication. However, the numbers for the one year of data available for analysis were too small for statistical analysis.

c. Plan for the Coming Year

Utah has committed to joining the Association of State and Territorial Health Officers (ASTHO) and the March of Dimes (MOD) in a partnership aimed at preventing preterm birth and infant mortality. The partnership was created to support ASTHO's Healthy Babies President's Challenge and the MOD's Prematurity Campaign. In our commitment to this partnership, Utah has agreed to set a goal to reduce our rate of premature birth by 8% by 2014 using our 2009 rate as a baseline. This reduction is reflected in our MCH Block grant projected performance objectives for this indicator. Utah's 2009 rate of preterm birth was 9.7%; an 8% reduction would mean that by 2014 our preterm birth rate would not exceed 8.9%.

The Utah Department of Health has recently undertaken a strategic planning process with one of four goals being the "Healthiest People-The people of Utah will be the healthiest in the country." One of the key strategies highlighted under this goal is to "focus efforts on women to achieve healthier pregnancies and births." It is recognized that working to decrease tobacco use during pregnancy, reducing the teen birth rate, and ensuring women get early prenatal care and appropriate obstetric care will lead to healthier babies. Additionally, decreasing rates of prematurity and low birth weight will help babies grow into healthy children. Work is beginning by convening stakeholders for Healthy Utah Babies to come together to help identify key questions and Utah communities at risk for poor pregnancy outcomes. From this an action plan will be developed and the three Bureaus that serve the MCH population, Maternal and Child Health, Child Development and Children with Special Health Care Needs programs will lead the charge in assuring that Utah does in fact have the Healthiest Babies in the nation.

One of the first actions taken to inform the Health Utah Babies work will be to compile and analyze pertinent data to inform our actions. We will utilize various health datasets to assist with targeting our efforts. We may also carry out formative research in the form of focus groups and/or key informant interviews once we have exhausted our quantitative data analysis. In addition, the Department will play a key role in supporting the March of Dimes efforts in participating in a Prematurity Summit to be held in November 2012.

Another partnership currently underway by the Department is for the Center of Medicare and Medicaid's (CMS) Strong Start for Mothers and Newborns Initiative to reduce preterm births. The UDOH has entered into a partnership with the University of Utah (UofU)'s Department of Obstetrics, Intermountain Healthcare, the Salt Lake Community Health Centers Inc. and Medicaid ACOs to reduce the rate of preterm birth in Utah. The UofU will submit the grant in June. The Department will assist with data analysis and other project activities. The MIHP will develop a preterm birth risk recurrence algorithms to help providers educate women on their future risk.

State Performance Measure 4: *The percentage of Medicaid eligible children (1-5) receiving any dental service.*

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					39
Annual Indicator				37.5	37.2
Numerator				32945	33907
Denominator				87885	91229
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	37.2	37.3	37.5	37.5	38

Notes - 2011

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

Notes - 2010
This is one of the new SPMs identified during 2010 Needs Assessment.

Numerator: Medicaid CMS 416, FFY2010
Denominator: Medicaid CMS 416, FFY2010

Notes - 2009
This is a new measure identified during 2010 Needs Assessment

a. Last Year's Accomplishments
The Performance Measure was not achieved. The Performance Objective was 39.0% and the Annual Indicator was 37.2%.

The Oral Health Program (OHP) has worked closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. The educational video "A Healthy Smile for a Healthy Baby" was distributed to dentists, physicians and other health care providers. We 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.

The OHP has collaborated with staff in Medicaid to expand current CHEC (Utah's EPSDT) outreach programs and promote CHEC dental case management. 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. OHP supported the Utah Oral Health Coalition in educating the medical and dental provider community in an awareness campaign emphasizing the benefits of early and regular dental visits.				X
2. OHP collaborated with Medicaid and Health Care Financing in promotion of the CHEC Dental Case Management Project.	X			
3. OHP worked with Utah Dental Association Access Committee in advocating and promoting early childhood caries prevention and intervention programs and the promotion of increased participation from dentists willing to treat Medicaid patients.				X
4. OHP promoted oral health training and education in Head Start, Early Head Start and WIC programs.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Oral Health Program (OHP) is working closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. With funding from the federal Office of Head Start, the Oral Health Program is providing statewide training and education to all twelve Head Start Programs. Training and education are also being provided to WIC and local health department staff. We continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. Oral health education material is posted on the OHP website and is being promoted.

The OHP 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 Program is doing extensive outreach to Head Start Programs, students in the health care field, such as physician assistant students, etc. providing education regarding the importance of oral health, assessing a young child's mouth for obvious dental problems and application of fluoride varnish.

The Program works to encourage early dental visits and to promote oral health care as an important part of a young child's daily routine.

The OHP continues to work closely with the Utah Dental Association in efforts to increase the number of dentists willing to see Medicaid patients eliminating barriers.

c. Plan for the Coming Year
The Oral Health Program (OHP) will continue to work closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. We will continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. The oral health education material that is posted on the OHP website will be updated and further promoted.

The OHP will collaborate with staff in Medicaid to expand current CHEC outreach programs and promote the CHEC dental case management system. In addition, the OHP will work with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an optional procedure during CHEC well child exams.

The OHP will also continue to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services by identifying and eliminating barriers.

The OHP is in the process of trending utilization data from the Medicaid 416 report. These data will help in identifying counties and local health departments which may need additional technical assistance to address access to dental care for children. The OHP has received funding from the federal Office of Head Start for training and education this year and plans to apply for additional funding next 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	2007	2008	2009	2010	2011
Annual Performance Objective					0
Annual Indicator					
Numerator					
Denominator					
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0	0	0	0	0

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.

Notes - 2010
This is a new SPM identified during 2010 Needs Assessment. State is currently working on developing a new survey tool as a data source for this measure. As a result, no projections are set for this measure.

Notes - 2009
This is a new SPM identified during 2010 Needs Assessment.

a. Last Year's Accomplishments
At this point we do not have a baseline on which to gauge progress in this area. This relatively new State Performance Measure was established in FY2011 based on the MCH Needs Assessment. A review of current surveys to assess developmental screening was done. A survey has been developed for both family practice and pediatric practices to determine the proportion of providers who routinely screen for developmental delays using evidence based tools. A final review of the survey content from external experts has been requested. Optimal delivery methods have been reviewed, discussed and plans developed for distribution of the surveys.

Utah Medicaid is still bundling the well child check and developmental screening codes. Medicaid was made aware of the concerns for unbundling through meetings and discussions. A point person within Medicaid has been identified. TA was included in the FY2011 Block Grant Application to identify other states which have been successful in unbundling these codes.

Baby Watch/Early Intervention (BW/EI) has not implemented state wide ASD screening due to resistance on the part of the BW/EI providers. One EI/BW provider in northern Utah created a two question screening protocol during the intake process which has resulted in improved service delivery for those young children found to be at risk.

The state's ECCS grant provided funding to the Help Me Grow (HMG) program which currently operates in one county in Utah. Help Me Grow is a resource and referral program that has been successful in creating an integrated child and family referral service. The Program incorporates the use of the ASQ (Ages and Stages Questionnaire) developmental screening tools with families. Help Me Grow distributes ASQs to all parents of young children who enroll in the HMG program. HMG helps parents score the questionnaire and shares the results with the child's medical homes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. The Bureau of Child Development reviewed a number of different surveys which have been used in other states to assess if developmental screening was done.			X	
2. Staff developed a Developmental screening survey for providers of health care to young children.			X	X
3. The Bureau of Child Development through its ECCS grant provided funding to the Help Me Grow (HMG) program.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Developmental screening continues to be recognized as an essential process to assure the early and appropriate identification and diagnosis of children with developmental delays.

Surveys to assess the knowledge and use of standardized developmental tools are being finalized. These surveys will be distributed to members of the Utah Chapter of the American Academy of Pediatrics (UCAAP) and the Utah Chapter of the American Academy of Family Practice (UAAFP).

Efforts are continuing to advance discussions with Medicaid regarding the unbundling of the well child and developmental screening codes. The Department is currently working with the United Way agencies in Utah County (where the Help Me Grow program already exists) and Salt Lake County to expand HMG services into Salt Lake County. The eventual goal is to expand HMG statewide.

The medical director of the Division of Family Health and Preparedness has accepted the position of pediatric champion for HMG and will be working closely with the efforts being made around developmental screening. HMG currently provides ASQ (Ages and Stages Questionnaire) developmental screening tools to all families that enroll in HMG. HMG then scores them and shares the results with child's medical homes.

c. Plan for the Coming Year
The Division will share the analysis of developmental screeening survey responses with pediatric medical homes and determine a baseline level of providers performing screenings for future survey results. Results of the survey will be submitted in an article to the UAAP and UAAFP newsletter with encouragement to implement developmental screening tools into practices.

The Division will continue to work with Medicaid on the unbundling of developmental screening codes.

The Division will offer support to Baby Watch/Early Intervention if there is interest on the part of the providers in implementing ASD screening.

The Medical Director at the Division of Family Health and Preparedness will work closely with the Help Me Grow staff to maximize the number of medical homes that receive the ASQ (Ages and Stages Questionnaire) results and will assist in the follow-up process to assure early and appropriate referrals are made.

The Bureau of Child Development's Early Childhood Interagency Coordinator will work with the

Help Me Grow program to develop the plan for the statewide expansion of HMG and to develop opportunities to integrate HMG into more of the Department's early childhood programs and services. The Department believes that HMG has the potential to be an umbrella service that could link multiple early childhood programs and services and integrate them with ongoing developmental screening among other services.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					10.6
Annual Indicator			10.7	10.7	7.8
Numerator			164	164	127
Denominator			1533	1533	1628
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.8	7.7	7.7	7.6	7.6

Notes - 2011
Numerator: YRBS, 2011, survey sample data
Denominator: YRBS, 2011, survey sample data

Notes - 2010
Numerator: YRBS, 2009, survey sample data
Denominator: YRBS, 2009, survey sample data

Notes - 2009
This is a new SPM identified during 2010 Needs Assessment.

Numerator: YRBS, 2009
Denominator: YRBS, 2009

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was to reduce high school tobacco use to 10.6% and the Annual Indicator was 7.8% (Source 2011 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. FY11 television and print ads to prevent youth tobacco use included the Terrie Hall ads that showed the devastating health effects of tobacco use and anti-tobacco ads that focused on tobacco industry manipulation.

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 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. One Good Reason, Utah's statewide anti-tobacco youth group, educated Utahans about new, dissolvable tobacco products that resemble breath mints and strips. The composition, packaging, and flavoring of these products might be particularly appealing to children. One Good Reason also provided peer-to-peer education and grassroots marketing for youth who are increased risk for tobacco use. The TPCP partnered with local health departments to conduct an average of three compliance checks in each tobacco retail outlets. 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 non-compliance and educate retailers about Utah's tobacco access laws, local health departments 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. In 2011, 93% of Utah youth ages 13 to 17 reported that they saw or heard anti-tobacco ads at least once a month during the past six months, and 92% said the TV ads made them think of the negative effects of tobacco use. Since 2002, 19 of Utah's 41 school districts worked with TPCP and local health departments to strengthen tobacco-free school policies, tobacco education, and policy enforcement. These districts serve nearly 200,000 students in 361 schools. Since 2001, illegal tobacco sales to underage youth during compliance checks declined by 64%. At 5.7%, the rate of non-compliance is at its lowest recorded level.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. TPCP used media to counter tobacco industry advertising.			X	
2. TPCP continued to offer tobacco cessation services for youth.		X		
3. TPCP partnered with local health departments and school districts to strengthen tobacco-free policies.		X		
4. One Good Reason, Utah's statewide anti-tobacco youth group, educated Utahns about new, dissolvable tobacco products.			X	
5. One Good Reason also provided peer-to-peer education and grassroots marketing for youth.		X		
6. TPCP partnered with local health departments to conduct compliance checks in tobacco retail outlets.			X	
7. TPCP worked with an independent evaluation team to conduct telephone surveys to evaluate anti-tobacco media campaigns.			X	
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. For television, following national research findings, adult cessation ads that also resonate with youth were selected for the youth media market.

Cessation Interventions: The TPCP offers tobacco cessation services for youth 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 One Good Reason provides peer-to-peer education and grassroots marketing for youth who are 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 select 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 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.

One Good Reason, Utah's tobacco-free youth coalition, will partner with local youth coalitions to form a unified, youth-led statewide coalition model to increase visibility of the youth anti-tobacco movement and assist with tobacco policy change.

Since 2002, more than half of Utah's 41 school districts have participated in efforts to develop comprehensive school tobacco policies. School districts were selected based on high tobacco use rates in their areas. In FY2013, local health departments will resume overseeing policy change with the remaining school districts.

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	2007	2008	2009	2010	2011

Annual Performance Objective	28	25.9	25.9	25.5	25.9
Annual Indicator	25.9	25.9	26.0	26.0	26.7
Numerator	499	499	408	408	450
Denominator	1926	1926	1569	1569	1687
Data Source		See footnote for source	See footnote for source	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26.7	26.6	26.6	26.5	26.5

Notes - 2011
Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2010
Numerator: YRBS, 2009
Denominator: YRBS, 2009

Notes - 2009
Numerator: YRBS, 2009
Denominator: YRBS, 2009

a. Last Year's Accomplishments
The Performance Measure was not achieved. The Performance Objective was 25.9% and the Annual Indicator was 26.7%.

The Utah Department of Health Violence and Injury Prevention Program (VIPP) continued to provide data collection and analysis services on Utah suicides (suicide fatalities, suicide emergency room visits, and suicide hospitalizations). VIPP also developed a state plan for injury in which suicide prevention was a priority for ages 15 to 19 years of age. Staff also participated on the state suicide prevention coalition.

VIPP continued to facilitate the state Child Fatality Review Committee in which the Division's Medical Director also attended and participated.

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.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. VIPP provided data collection and analysis services.				X
2. VIPP developed a state plan for the prevention of suicide for ages 15 to 19.			X	
3. VIPP facilitated the state Child Fatality Review Committee.			X	
4. Utah NAMI continued to provide the Hope For Tomorrow Program.				X
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
The Violence and Injury Prevention Program (VIPP) continues to provide data collection and analysis services, as well as develop a plan to prevent youth suicide among ages 15 to 19. VIPP continues to participate on the Utah Suicide Prevention Council. A school health consultant was hired during this fiscal year and serves on the Child Fatality Review Committee and the Utah Suicide Prevention Council.

c. Plan for the Coming Year
VIPP will co-chair the Utah Suicide Prevention Council with the Youth Suicide Specialist at the Department of Substance Abuse and Mental Health. VIPP will also participate on the Policy subcommittee of the Council. The Council will finalize a new state plan for the prevention of suicide. VIPP will continue to provide data collection, analysis and fact sheet publication and dissemination.

VIPP will continue to facilitate the Child Fatality Review Committee (CFRC) and make recommendations on the reviews of youth suicides. Additionally, the Divisions' Medical Director over CSHCN/MCH/CD will attend and participate on the CFRC.

State Performance Measure 8: *Percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past 7 days.*

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					47.5
Annual Indicator			47.3	47.3	48.5
Numerator			744	744	811
Denominator			1572	1572	1672
Data Source			See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	48.5	48.6	48.6	48.9	48.9

Notes - 2011
Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2010
Numerator: YRBS, 2009
Denominator: YRBS, 2009

Notes - 2009
This is a new SPM

Numerator: YRBS, 2009
Denominator: YRBS, 2009

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 47.5% and the Annual Indicator was 48.5%.

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. Willy Lanier, the EIS Field Officer from the CDC, conducted an assessment with GMS. The purpose of this study was to determine the factors that are associated with teacher awareness of policies and the factors that are associated with implementation. This assessment was on active GMS that had achieved the Gold level. Two policies were selected to determine policy awareness. The two policies were the Bronze #1: Structured Physical Activity Policy, and Gold #2: Non-Food Rewards Policies. Based on information gathered from the study the following recommendations have been given to improve teacher awareness and implementation of policies:

- Staff educated principals and teachers about childhood obesity epidemic.
- Staff involved teachers in the development of policies.
- Staff promoted the concept that principals should tell teachers it's a priority.
- Staff promoted the concept that School Coordinators should remind teachers at least once per semester about policy content and location

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 the third week of April 2011, the PANO program participated in the Unplug n' Play and the National TV Turn Off Week projects. Information was shared with Parent Teacher Associations. The 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 2010 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) brings partners together to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies. In FY11, the PANO school workgroup was immersed into AFHK to strengthen the efforts with partners. AFHK completed activities in the PANO strategic 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 PANO program promoted increased healthful eating among Utah youth through the Gold Medal Schools program.			X	
2. The PANO program promoted regular physical activity among Utah youth through the Gold Medal Schools program, Unplug n' Play, National TV Turn Off Week, and Walk to School Day.			X	
3. The PANO program monitored the prevalence of youth obesity by participating in the Youth Risk Behavior Survey.				X
4. The PANO program oversaw the Gold Medal Schools program.		X	X	
5. The PANO program participated in the Action for Healthy Kids coalition.				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The Utah Department of Health (UDOH), Physical Activity, Nutrition and Obesity Program (PANO) continues to work on programs to promote increased healthful eating and regular physical activity to prevent and control obesity and other chronic diseases among Utah youth. Most of the PANO program activities target policy, systems, and environmental changes at the state level, but also provide technical assistance to local health departments to implement community-level specific change, supported by individual behavior change programs.

The following activities are being implemented. (1) The Gold Medal School Program continues to help elementary schools establish policy and environmental policies that enable students and staff to be physically active and eat healthful food. (2) The "Unplug 'n Play" program encourages students and their families to limit TV and other screen time to less than two hours per day. (3) Walk to School Day encourages students and their parents to walk to school safely. (4) Body mass index trends are tracked in a sample of elementary students to see how Utah students compare to national students. (5) The Action for Healthy Kids coalition continues to work towards improving the nutrition and physical activity environments in Utah's schools. (6) The Utah Elementary School Height and Weight Measurement project continues. All planning activities were completed and the actual weighing and measuring of students started in January 2012.

c. Plan for the Coming Year
The Utah Department of Health (UDOH), Physical Activity, Nutrition and Obesity Program (PANO) will continue to work on programs to promote increased healthy eating and regular physical activity to prevent and control obesity and other chronic diseases among Utah youth. Most of the PANO program activities will center on policy, systems, and environmental changes at the state level, but also provide technical assistance to local health departments to implement community level specific change, supported by individual behavior change programs. The following list of activities represents those that will continue to be implemented.

(1) The Gold Medal School Program will continue to help elementary schools set up policy and environmental supports that make it easier for students and staff to be physically active and eat healthy food. This program is designed to create policy and environmental changes to support behavior change. Schools voluntarily participate in the program, and to date 390 schools from 39 out of 41 districts have participated in some manner. The UDOH partnered with the Utah State Office of Education, the Utah Parent Teacher Association, Intermountain Health Care, and Action for Healthy Kids in the development and implementation of this program.

(2) The "Unplug 'n Play" program will also continue to be implemented. This program encourages students and their families to limit TV and other screen time to less than two hours per day. Recent years have included contests between schools to track the greatest proportion of students who turned off their television for a week, and surveys of school media use policies.

(3) Walk to School Day will be promoted in October to encourage students and their parents to walk to school safely. The goal is to encourage regular walking or cycling to school throughout the year, but the UDOH has recently begun partnering with the Utah Department of Transportation to promote Walk More in Four, a program to promote walking in the four weeks prior to International Walk to School Week/Day.

(4) Height and weight trends will be tracked in a sample of elementary students to see how Utah students compare to the U.S. Students in selected schools within the 1st, 3rd, and 5th grades. This evaluation will identify Utah specific childhood obesity data that is representative of elementary school students statewide.

(5) The Action for Healthy Kids coalition will continue to meet with the goal to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	12	12	12	11	5.5
Annual Indicator	11.1	10.6	10.4	5.2	4.0
Numerator	2371	2333	2305	1190	1083
Denominator	21362	21978	22080	22745	26880
Data Source		See footnote for source	See footnote for source	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4	4	4.1	4.1	4.1

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.

Notes - 2010
Numerator: The number of children served in the rural area based on the Mega West billing system, 2010.
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

Notes - 2009
Numerator: The number of children served in the rural area based on the Mega West billing system, 2009
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 5.5% and the Annual Indicator was 4.0%.

Flat Federal funding, drastic State budget cuts and an increasing rural population continued to present major challenges in maintaining service delivery and achieving the performance measure. Budget issues led to the need for staff reductions and an inability to maintain the same level of service as previous years. Although good portions of some services were cut, special attention was given to determining the most effective changes and cuts to make, in order to ensure the continued service provision of the most viable types of care in the most underserved areas. Despite these funding problems, efforts were made to continue to focus on providing the highest level of care possible to the children in rural areas of Utah. The Bureau of Children with

Special Health Care Needs (CSHCN) continued contractual agreements with local health departments and with Intermountain Health to provide clinics at six different sites throughout the state. The contracts provided for RN nurse care coordinators and clerical support staff to schedule clinics, manage care coordination services, arrange tests, collect reports and maintain and manage patient charts, as well as office and clinic space. CSHCN provided training and support in the areas of care coordination, patient and chart management, community and tele-health staffing procedures, and workload management. CSHCN continued to provide ongoing support and training in regard to client database software, as well as billing programs used by the local sites to manage scheduling and patient information, in addition to chart tracking and management procedures and protocols. Contracts with the Department of Pediatrics, at the University of Utah Hospital were renegotiated and extended to provide consistent pediatric, sub-specialty evaluation services for these clinics as well.

The Bureau continued the use of our referral form, available on-line, to be used to solidify close coordination with primary providers. CSHCN was able to maintain its efforts to support the statewide Medical Home effort, and provided close contact and coordination with local primary care medical home providers surrounding optimal care for children. The Bureau continued to support and facilitate collaboration and coordination between the rural clinics, pertinent CSHCN programs and ancillary agencies often involved the special populations served by the clinics, which included Neonatal Follow-up Program, Specialty Services; Fostering Healthy Children and Baby Watch Early Intervention programs. CSHCN continued it's agreement with Intermountain Health, the primary health care provider in the State, to allow for access to their electronic health records (EHR) system, in addition to selecting a viable EHR system to be implemented in clinics statewide over the next year.

CSHCN continued its provision, albeit on a smaller scale due to staff reductions, of long-distance clinical health care and community staffing using tele-health videoconferencing technology in place through established video conferencing networks, thus, enhancing and supplementing services to rural children with special needs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN engaged in strategic planning and reorganization of Bureau staff and resources in response to drastic State budget reductions.				X
2. CSHCN continued contractual agreements to provide clinics at six different rural sites.				X
3. Local RN and office support staff provided clinic coordination, scheduling, management, chart maintenance, and follow-up for each clinic.		X		X
4. CSHCN continued support and training for all outlying staff covering care coordination, patient and chart management, community and tele-health staffing procedures and general clinic management.		X		X
5. CSHCN continued to support and assist local clinics in coordination with the statewide Medical Home effort, other pertinent CSHCN programs, and care management efforts with local primary care providers.		X		X
6. CSHCN maintained ongoing use of referral form available on-line, to better facilitate communication and coordination with primary health providers.		X		X
7. CSHCN continued an agreement to gain access to electronic medical records maintained by the primary health care system in				X

the State.				
8. CSHCN selected an appropriate EHR to implement in its clinics statewide.				X
9. CSHCN continued use of tele-health technology to provide long-distance care, coordination and staffing, optimizing the care for rural children with special needs.	X			
10.				

b. Current Activities
State budget cuts and flat Federal funding continues to take a toll on abilities to provide services to the rural communities. Even with staff and service reductions, CSHCN Bureau is continuing its efforts to provide optimal care and services to rural children with special health care needs through specialty clinics and tele-health technology.

CSHCN contracts with local health departments and other agencies to conduct itinerant clinics in six sites in the state. Close scrutiny of the need for, and provision of, clinical services continues to support changes leading to greater efficiency and cost-containment. In response to tightening funding from all sources, the Bureau is set to embark on a more targeted strategic planning effort, in May 2011, to focus on maximizing our provision of services to the most needy of children and families. Additionally, joint efforts with our contract partners are being made to facilitate greater efficiency and production thru those collaborations.

Through the use our on-line referral form, CSHCN continues to promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, working with local primary care medical home providers to coordinate the care and access to resources for children. To ensure better care coordination, increased access to private electronic health (EHR) records was continued, along with the formal adoption and implementation of our own EHR system, CaduRx, in all of our clinics.

c. Plan for the Coming Year
Flat Federal and State funding, combined with an increase of population in some rural area and a on-going shortage of pediatric sub-specialists, continues to present challenges in providing needed care for Utah's Special Needs Children. Regardless of the loss of staff and services due to these challenges, the Bureau of CSHCN will continue to contract with local health departments and other entities to conduct itinerant clinics in six sites across the state. CSHCN will continue ongoing needs assessment and targeted strategic planning in order to evaluate the need for, and to maintain the services most in demand at those sites with increasing populations. Further exploration of consolidation of clinic sites that only serve a small population of children will continue. Through these contracts, local registered nurse care coordinators and clerical staff will schedule and conduct clinics, provide care coordination services, arrange tests, collect reports and maintain medical charts. CSHCN will provide ongoing consultation and support on care coordination issues to contract staff, along with training in these areas. CSHCN looks to implement a new electronic health records (EHR) system used at each site to schedule clinics, collect patient data, records maintenance and billing, providing all pertinent staff training, assistance and consultation as needed.

CSHCN will promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, and will work closely with local primary care medical home providers to further enhance our referral process and use of the referral form to better coordinate the care and access to resources for children. Additionally, rural nurses will continue to collaborate, and be assisted in doing so, with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children Program and Specialty Services. These efforts will provide opportunities for community providers to join and interact with CSHCN clinical staff regarding specific care management issues. An ongoing Quality Improvement process will be continued as well.

The CSHCN Bureau will continue its efforts to provide optimal care and services to rural children with special health care needs through tele-health technology, looking to expand in this area as a cost saving method. Collaboration and contracting with entities from the University of Utah will be renegotiated to optimize the use of their sub-specialists at our clinics. Additionally, CSHCN, along with implementing our own EHR, will increase it efforts to collaborate with the CHARM, UHIN, CHIE and private EHR entities to move toward clinical information sharing between viable systems.

State Performance Measure 10: *The percentage of children (birth -17) eligible for Medicaid DM who are eligible for SSI.*

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					85
Annual Indicator			75.0	92.5	92.5
Numerator			3821	4899	4899
Denominator			5093	5295	5295
Data Source			See footnote for data source	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	92.5	92.5	92.5	93	93

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.

Notes - 2010
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.

Notes - 2009
This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Medicaid Report: PACMIS MR655 Part D, Utah Cases Served Statewide by Program Type and eREP Report ER-M-MP 650 Statewide Served by Benefit Type, “Number of CHILDREN served by Program combined DWS, DHS and Health”.

Denominator: SSA, Social Security Record (Characteristic Extract Record Format), 100% Data

“Number and percentage distribution of children in Utah receiving Federally Administered SSI payments, by selected characteristics, Dec 2009”.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 85% and the Annual Indicator was 92.5%.

In 2010, CSHCN conducted a survey of over 1000 Utah families of children and youth with special health care needs. The survey collected information from families about the challenges, barriers and needs in supporting their child with special needs. Review of the data showed that financing of health care was one of the families' top needs and concerns. Information from the data collected has been used to further develop training, information and education provided by the Utah Family to Family Health Information Center and the Family Involvement and Leadership Program about resources for funding of health care services including the potential eligibility for the Medicaid disability category.

Many families have a commercial or private insurance plan but the restrictions on the amount or scope of benefits create many unmet needs for families with children with special health care needs. Comprehensive health coverage for a child with special needs is critical to identify health problems early, prevent deterioration of health and maximize the child's potential to survive and thrive. Utah Family Voices' Family to Family Health Information Center provides general information about the Medicaid disability category and eligibility criteria are provided by to families who contact the center for information about concerns with health care financing issues.

The Utah Family Involvement and Leadership Program was established in the CSHCN Bureau which combined many activities of Family Voices and the Bureau to expand limited resources. The program director and parent partners reviewed and collected existing information and education for families about SSI and the Medicaid disability category. Informational materials are continually updated to be consistent with policies of the Medicaid program, the Social Security Income program, Disability Determination Services and the Affordable Care Act.

Handouts on Disability Medicaid and EPSDT were handed out across the state through information fairs, workshops and conferences. All parent intakes involve asking the families about coverage and potential eligibility for Medicaid D or the Spend down program. Presentations were made to both families and professionals about all health care financing options in addition to public health programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Involvement and Leadership Program updated Medicaid D and EPSDT fact sheets.		X		
2. Family Involvement and Leadership Program developed a presentation on Health Care Reform Impact on CSHCN		X		
3. Family Involvement and Leadership Program disseminated fact sheets and other relevant health care financing materials at agency fairs, workshops and conferences. (July 01, 2010 - June 30, 2011).		X	X	
4. Family Involvement and Leadership Program screened incoming intake calls from families for potential eligibility of Medicaid.		X		
5. Family Involvement and Leadership Program provided one-on-one support to families filling out public health care eligibility applications.		X		

6.				
7.				
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b. Current Activities
The staff at the Bureau of CHSCN and Utah Family Voices have continually reviewed and revised fact sheets and other materials to provide accurate information at display booths through the state at ongoing health fairs provided for families of children with disabilities and special health care needs.

The information is being provided through the various workshops for families and professionals about the resources that exist for health care financing. Presentation at statewide conference includes key information about Medicaid and SSI, focusing on the disability category and the link between the potential eligibility of both of the programs to help meet the health care needs of children.

Key information about the disability category of Medicaid will be included in newsletters of the Family to Family Health Information Center as well as the partner disability and advocacy organizations. Updated information on health care financing including Medicaid Disability education was placed on the Family pages of the Medical Home Portal. The information is being share with participating Medical Home projects in the state and to the multidisciplinary trainees involved in the Utah Regional Leadership Education in Neurodevelopmental Disabilities program to educate about the needs and potential resource for the families they serve.

The importance of Medicaid for families of children with complex and chronic conditions is added to all workshops and presentations given by family staff.

c. Plan for the Coming Year
Utah Family Voices will provide information and education to families about effective record keeping in efforts to help the Medicaid Review Board determines the eligibility of their child. The staff at the Bureau of CSHCN and Family Voices will include information about getting interpretation for families who not speak English or who are deaf and refer to the available application in Spanish.

The staff will work with the Department of Workforce Services in identifying community intake workers that have extensive knowledge about the Medicaid disability category. Identifying key intake workers throughout the state will enable families to get timely, accurate information to complete application to assist with the potential eligibility of essential services for children with special health care needs.

Additional newsletters with education about Medicaid Disability, Social Security Income and other relevant public and private health care resources will be distributed in collaboration with disability groups and organizations, especially those groups focusing on Autism in efforts of helping more children access health care and covered therapies. Information developed will be shared with Parent Partners in the Medical Homes and Specialty Clinics to distribute to their relevant patient's families.

Information will be developed and shared with the Office of Health Disparities Reduction to build partnerships in developing effective outreach and education to families with different cultural and linguistic needs. Additional materials will be adapted and provided in Spanish to share with families in CSHCN clinics, Medical Homes and support groups in the Hispanic community.

Utah Family Voices will collect data from families calling for information about Medicaid and

conduct a focus group of family experiences applying for Medicaid and SSI to identify challenges and barriers. The data will be shared with the Department of Workforce Services and the Medicaid advisory committee to address possible solutions.

The Family Involvement and Leadership, Utah Family Voices Director will participate in the Utah Department of Health Strategic Planning workgroups to provide solutions and expertise from a family perspective and the perspectives of families of children with special health care needs throughout the state.

E. Health Status Indicators

HSI #01A
The percent of live births weighing less than 2,500 grams.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Utah saw no change in the percentage of low birth weight (LBW) births in 2010 at 7.0%. Utah remains below the national rate for LBW births (8.2%) and has met 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. However, Utah was one of the recipients of MCHB's "First Time Motherhood/New Parent Initiative" funding awards which enabled the program to implement the "Power Your Life" preconception social marketing campaign. In addition, Utah 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?
The "Power Your Life" social marketing campaign kicked off in July 2010. The campaign targets young women in Utah (special emphasis on younger, racial/ethnic minority women) with important preconception messages. The focal point of the campaign is an interactive website where women can learn about how to achieve optimal health before they conceive. Mass media messages were implemented to drive the target audiences to the website. There is abundant recent research indicating the link between optimal preconception health and improved pregnancy outcomes. In addition, contracts for Abstinence Education and Comprehensive Teen Pregnancy prevention programs 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:
The percent of live births weighing less than 2,500 grams in Utah has increased slightly over the past decade (2000-6.7% to 2010 7.0%). Several subpopulations of Utah women have higher rates; for example younger and older women experienced high rates of LBW; women aged 15-19 had a rate of 7.9% in 2010, women over 35 years or older had a rate of 9.0% compared to women age 20-34 years (6.7%). In addition, Utah Hispanic women had a rate of 7.4% in 2010 compared to non-Hispanic women (6.9%). Lastly, Utah women of color experienced higher rates of LBW than Utah White women (6.8%): Black (11.3%), American Indian (7.3%), Asian (9.6%), Hawaiian or Other Pacific Islander (11.3%).

HSI #01B
The percent of live singleton births weighing less than 2,500 grams.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Please see HSI #01A a.

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 alphahydroxyprogesterone (17P) beginning in the second trimester of a singleton pregnancy for women with a history of previous preterm birth. The Maternal and Infant Health Program (MIHP) has worked with multiple partners over the past year to promote the use of 17P for the prevention of recurrent preterm birth in singleton pregnancies. Pregnant women who have had a previous spontaneous preterm birth, particularly in the immediate preceding pregnancy, should be offered progesterone supplement beginning at 16-20 weeks of gestation. The MIHP continued its campaign to increase awareness among women who have delivered a preterm infant about the option for progesterone supplementation (17P). Information cards were disseminated across the state. The same information was placed on the MIHP website.

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 (2000-5.2%, 2010-5.3%). However, the percentage of multiple births in Utah has risen slightly over the past decade (2000-2.8% to 2010-3.2%). A Utah PRAMS data report indicates that from 2004 to 2008, among women with ART and women who used ovulation stimulation, the rate of LBW infants were 21.0% and 9.9% respectively. The increased use of these treatments is likely a contributing factor to the rates of LBW births.

HSI #02A
The percent of live births weighing less than 1,500 grams.

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%, 2010-1.1%).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. Several years ago the Department considered a legislative funding priority for a program targeting women who delivered a VLBW birth during the interconception period with case management and intensive interventions to reduce her risks of having a repeat VLBW birth. The concept did not make the Department's final list of funding priorities due to budget shortfalls during the economic downturn.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
Utah was granted First Time Motherhood/New Parent Initiative funding from HRSA's MCHB to implement a social marketing campaign about the importance of preconception health to healthy birth outcomes. The campaign, "Power Your Life, Power Your Health" kicked off in July of 2010 with TV and radio advertisements, an interactive website and dissemination of educational materials at community cultural events. The centerpiece of the campaign is the website where women can enroll to receive free vitamins and access a reproductive life planning tool. It is hoped that addressing wellness and reducing risks prior to pregnancy will decrease our rates of VLBW and LBW in Utah.

c. 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; women aged 15-17 (1.83%) and those aged 40-44 (1.89%) had the highest VLBW rates. Women who report a pre-pregnancy BMI in the obese category experienced significantly higher rates of VLBW births (1.4%) compared to women in the normal pre-pregnancy BMI category (0.91%). Women who reported smoking during pregnancy had twice the rate of women who did not (2.17% vs. 1.04%). Lastly, Black women (3.07%) and Pacific Islander women (2.91%) had rates nearly three times higher than White women (1.06%). The largest percentage of VLBW births is seen in twin gestations with a VLBW rate of 7.6%. However, while the number of higher order multiple live births is quite low (2010 triplets n=66), the rate of VLBW births are significantly higher at 50.0%. Utah PRAMS data (2008) indicate that approximately 34% of twin gestations and 100% of higher order multiple births were conceived through assisted reproductive

technologies.

A high percent of VLBW infants do not survive. The 2009 birth weight specific mortality rate for VLBW infants was 249.1/1000 births. The biggest risk for mortality is in infants under 500 grams as evidenced by the mortality rate of 907.9/1000 births. The largest percentage of VLBW infant deaths is due to Perinatal Conditions (n=109). These cases are reviewed in our Perinatal Mortality Review Program and findings from reviews indicate that major contributors include an array of social determinants of health.

HSI #02B
The percent of live singleton births weighing less than 1,500 grams.

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?
The previously mentioned interventions to promote the use of 17P and the importance of preconception health through the "Power Your Life" campaign are hoped to have an effect on the rates of VLBW births as well as the LBW births.

c. Interpretation of what the data indicate:
The percent of singleton live births weighing less than 1,500 grams in Utah has remained relatively stable over the past decade (2000-0.82%, 2010-0.84%). Risk factors for VLBW singletons mirror those of all VLBW infants.

HSI #03A
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Utah has 13 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP). LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing injury among children.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
Safe Kids is continually looking to attract new partners with similar goals for ages birth -14. Allied partners, outside of state/local government, have also been helpful when advocating for new laws and when bills are introduced in the legislature.

The VIPP has produced a Small Area Injury Report that breaks down death, hospitalization and ED data further within local counties for leading causes of unintentional injuries.

c. Interpretation of what the data indicate:
Utah's mortality rate of unintentional injuries to children has decreased 28% since 2005, from 10.02 per 100,000 (2005) to 6.41 per 100,000 (2010), though there are too few each year to determine statistical significance. This decrease can be attributed to new laws and educational campaigns. However, Utah also gathers Emergency Department data and hospitalization data which continue to give partners a good understanding of where problems exist.

HSI #03B

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Utah has 13 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing motor vehicle related deaths and injury among children.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
Safe Kids is continually looking to attract new partners with similar goals for ages birth -14. Allied partners, outside of state/local government, have also proven to be helpful when advocating for new laws and when bills are introduced in the legislature.

c. Interpretation of what the data indicate:
Utah's mortality rate of child motor vehicle fatalities has decreased 52% since 2005, from 4.64 per 100,000 (2005) to 2.0 per 100,000 (2010), though numbers are too small to determine statistical significance. This decrease can be attributed to new laws and the combined educational campaign efforts of all the partners. However, Utah also gathers ED data which, combined with hospitalization data, continue to give partners a good understanding of where problems exist. The VIPP has produced a Small Area Injury Report that breaks down data further within local counties for leading causes of MV related fatalities.

HSI #03C
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

a. What has influenced the program's ability to maintain and/or improve the HSI?
The Utah Teen Driving Safety Task Force, co-chaired by staff from the Violence and Injury Prevention Program, was formed in 2007 to better coordinate activities and resources of the many partners. Local health departments, law enforcement, highway safety, children's hospital, youth groups, and many other partners, have worked hard to educate teens and get them to adopt safe driving behaviors that they will continue to practice as they get older. This focus on teen drivers has also been a priority for local health department contracts with the UDOH for over five years.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
The Utah Teen Driving Safety Task Force continues monthly meetings to better coordinate activities as well as resources. The Task Force tries to provide a different approach or twist to the annual Don't Drive Stupid Campaign in order to engage more teens. This year a teen video and poster contest for a PSA was conducted and the Teen Memorial booklet was distributed statewide to Driver's Education Classes.

c. Interpretation of what the data indicate:
Utah's rate of motor vehicle fatalities for those aged 15-24 has decreased 45%, from 16.8 per 100,000 (2007) to 9.14 per 100,000 (2010) since 2007 when the Utah Teen Driving Safety Task Force was formed. That is a statistically significant decrease, despite a small number of deaths each year. This decrease can be attributed to the combined efforts of the partners in a statewide educational campaign and changes in laws.

HSI #04A
The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Utah continues to be one of the states with the highest number of young children per family. LHD contracts require an active role in the Safe Kids coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing injury among children. Work continues to address this trend with the Safe Kids Coalitions/Chapters around the state despite level funding over this same time period. Annual educational efforts and advocating for changes in laws continue to remain the focus for ages birth-14.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
Safe Kids is continually looking to attract new partners as well as funding to address the needs of those aged birth-14. The VIPP has produced a Small Area Injury Report that breaks death, hospitalization and ED data down further within local counties for leading causes of unintentional injuries.

c. Interpretation of what the data indicate:
The non-fatal rate of injuries among children has decreased since 2001. During that 9 year time period the rate of non-fatal injuries among children has decreased 31%, from 898 per 10,000 in 2001 to 616 per 10,000 in 2009 (based on combined hospital discharge and ED data). A decrease in the rate was also observed since 2007 based on hospital discharge data alone (139.2 (2007) to 116.9 (2010) per 100,000).

HSI #04B
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Utah leads all states with the number of young children per family. Utah has 13 active Safe Kids Coalitions or chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages birth-14 and their families. Despite level funding during this time period, Safe Kids members have been good advocates for any necessary changes in laws focused on preventing injury among children; they have also been crucial in protecting the booster seat law from attempts to weaken it.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
The UDOH, Safe Kids, and other traffic safety partners are continuing to improve MV related safety. Efforts include educating on the value of a primary seatbelt law for all ages and educating on the importance and impact of the booster seat law in order to defend against threats to weaken the booster seat law.

c. Interpretation of what the data indicate:
Utah has seen a decrease in the non-fatal MV rate of injuries to children since 1999. During that 11 year period, the rate of non-fatal MV injuries has decreased 46% from 501.7 per 100,000 in 1999 to 269.3 per 100,000 in 2009 (based on combined hospital discharge and ED data). The rate of non-fatal MV injuries for ages 0-14 decreased 22% between 2009 and 2010 (19.4 to 14.8 per 100,000 respectively based on hospital discharge data only).

HSI #04C
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

a. What has influenced the program's ability to maintain and/or improve the HSI?
The Utah Teen Driving Safety Task Force, co-chaired by staff from the Violence and Injury Prevention Program, was formed in 2007 to better coordinate activities as well as resources of the many partners. Local health departments, law enforcement, and many other partners have worked hard to educate teens and young adults to adopt safe driving behaviors. A focus on teen drivers has also been a priority in local health department contracts with the UDOH for over five years. All participating partners are operating under one slogan and outreach campaign.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
The Utah Teen Driving Safety Task Force continues monthly meetings to better coordinate activities as well as resources. The Task Force tries to provide a different approach or twist to the annual Don't Drive Stupid Campaign in order to engage more teens. This year a teen video and poster contest for a PSA was conducted and the Teen Memorial booklet was distributed statewide to Driver's Education Classes.

c. Interpretation of what the data indicate:
The non-fatal rate for MV injuries for those aged 15-24 has decreased significantly since 1999. During that 11 year period, the non-fatal MV injury rate decreased 50%, from 2,400 per 100,000 to 1,200 per 100,000 for those aged 15-24. Using hospital discharge data alone there was a 10% a decrease from 70.9 per 100,000 in 2009 to 62.5 per 100,000 in 2010.

HSI #05A
The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff within the Bureau of Epidemiology has improved services with a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community. The Utah Department of Health coordinates with public and private providers offering STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 and 20-24. The Centers for Disease Control funding for prevention, testing, treatment, and local health department support remains steady.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
This indicator assists UDOH programs in monitoring trends in rates, which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Changes in organization at UDOH provide new opportunities for collaboration between programs. As programs continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections that other programs and staff have already made, as well as strengthen our efforts to reach these populations statewide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c. Interpretation of what the data indicate:
Data for 2011 indicate a Chlamydia rate of 14.6 per 1,000 females aged 15 through 19 years old, a 2.8% increase since 2010 when the rate was 14.2 per 1,000 females aged 15-19 years old. The 2011 case increase may be due to several reasons, including data management issues that have not been identified and a possible increase in Chlamydia testing.

This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends.

HSI #05B
The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

a. What has influenced the program's ability to maintain and/or improve the HSI?
Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff and duties within the Bureau of Epidemiology have improved services. There is now a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community. The Utah Department of Health coordinates with public and private providers offering STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 and 20-24 years of age.
The Centers for Disease Control funding for prevention, testing, treatment, and local health department support remains steady.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?
This indicator assists UDOH programs in monitoring trends in rates which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Changes in organization at the UDOH provide new opportunities for collaboration between programs. As programs continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections other programs and staff have already made, as well as strengthen our efforts to reach these populations statewide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c. Interpretation of what the data indicate:
Data for 2011 indicate a Chlamydia rate of 6.2 per 1,000 females aged 20 through 44 years, a 7% increase from 5.8 per 1,000 females aged 20-44 years in 2010.

This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends.

F. Other Program Activities

The State Title V agency is involved in many activities that address the needs of mothers and children in the state. With the reorganization of the Department, we have new opportunities to integrate programs that serve mothers and children, to explore new opportunities and to develop new relationships internally and externally. Many of the activities that we engage in have been

described in other sections of the Annual Application and Report and the Five Year Needs Assessment documents.

/2012/ We focus on areas of MCH that are not necessarily included in the Performance Measures or our state priorities, such as preconception health and health care, promotion of healthy spacing between pregnancies, review of maternal mortality cases, school health, and others. We are concerned about the lack of focus on the health of mothers because the main focus seems to be on infants. We promote the importance of the mother's health as it directly relates to her own health status, but also the health of any 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//

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//

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//

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 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	6013353	4988285	5967609		6238800	
2. Unobligated Balance *(Line2, Form 2)*	1424947	2457000	2521991		2152885	
3. State Funds *(Line3, Form 2)*	12431500	12551600	12581700		11571700	
4. Local MCH Funds *(Line4, Form 2)*	4337379	2432253	3257004		2432253	
5. Other Funds *(Line5, Form 2)*	11254500	9059900	10259000		8620000	
6. Program Income *(Line6, Form 2)*	6542100	6392300	6404800		7999700	
7. Subtotal	42003779	37881338	40992104		39015338	
8. Other Federal Funds *(Line10, Form 2)*	56604500	60151100	60298300		61386400	
9. Total *(Line11, Form 2)*	98608279	98032438	101290404		100401738	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	5894708	5624234	5870240		5908287	
b. Infants < 1 year old	6318827	7453764	5910108		5521947	
c. Children 1 to 22 years old	12667704	8056320	11751736		10297338	
d. Children with	15484711	15129556	15726864		15693160	

Special Healthcare Needs						
e. Others	664829	419380	575156		421606	
f. Administration	973000	1198084	1158000		1173000	
g. SUBTOTAL	42003779	37881338	40992104		39015338	
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	89500		95000		90000	
c. CISS	104100		124000		0	
d. Abstinence Education	0		319000		343600	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	45088500		49939600		49698600	
h. AIDS	0		0		0	
i. CDC	1382100		1293300		1191000	
j. Education	8432900		8527400		6990400	
k. Home Visiting	0		0		0	
k. Other						
Other	0		0		3072800	
See Notes	1507400		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	10036795	9284467	9742362		10067046	
II. Enabling Services	18134409	16170389	17510487		15923520	
III. Population-Based Services	5575435	4227188	5253125		4539187	
IV. Infrastructure Building Services	8257140	8199294	8486130		8485585	
V. Federal-State Title V Block Grant Partnership Total	42003779	37881338	40992104		39015338	

A. Expenditures

Please see notes related to each Form.

B. Budget

The Division of Family Health and Preparedness (FHP) is organized to address specific maternal and child health needs through a partnership between State agencies and the public and private sector to form a coordinated statewide system of health care. FHP's Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year (July 1 -- June 30).

The amount of state funds that will be used to support Maternal and Child Health programs in

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 $11,571,700 of state funds appropriated by the Legislature for MCH activities. A total of $7,999,700 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of $6,293,763. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and combined with other federal and private funding to expand and enhance MCH programs and activities. Programs including Pregnancy Riskline, Fostering Healthy Children, and Baby Watch/Early Intervention, benefit from this use of the state funds. FHP receives private funding which is used to enhance selected programs or projects such as WEE Care and Pregnancy Riskline. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities

FHP assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

FHP will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

FHP will allocate funds under this title fairly among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. There are a number of program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as WIC, Newborn Screening, and Baby Watch/Early Intervention.

The Department negotiates contracts with each of the twelve local health departments encompassing many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and perinatal, sudden infant and childhood death tracking. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff 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.

The FY2013 state budget for FHP was held static but was reduced by just over $120,000 in FY2012. This cut is in addition to the $1.4 million cut taken the previous year. The FY2012 reductions primarily impact the Division's administrative programs. Included in this cut was

$44,400 to Head Start which results in the loss of the federal Head Start Collaboration grant. Despite the ongoing budget challenges, the Division continues to allocate all available resources (MCH Block Grant funds, state funding, Medicaid, other private and public grants, and local funds) to most effectively address the changing maternal and child health needs throughout the state.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.