



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

**State Narrative for
Utah**

**Application for 2011
Annual Report for 2009**



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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.

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, 2010. The State Title V Office has on file a copy of the Assurances and Certifications non-construction program, debarment and suspension, drug free work place, lobbying program fraud, and tobacco smoke. They are available at any time for review upon request. The state Title V agency is compliant with all the federal regulations governing the Title V funding allocated to Utah.

D. Table of Contents

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

E. Public Input

Public input is a valued part of the annual MCH Block Grant application process. In April 2010, the Maternal and Child Health (MCH) bureau announced to the public through newspaper announcements, internet, email messages, and other mechanism that the Utah Department of Health, Division of Family Health and Preparedness was soliciting public input for FY11 MCH Block Grant.

It was explained in the announcement that the Division of Family Health and Preparedness is responsible for administration of the MCH Block Grant received by the State of Utah under the provisions of Title V of the federal Social Security Act. Under this capacity, the Division is required annually to submit an application to the U.S. Department of Health and Human Services. Public notices published in major newspapers throughout the state made it known that the proposed program activities related to annual goals for the Fiscal Year 2011 MCH Block Grant Application were available for public review and comment.

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 2011 Annual Goals webpage which outlined the proposed activities for each goal. This year significant modifications were done on the website to enhance the webpage look and to make it user friendly. We changed graphical user interface for easier user experience. Emails with web URL were sent to specific stakeholders including: parents, consumers, health care providers, academia, community-based advocacy organizations, local health departments, community health centers and various government agencies requesting input and feedback. The online comments were accepted from April 26 to May 20, 2010. During this time, the MCH Block Grant website had 337 page views.

We also prepared public comment announcement flyer to spread the news. The UDOH news

media person reviewed and approved the content of the flyer. This notification was posted on the Utah Department of Health (UDOH) employee intranet, Dohnet, which is available to approximately 1,300 employees. To increase public awareness about MCH program activities, we additionally requested Center for Multicultural Health Office staff to add the public comment announcement in their on-line newsletter Connections. Flyers requesting input were posted throughout the UDOH Building.

All input received was compiled in a document and shared with the core program staff responsible for individual National and State Performance Measures to consider for incorporation in the final 2011 Annual Plan. Comments were incorporated into the plan as appropriate.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

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

MCH Needs Assessment Leadership Team

The Needs Assessment Leadership team consisting of the Title V Director, CSHCN Director, MCH/CSHCN/CD Medical Director, program staff, MCH Epidemiologist and a parent advocate, reviewed the data from the performance measures, health status indicators and health system capacity indicators and data specifically collected through surveys and key informant interviews.

Needs Assessment Methodology

The FY2011 - 2016 needs assessment is based on multi-faceted approach consisting of three major components: 1) review of literature of needs assessment methodologies, 2) review of survey reports and trend data for all performance measures and indicators, and 3) collection of new data from stakeholders, parents and key informants using surveys and interviews. Utah's needs assessment process included both quantitative and qualitative data.

After review of a number of processes, the needs assessment leadership team decided to use some of its previous processes and some different methods to enhance the scope of information gathered from external stakeholders.

The Needs Assessment Leadership Team reviewed Utah data sources, National and State Performance measures, Health System Capacity Indicators and Health Status Indicators to help identify issues that might be addressed over the next five years. A general public survey asking for input on important health issues for mothers and children, including those with special health care needs and a survey of parents of children with special health care needs provided information to assist us in identification of the top issues. Key informant interviews of some Maternal and Child Health leaders in the state provided additional information.

Prioritization Process

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

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

State Performance Measures for Maternal and Child Health

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.

State Performance Measures for Children and Youth

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 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.

State Performance Measures for Children and Youth with Special Health Care Needs

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.

As we review the work needed to address the ten priority areas, we will engage our key partners in crafting implementation strategies to carry out the priorities. Partners will include representatives of local health departments, advocacy organizations, existing advisory committees, and parents.

III. State Overview

A. Overview

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

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

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

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

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

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

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

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

Utah also ranks first for child dependency ratio at 51.8 versus 37.7. Based on the 2008 American Community Survey, Utah had a significantly higher percentage of its population with a high school diploma at 90.4% versus 85% nationally among individuals 25 years and older. Utah's population is similar to the nation for percent of the population with a bachelor's degree or higher degree (29.1% in Utah compared to 27.7% of the U.S. population). Even though the proportion of Bachelor's degree and higher education achievement was comparable, Utah has a higher percentage of individuals with some college but no degree at 27.4% compared to 21.3% nationally. The high school dropout rate in Utah is lower than the U.S. at 3.1% of youth ages 16 to 19 years old versus 4.4% at the national level for grades 9 through 12. Data from the 2008 survey indicate that Utah ranks 7th in the country for high school graduation at 90.4% compared to the national rate of 84.1%. In 2008 Utah ranked 17th among states for Baccalaureate degrees at 29.1% and 24th for advanced degrees at 9.4% compared to 10.2% nationally.

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

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

Based on the Utah Health Access Survey (UHAS), 11.9% of Utah's population reported no health insurance in 2008, a steady increase from previous years. The proportion of uninsured has increased in the maternal and child populations as well. In 2008, 8.4% of children under age 18 were uninsured compared to 7.3% in 2003. Of females ages 18- 49, 14.3% reported no health insurance in 2008 compared to 11.3% in 2003. More than a third (36.5%) of the Hispanic population reported no insurance in the 2008 UHAS. The steadily climbing rates of uninsured individuals in the state especially children and women of childbearing ages, is very concerning. The Governor sponsored a state summit in 2005 to discuss issues related to a state plan to address the increasing rates. The Governor and the state legislature are leading an effort to develop a health care reform package to address the growing population of uninsured.

Utah's median household income was somewhat higher than that of the U.S. However, Utah's

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

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

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

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

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

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

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

Utah's public health system consists of 12 autonomous local health departments (LHDs). Six of the 12 local health departments are multi-county districts and cover large geographic areas. Many districts include both rural and frontier areas within the service region. Many local health departments are gradually moving away from direct services, recognizing that they do not have the capacity to provide primary care for those living in their communities. Each local health department determines which services they provide for mothers and children in their district.

In the past few years, we have required the local agencies to conduct an assessment of health care needs for mothers and children. While some districts were reluctant to engage in the process, many found it to be helpful. When you do the same thing for years, sometimes it is difficult to step back and look at what you are doing versus what your needs are. This process helped some local health departments to reassess the services they offer and approaches they use. We since have simplified the reporting requirements due to concern over workload on local agencies.

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

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

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

The hospital health care system for MCH populations is well developed in Utah, with six large tertiary perinatal centers and three tertiary children's hospitals. We are reviewing data from all

birthing hospitals to evaluate which hospitals really meet the criteria for a tertiary center. We would like to promote the importance of have tertiary level maternal fetal medicine physicians (MFM) as part of the definition of a tertiary perinatal center in addition to the neonatologist. In order to have good outcomes, the care of the mother needs to be at a tertiary level.

All but one of the perinatal centers has a University of Utah Health Sciences MFM faculty member assigned and are well recognized throughout the state and the Intermountain West as a consultation and referral center for obstetrical and pediatric providers. The centers work with hospitals within their referral areas to encourage consultation and referral as needed, depending on the condition of the mother, infant or child.

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

Utah, not unlike other areas of the country, suffers from a shortage of certain types of health care providers in different geographic areas, including nurses, neonatologists, dentists, mental health professionals, etc. Provider shortages exist throughout the state. Utah's 2007 physician-to resident ratio was eighth lowest in the nation at 208 physicians per 100,000 resident population compared to a national rate of 271. The Health Professional Shortage Area (HPSA) maps detail areas of the state with provider shortages for medical, dental and mental health providers.

Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. The University of Utah Health Sciences Center is currently working on a proposal for a dental school; however, local dentists by and large do not support the efforts. Mental health providers, especially those specializing in children's mental health, are limited, in part due to the mental health system in the state which is a Medicaid carve-out serving primarily the chronically mentally ill, but not necessarily those with acute conditions.

Urban areas also experience shortages of certain types of health care providers, such as nurses, pediatric neurology, genetics, developmental pediatrics and primary care providers who care for adults with special health care needs as they have transitioned from their pediatric providers.

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

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

Since the income eligibility level for Utah's Prenatal Medicaid program has not been increased from the original 133% of the FPL since its beginning in 1990, many women and their families, best categorized as working poor, are ineligible for health care coverage, making it difficult for them to access health care, especially prenatal and family planning services. Medicaid's current eligibility level for children birth to 5 years is 133% FPL and 100% FPL for children 6 -18 years of

age. Both the prenatal and the children's programs require an asset test for eligibility determination. The asset limit of \$3000 (reduced in 2010 from \$5000) prohibits many families that otherwise would qualify for the program from being eligible. Bills have been proposed in recent Legislative Sessions to remove the asset test without success.

Utah CHIP Program began in 1999 with an income eligibility of 200% of the FPL for children from birth to 18 years. The Program has suffered from budgetary limitations and has had to cap enrollment to stay within its budget. Since opening of the program until 2008, the state legislature had not appropriated enough funding for the program to maintain open enrollment. After inadequate increases in 2004, 2005, 2007, the 2008 State Legislature authorized additional funding for the CHIP Program and designated it as a state entitlement program. Obviously the legislators value the program as they are very reluctant to authorize "entitlement" programs.

In March 2002, Secretary of Health and Human Services, Tommy Thompson, signed Utah's Primary Care Network (PCN), which had been approved by the 2002 Utah Legislature. Approximately 25,000 adults with incomes between 100% -150% of FPL without insurance will be able to qualify and enroll for preventive health services under this plan. PCN will enable women who are enrolled in prenatal Medicaid to continue preventive health care coverage for primary preventive care, including family planning services if desired.

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

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.

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

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

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

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

feeling the impact of the projected decreases in revenues. The decrease in the Title V Block Grant over several years and the fact that the funding allocation has not kept up with inflation rates result in challenges for us to continue to provide the same level of services. Examples include loss of staff positions, loss of content areas, such as SIDS and school nurse consultation.

Documenting disparities at times is difficult given small numbers of populations in which to draw significance. The Department has endeavored to include data on subpopulations in the state in an attempt to better quantify the issues faced by various groups of individuals. The 2004 Legislature appropriated funding for the Center for Multicultural Health, which was supplemented in later years. The Center is housed in the Division of Family Health and Preparedness and assists the Department of Health in identifying priorities and needs of specific key populations in the state, updating an Ethnic Health Report, assessing the adequacy of ethnic data from common public health data sources and recommending improvements, inform 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.

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 multi-cultural 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 will develop "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 will better enable 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 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, infant and fetal deaths to identify public health issues amenable to prevention.

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

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

Related legislation or statutes, which impact Utah's Title V programs, include the ongoing challenge of addressing the needs of minors relative to sexuality and prevention of pregnancy, STDs, and HIV/AIDS. Current state law prohibits any government agency, including local health departments, from providing contraceptive information or services to minors without parental consent. The optimal situation is, obviously, parental involvement and the Utah Department of Health has worked, largely through the Title V-funded Abstinence-only Education Program, to promote increased parental knowledge, skills and abilities to discuss sexuality issues with their children in their homes.

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 has not sought federal funding to continue YRBS Surveillance. The Utah Department of Health coordinates this survey in collaboration with the State Office of Education and with support for data analysis by CDC.

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

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

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

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

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

Each program that addresses the health of mothers and children has a specific program plan that identifies goals, objectives and activities. The process of strategic planning for each program varies from program to program. The Maternal and Infant Health Program, (formerly the Reproductive Health Program) has developed a plan based on the National and State Performance Measures and the one state Outcome Measure. 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 dental services for pregnant women is incorporated in the Oral Health Program plan. Generally each program holds an annual program staff retreat to review the previous year's accomplishments, strategies and needs. Based on these discussions, program managers amend program plans as needed. The

annual report and application process provides an opportunity for each program to review its accomplishments and to amend their program plan as needed based on its achievement of the assigned measures.

An attachment is included in this section.

An attachment is included in this section.

B. Agency Capacity

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.

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.

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.

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

CSHCN Bureau

The CSHCN Bureau oversees eight programs focused on improving the statewide system of care for CSHCN and their families. The Bureau provides services through local and itinerant clinics, care coordination for children seen in clinics and for target groups of children such as those in foster care and those dependent on technology living at home. The Bureau works closely with hospitals and health providers to ensure that all newborns receive hearing and blood screening. CSHCN staff works closely with medical homes/primary care providers to ensure care is coordinated. Families are billed for clinic services on a sliding scale based on Federal Poverty

guidelines. Clinics are primarily funded by the Title V grant, Medicaid, CHIP, state, and collections from private insurance. Newborn blood screening kit fees now partially fund newborn hearing screening and fully fund the Newborn Blood Screening program.

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 (UNSHIE) 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.

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 1200 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.

Maternal and Child Health Bureau

The Maternal and Child Health Bureau oversees four programs, three of which are primarily funded with Title V funding: Data Resources, Maternal and Infant Health, and Oral Health. WIC is discussed later. The MCH Bureau oversees local health department contracts for services to mothers, children and youth, 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 six components. Prenatal and family planning focus on access to care, Presumptive Eligibility, and enhanced Medicaid services primarily in the underserved areas in the state. 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 state-funded WeeCare, nurse case management for high risk pregnant women enrolled in the state Public Employees' Health Plan.

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 health data such as hematocrits, saving unnecessary repeat testing.

Newborn Screening Program oversees the state newborn blood screening of 39 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 will issue "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 Administration of Children and Families, Office of Child Abuse and Neglect, 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 supporting evidence-based practice. OHV acts as a catalyst and resource center for entities interested in evidence-based home visiting 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 provides services to 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 Child and Family Services Division contracts with the Fostering Healthy Children Program described above. The Department works with the Division of Mental Health and Substance Abuse (DMHSA) on a variety of efforts, such as the Early Childhood Systems grant and UDOH's Adolescent Health Network committee.

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.

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.

Additional information is in Section E.

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 HIV/AIDS among its student populations. For a period of time the legislation resulted in loss of YRBS funding, but when CDC unbundled YRBS, the State Office of Education (USOE) successfully sought 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 federal grants to determine if the funding allocation to the LHDs is "fair". The law requires that federal grant funds may not be disbursed or encumbered by the Department before committee approval. Committee members review grant guidance to determine if the funding allocation is appropriate. The law went into effect July 2010. The Committee was formed early and has focused on 7 federal grants including Immunizations, STD, Cancer Control, PANO, Tobacco, Diabetes, and the Preventive Block grant. After these, the Committee will review other federal grants.

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. 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.

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

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

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

Preventive and primary care services for children

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

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

In 2009, the Office of Home Visiting 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 Health Families America programs in four communities. The Department of Workforce Services has given the Office \$1 million over two years to support the local programs. Other LHDs are interested, but lack funding. We are very interested in expanding home visiting programs in the state.

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

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

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

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

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.

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.

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/>

An attachment is included in this section.

C. Organizational Structure

In August 2009, Gary Herbert became the 17th Governor of Utah. He had been the Lt. Governor and moved into this position when former Governor Jon M. Huntsman, Jr. was appointed by President Obama as Ambassador to China. Governor Herbert has retained the Utah Department of Health's Executive Director, David N. Sundwall, who was originally appointed by Governor Huntsman. Dr. Sundwall has extensive experience at the national and federal level. Since this position is a cabinet-level position, Dr. Sundwall reports directly to the Governor and sits on his cabinet.

Due to discussions Session among Utah legislators during the 2009 Legislative to dismantle the Department of Health, 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 Health Care Financing (Medicaid). Former Title V Director Dr. George W Delavan retired in June 2009 which provided the Department an opportunity to examine its organizational structure. The reorganization allowed the Department to implement cost savings and align programs in a different way.

Utah's Title V programs, the MCH and CSHCN Bureaus, were moved into a new Division: Family Health and Preparedness. The Division is headed by Marc Babitz, MD, a primary care physician with many years of experience in primary care practice, national and regional positions. The Division also includes EMS, emergency preparedness, and primary care clinics. Unfortunately the Bureau of Health Promotion and the Immunizations Program were moved to the other Division.

Dr. Babitz has appointed Nan Streeter as the state Title V Director and Deputy Director of the Division of Family Health and Preparedness over the MCH and CSHCN Bureaus and the newly formed Bureau of Child Development (CD). In addition, Harper Randall, MD was appointed the MCH/CSHCN Medical Director.

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

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

mothers and children. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse, who brings more than thirty years of experience to this position.

Organizational charts are attached.

Describe concisely how the State health agency is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V" [Section 509(b)].

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

Programs funded by Title V

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

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

Programs that focus on mothers and children

The programs are described in more detail in Section B.

Child Development

The Bureau includes the child development specialist and the child health consultant, both vacant positions. It also oversees the Early Childhood Systems grant. It also includes Baby/Watch/Early Intervention, Child Care Licensing, the Office of Home Visiting, and the Head Start State Collaboration Office.

Children and Youth with Special Health Care Needs Programs

The eight CSHCN programs include: Fostering Healthy Children, Newborn Blood Screening, Specialty Services, (including Newborn Hearing Screening), Developmental Consultative Services, Neonatal Follow-up, Pregnancy Risk Line, Utah Birth Defects Network, and the Technology Dependent Waiver programs.

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.

Other programs that reach mothers and children:

Violence and Injury Prevention Program (VIIPP) works to reduce injury in the state of Utah, with a specific focus on youth injury prevention.

The Baby Your Baby Program (BYB) and other health promotion programs including asthma, diabetes prevention, Tobacco Prevention and Control are housed in a sister Division, but work closely with MCH programs.

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

An attachment is included in this section.

D. Other MCH Capacity

Number and location of Title V program staff

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

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

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

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

Senior Level Management

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

Three Bureau Directors oversee the Department's MCH/CSHCN programs. Teresa Whiting, with the Department for 4 plus years, oversees the Bureau of Child Development. Teresa has a degree in child and family development and extensive experience in child care, Head Start and

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

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

Staff that provides planning, evaluation, and data analysis capabilities

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

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

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

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

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

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

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

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

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

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

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

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

MCH workforce information such as FTEs, tenure of the State MCH workforce, and projected changes to the workforce

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

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

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

E. State Agency Coordination

Utah Title V agency 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.

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 contracting with the Fostering Healthy Children Program, an exceptional program in ensuring that 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. 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. 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.

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 CSHCN 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. The Medical Director started quarterly meeting 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. CSHCN Bureau staff participates on the DDS Advisory Committee that has fostered cross training of CSHCN Bureau and DDS staff. CSHCN has a staff member on the Traumatic Brain Injury Advisory Committee, housed in the Vocational Rehabilitation office. A member of Voc Rehab sits on the CSHCN Medical Home Advisory Council. The MedHome Portal Website has worked with Vocational Rehabilitation Office to develop the transition to adulthood module. 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.

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 the Association of Utah Community Health (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.

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 Title V agency works with the Utah Chapter of the American Academy of Pediatrics through its UPIQ (Utah Pediatric Partnership to Improve Healthcare Quality) efforts. More details about UPIQ are in Section B.

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.

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 participate in the Department's Child Fatality Review Committee to identify those deaths that possibly are preventable.

The PCMC strategic plan for children and youth with special health care needs includes support of Medical Homes. The MCH/CSHCN/CD Medical Director serves on the PCMC Pediatric Education Services Continuing Medical Education Committee, which credentials physician CME credits and identifies topics for Pediatric Grand Rounds. 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 University of Utah Department of Pediatrics, Utah State University, 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.

CSHCN continues to provide support to medical homes through newsletters and yearly site visits. Phone conferences were discontinued due to a lack of interest from the Medical Homes. The ASD grant has recruited new medical home teams to participate. Six dental homes will be recruited and trained next year.

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

Intermountain Healthcare, the largest health system in the state, 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 (University of Utah, Brigham Young University and Westminster College). The University of Utah also offers a PhD in Public Health. None of the programs has a specific focus on maternal and children health, but rather a more traditional public health focus.

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

Title V staff members have been involved with the Rocky Mountain Public Health Education Consortium which provides a number of educational offerings through on-site educational opportunities, such as the MCH Summer Institute, a MCH PH Certificate Program through the University of Arizona and distance learning opportunities, such as on-line modular courses. The Consortium is a collaboration of academic and state, local and tribal MCH leaders working to provide workforce development opportunities for public health professionals working in areas with a dearth of educational programs. The Division has sponsored several staff members to participate in the MCH PH Certificate Program and several have gone on to obtain their MPH degrees. However, with budget cuts, we are not able to sponsor staff participation.

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.

University 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 University of Utah 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.

Department of Pediatric faculty serves on CSHCN advisory committees, including the Early Intervention Interagency 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 University of Utah Department of Pediatrics, Utah State University Center for People with Disabilities, and Utah Family Voices. Other partners are invited to participate as specific issues arise. The CEG meets monthly.

Utah CSHCN is in its third year of the MCHB-funded Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) program. CSHCN collaborates with Utah State University, Center for Persons with Disabilities and University of Utah, Department of Pediatrics, in an MCHB Leadership Grant. ULEND 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 ULEND supplemental grants, in its fifth year for audiology and ASD.

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 has hired the Utah Family Voices Director to provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. The Family Voices Director works closely with the Utah Parent and Information Center in teaching and mentoring other families of children and youth with special health care needs. CSHCN also contracts with the Liaison for Individuals Needing Coordinated Services (LINCS) to provide direct services. CSHCN includes families in the Part C inter agency coordinating council.

F. Health Systems Capacity Indicators

Introduction

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

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

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

c) Interpretation of the data includes a collaboration between program staff and data staff to ensure that each understands the context of the issue and the data meaning and quality. We always operate from the perspective of team work and require collaboration between data and program staff. This approach has been very successful for us and results in higher quality work.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	16.4	14.6	15.4	17.0	17.0
Numerator	409	372	403	451	451
Denominator	249960	255456	261329	265602	265602
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.

Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2008

Denominator: IBIS Population estimates for 2008

Notes - 2008

Data reported are the most recent data available.

Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2008

Denominator: IBIS Population estimates for 2008

Notes - 2007

Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2007

Denominator: IBIS Population estimates for 2007

Narrative:

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

The Asthma Program, funded with CDC funds, has conducted several activities to help children under five to manage their asthma. In the past year, 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 across the state, conducted focus groups for mothers of children under five and are developing asthma educational materials based on these results. The goal is to help young mothers to recognize and manage young children's asthma symptoms. Two local health departments were funded to help spread asthma programs, education, and resources across the state.

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

The Asthma Program develops strategies in accordance with a five-year Utah Asthma Plan developed for 2007 -- 2011. 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 society including: schools, community, health systems, environmental, and others.

The Asthma Program has added numerous resources for health care providers and the public to its website. Specific resources include a health care provider manual, guidelines for providers in managing adult asthma and pediatric asthma as well as a guide to asthma and medications. Recently, guidelines were developed regarding mold and how to safely eradicate it and education on dangers of mold for people with asthma. The Utah Asthma Program websites includes many resources from a variety of sources as well as those that the Program has developed. The website address is <http://health.utah.gov/asthma/>

New strategies recently developed include asthma trainings for child care providers and education for mothers of children under five. The Asthma Program is working to further develop these strategies and continues to develop new strategies in accordance with the Utah Asthma Plan and as need arises.

c. Interpretation of what the data indicate

The rate of hospitalization has increased since 2006 from 14.7 per 10,000 in 2006 to 17.0 per 10,000 in 2008. However, the 2008 rate is less than the 2004 rate of 18.8 per 10,000, showing some improvement compared to five years ago.

Data identified several pockets of the state with higher than average asthma rates. The distribution of areas with increased rates was puzzling because one community with a high rate was adjacent to one with a much lower rate. Obviously more study is needed to identify the reasons for the discrepancy. The Governor has made the environment a high priority, especially air quality, so this will assist us in our efforts to reduce the need for hospitalizations.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	82.5	83.9	86.4	87.4	83.0
Numerator	26629	26977	18747	19088	18803
Denominator	32282	32137	21701	21831	22647
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data reported are the most recent data available.

Numerator: CMS 416 for FFY 2009

Denominator: CMS 416 for FFY 2009

Notes - 2008

Numerator: CMS 416 for FFY 2008

Denominator: CMS 416 for FFY 2008

Notes - 2007

Data from the CMS 416 for FFY 2007

Narrative:

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

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

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

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

c. Interpretation of what the data indicate

The percent of Medicaid enrollees under age one receiving at least one initial periodic screen has been increasing since 2002 from 81.4 percent to 87.4 percent in 2008. The increases may be indicative of a positive impact of efforts to improve access to care for infants on Medicaid. However, we have more work to do to ensure that all Medicaid enrolled infants have access to

health care given that more than 13 percent did not receive an initial screen.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	97.1	97.4	96.8	99.3	97.6
Numerator	135	185	182	286	283
Denominator	139	190	188	288	290
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

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

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

Notes - 2008

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

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

Notes - 2007

Office of Healthcare Statistics, CHIP, 2007

Narrative:

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

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

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

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

c. Interpretation of what the data indicate

This Health System Capacity Indicator has shown dramatic improvement. In 2002 only 53.5% of infants had received a periodic screen and in 2008, 99.3% received a service. The increases may be due to better reporting of information.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	78.8	82.2	83.2	82.5	82.5
Numerator	39844	43970	44762	44643	44643
Denominator	50581	53475	53810	54085	54085
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.

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

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

Notes - 2008

Data reported are the most recent data available.

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

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Denominator: IBIS Population estimates for 2007

Narrative:

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

Utah Medicaid for prenatal eligibility is at the lowest allowable level of eligibility for enrollment. Utah women's income must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Because of this, many working poor women who may be eligible in most other states across the country are reduced to self pay for prenatal care affecting entry into and adequacy of prenatal care. The federal restrictions on Medicaid eligibility based on citizenship status prevents a growing population of pregnant women from receiving early and adequate 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 unfunded pregnant women who reside within the city limits, but funding is woefully inadequate to cover the need.

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

We continue several initiatives to increase the rate of women who receive adequate prenatal care including: promoting safety net providers who will cover uninsured women and encourage early and adequate prenatal care services. We implemented the Baby Your Baby media campaign which utilizes the "13/13" message, start prenatal care by your 13th week of pregnancy and get at least 13 visits. These messages are aired via television, radio and print in both Spanish and English.

c. Interpretation of what the data indicate

In 2008, 82.5% of Utah women delivering a live birth received adequate prenatal care based on the Kotelchuck Index.

Among Hispanic women, only 65.5% received adequate prenatal care compared to 83.6% of non-Hispanics. This disparity is likely due to the large number of immigrants in Utah who do not qualify for prenatal Medicaid. 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. This low adequacy percentage may also reflect different cultural norms among Hispanic women who may see pregnancy as a time of health instead of a time to seek medical care.

Higher rates of inadequate prenatal care occur among women who reported an unintended pregnancy regardless of age. Among women who delivered a live birth and reported their pregnancy was unintended, 72.9% received adequate prenatal care compared to 88.7% of women who reported their pregnancies as intended.

Lower rates of adequate prenatal care also are noted among women who have had 3 or more previous live births. Among this group, 75.8% received adequate prenatal care compared to 81.5% of women with fewer than 3 previous live births. This disparity may be due to lack of time, day care for children and/or a feeling that they're experienced with pregnancy and do not need as many visits.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	93.5	93.5	93.5	86.6	86.6
Numerator	150379	150379	150379	142476	142476
Denominator	160915	160915	160915	164602	164602
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

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

Denominator: The number of children enrolled in Medicaid plus the proportion of children with no

insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Healthcare Access Survey, 2008.

Notes - 2008

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

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

Notes - 2007

Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid and estimates of a service received using Medicaid HEDIS data.

Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Health Status Survey 2005.

Narrative:

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

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

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

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

c. Interpretation of what the data indicate

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

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	48.8	48.6	51.2	51.4	52.6
Numerator	14127	13889	14920	15211	18550
Denominator	28943	28596	29135	29599	35280

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Medicaid CMS 416, FFY2007
Denominator: Medicaid CMS 416, FFY2007

Narrative:

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

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

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

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

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

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

c. Interpretation of what the data indicate

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

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	25.1	19.9	22.5	23.1	18.7
Numerator	895	742	919	981	846
Denominator	3569	3728	4089	4239	4522
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

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

Denominator: SSI for calendar year 2009

Notes - 2008

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

Denominator: SSI for calendar year 2008

Notes - 2007

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

Denominator: SSI for calendar year 2007

Narrative:

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

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

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

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 CHIP or CSHCN clinics.

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

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

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

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

A presentation on "Being an Effective Representative Payee and Utilizing Work Incentives" was held. We invited medical staff, parent advocates and parents to this conference. The conference provides information about eligibility factors for SSI, income and asset limits and how to apply for SSI for children

c. Interpretation of what the data indicate

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 2009, the percent of identified SSI beneficiaries who received rehabilitative evaluation services decreased.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

Percent of low birth weight (< 2,500 grams)	2008	matching data files	8.9	5.9	6.8
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Narrative:

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

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

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

Many risk factors are not amenable to Title V interventions, such as income, however those that are, e.g., tobacco use, are being addressed through ongoing collaborations with Medicaid and Tobacco Prevention and Control Programs 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 link Medicaid and birth certificate data to identify Medicaid enrolled women early in their pregnancy who have had a previous spontaneous preterm birth. Once data have been matched, outreach to women who have had a previous preterm birth will take place to educate them about the potential preventive strategy-administration of 17 alpha hydroxyprogesterone (17P) to prevent a recurrent preterm birth in the current pregnancy.

c. Interpretation of what the data indicate

Data indicate that women enrolled in Medicaid fare far worse than their non-Medicaid counterparts. The percentage of low birth weight births among Medicaid women was 8.9% in 2008 compared to the state rate of 6.8%. Utah's Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that women enrolled in prenatal Medicaid are more likely to have numerous risk factors which make them more likely to have a LBW infant, for example they are more likely to be younger, have less than a high school education, be of a racial or ethnic minority group, be unmarried and use tobacco during pregnancy. These factors may be contributing to higher rates of LBW among our prenatal Medicaid population.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2008	matching data files	5.7	3.2	4.7

Notes - 2011

Medicaid and Non-Medicaid infant mortality rates are based on match file. However, the "All" infant mortality data is from the following source.

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

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

Narrative:

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

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 healthcare providers on a monthly basis. Case reviews result in recommendations from committee deliberations that are implemented, as possible, to prevent future infant deaths.

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

The Utah Department of Health's Preconception Workgroup, a coalition of six Department programs that work toward improving pregnancy outcomes, applied for and received funding from HRSA's MCHB for a First Time Motherhood/New Parent social marketing campaign. The funding has enabled us to contract with an expert social marketing firm to develop and implement a media campaign 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 PMR is now interested in enhancing its work to include review of infant morbidities by partnering with hospitals to look for systems approaches to improve neonatal care. The MIHP has partnered with the Department's Patient Safety Director who applied for funding for this new perinatal quality improvement effort. We are awaiting the results of that application.

c. Interpretation of what the data indicate

The rate of infant mortality for the nation as a whole was 6.7 infant deaths per 1,000 live births (2006). Utah compares favorably with a rate of 4.7 infant deaths per 1,000 live births (2008), one of the lowest infant mortality rates in the country. However, women enrolled in prenatal Medicaid have a higher rate of infant mortality than the state as a whole (5.7/1000 live births, 2008). Again, we know that women enrolled in prenatal Medicaid have numerous risk factors which make them more likely to experience an infant death, for example they are more likely to be younger, have less than a high school education, be of a racial or ethnic minority group, or be unmarried. These factors may be contributing to higher rates of infant mortality among our prenatal Medicaid population.

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

INDICATOR #05 <i>Comparison of health</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				MEDICAID	
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	67.9	84.1	79.1

Narrative:

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

Utah has seen a slight decline in the percentage of Medicaid enrolled women who entered prenatal care during the first trimester following two years of increasing rates. We also saw a slight increase in the percentage of Medicaid enrolled women who reported their pregnancies as unintended, which can contribute to later entry into prenatal care. Utah provides no state funding for contraceptive services and with MCH Block grant funding being stagnant over the past few years, local health departments and community based organizations are strapped to provide contraceptive services to low income women. Planned Parenthood of Utah receives Title X funding for family planning services, however the funding is inadequate for the number of women needing services.

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

We have seen a steady increase in the number of applications for presumptive eligibility for prenatal Medicaid come in through our online web-based application system, UtahClicks. We are contracting with the developer of the system to make some needed enhancements that may expedite submission and approval of applications. We hope that these enhancements will result in earlier entry into prenatal care for our Medicaid moms.

c. Interpretation of what the data indicate

Utah remains significantly below the Health People 2010 goal for 90% of women entering prenatal care during the first trimester; we do however continue to have comparatively good pregnancy outcomes. Analysis of outcome data stratified by trimester of entry into prenatal care reveals that there are no differences in outcomes between Utah women who enter care during the first trimester compared to women who enter care later in pregnancy. There are however, significantly worse outcomes for women who receive no prenatal care. While we continue to promote early and regular prenatal care in Utah through our Baby your Baby 13 Campaign (get in by the 13th week of pregnancy and get at least 13 visits), we are now placing more emphasis on promoting preconception health among reproductive age women.

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

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

State					
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	73.6	86.5	82.5

Narrative:

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

See HSCI #04. Utah Medicaid for prenatal services has the lowest allowable level of eligibility for enrollment. Utah women must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Because of this stipulation, many working poor women who may be eligible in most other states across the country are reduced to self pay for prenatal care affecting their entry into and adequacy of prenatal care. The federal restriction of prenatal Medicaid for U.S. Citizens only also prevents our growing Hispanic undocumented pregnant women from receiving early and adequate care and there are a limited number of safety net providers to provide prenatal services to this needy population. The Maternal and Infant Health Program contracts with the Salt Lake City Community Health Centers Inc. to provide prenatal services for unfunded pregnant women who reside within the city limits, but the funding is inadequate to cover the need.

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

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

c. Interpretation of what the data indicate

Women enrolled in prenatal Medicaid (73.6%) are significantly less likely than non-Medicaid (86.5%) women in Utah to have received adequate prenatal care based on the Kotelchuck index. We know that Medicaid enrolled Utah women are also much more likely to have reported their pregnancies as unintended and as a result, less likely to have entered prenatal care in the first trimester. Late first trimester entry into prenatal care is likely the reason for a lower percentage of adequate prenatal care being received by our Medicaid enrolled pregnant women.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2009	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP

Infants (0 to 1)	2009	200
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Narrative:

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

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

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

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

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

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

c. Interpretation of what the data indicate

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

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	200

Narrative:

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

See 6A

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

See 6A

c. Interpretation of what the data indicate

See 6A.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2009	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women		

Notes - 2011

Not eligible

Narrative:

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

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

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

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

c. Interpretation of what the data indicate

This HSCI has been constant since the Medicaid prenatal program was first implemented. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The asset test prevents an individual with some resources from being determined to be eligible. The state legislature controls the state funding that is required for this program limiting the eligibility to their current levels. It is not likely that this HSCI will change given the mindset of state legislators who are convinced young adults in college are taking advantage of prenatal Medicaid when their

parents could afford to pay for the needed care.

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

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	1	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:

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

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

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

Linkages in general have improved in the past few years, as well as surveillance efforts. The Department conducts an annual Health Status Survey which provides additional data on the

general population in the state. This dataset is often used for our work in MCH/CSHCN. The Data Resources Program has been able to link Hospital Discharge data with Vital Records data. In the future, we hope to link to the All Payor Database.

c. Interpretation of what the data indicate

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

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

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

Notes - 2011

Narrative:

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

During the years 2003 -- 2007, YRBS was funded by the Utah Department of Health with various sources because the State Legislature prohibited the state from applying for CDC funds related to HIV prevention, of which YRBS was linked. The YRBS was integrated into the SHARP project, a larger biennial school survey project that also includes questions from the Youth Tobacco Survey and a Utah substance abuse survey. The Utah Department of Health received a CDC grant to conduct the 2009 YRBS. The state was able to apply for these funds since they were delinked to the HIV prevention funds and CDC allowed health departments to apply for funding. The 2009 YRBS weighted results are available on the web-based Utah Department of Health Indicator-Based Information System for Public Health.

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

The Department of Health, in collaboration with the State Office of Education, 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 consistently received weighted YRBS data from the CDC. Utah will continue to administer the YRBS in collaboration with other state-sponsored school surveys to reduce survey cost, achieve adequate participation rates despite Utah's active parental consent requirement, and minimize the survey burden on schools.

c. Interpretation of what the data indicate

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

In reviewing the indicators for the National Performance Measures and the State Performance Measures, in 2009 we achieved 19 of 27 measures and did not achieve our objectives for 8 performance measures. Of the National PMs, 15 out of 18 were met. Of the 9 state PMs, 4 were met. We did better than the previous year for some, and some we fared worse. We will continue to review the measures we did not achieve to determine how we can improve these indicators in the future.

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

CYSHCH

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

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

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

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

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

C. National Performance Measures

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	841	403	479	463	463
Denominator	841	403	479	463	463
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Utah Newborn Screening Program Database, 2007

a. Last Year's Accomplishments

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

The Newborn Screening Program (NSP) continued its surveillance and identification of children with congenital hypothyroidism, galactosemia, biotinidase, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders and fatty acid disorders. Cystic Fibrosis was added to the screening panel on January 2, 2009. The program and the Cystic Fibrosis clinic worked closely in identifying the abnormal IRT screens and DNA alleles and referral for sweat testing and pulmonary consultation.

The Newborn Screening Subcommittee of the Genetics Advisory Committee met quarterly to discuss issues relating to newborn screening. The committee members followed the implementation of the cystic fibrosis screening closely.

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

Submission of timely and accurately identified screening specimens has a great impact on the health of newborns and on initiating the newborn screening cycle. Five areas were identified relating to submission and safety standards were developed. A quality assurance report card was begun to give feed back to hospitals on their compliance with newborn screening and the impact on the health of newborns. The program worked with the Department's patient safety consultant to identify areas of concern and the approach to take reporting these data. A meeting was held with representatives of hospital corporations and independent hospitals to review the proposed form and discuss the reasoning for the reports. Reports were sent to hospitals monthly.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Utah continued with its surveillance and identification of children.			X	
2. 640 Utah newborns required testing beyond the newborn screening.			X	
3. 463 newborns were referred to the medical home and/or a subspecialist for follow up/treatment for 'not normal' confirmatory testing.	X			
4. All newborns with 'not normal' results were referred to their medical home provider. Referrals to subspecialists were coordinated with the medical home.	X			
5. Final diagnosis (outcome) was obtained on all newborns that received confirmatory testing.	X			
6. Cystic Fibrosis screening was implemented.			X	
7. Report Card to hospitals for quality assurance was begun.				X
8. The NSP continued to work with the Hearing Screening Program and the Vital Records to match data using the Birth Record Number.				X
9.				
10.				

b. Current Activities

The Newborn Screening Program continues its surveillance and identification of children for State mandated screening disorders. Collaboration with stakeholders continues in testing of disorders and follow up. The implementation of cystic fibrosis (CF) to the screening panel began on January 2, 2009. Monitoring of all parts of the system is ongoing with corrections/additions/changes being made as necessary.

The Newborn Screening Subcommittee continues to advise the state. Requests for new disorders will be reviewed.

Emphasis will be placed on review of hospital practices surrounding collection and submission of screening specimens. Safety standards were defined, and a 'report card' highlighting five specific areas is being sent monthly to hospitals. A yearly summation of this information is underway and will be sent to corporate offices.

A protocol for collection of screening specimens on sick or preterm newborns will be established and distributed to appropriate hospital personnel. An initial discussion of this protocol was held with neonatologists and the metabolic consultant. A web cast education session was conducted in April.

c. Plan for the Coming Year

The Newborn Screening Program (NSP) will continue its surveillance and identification of children with state mandated screening disorders. Care coordination and data tracking will be on going. Collaboration will continue among the Pediatric Department of the University of Utah, the Associated Regional and University Pathologist, Inc, and the UDOH to provide testing of disorders and follow up.

Staff support will continue for the Genetic Advisory Newborn Screening subcommittee as it advises the Department on screening issues.

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

Submission of timely and accurately identified screening specimens will continue to be emphasized with the hospitals. Report cards documenting performance will be sent to birthing hospitals and lay midwives. Education will be available electronically and on-site.

The new protocol, testing for sick or preterm newborns, will be monitored for impact on outcomes in this population.

The NSP will continue to collaborate with data integration and streamlining of data collection. The birth record number (newborn screening number) will continue to be used to link newborn records. The Program will collaborate with the Fostering Healthy Children Program to ensure children under three years of age who are admitted to the state's foster care system have received screening. Work will continue to make screening results available electronically through CHARM and a new grant received, Utah Newborn Screening Clinical Health Information Exchange (UNSCHIE).

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

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

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

Total Births by Occurrence:	56788					
Reporting Year:	2008					
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.
Phenylketonuria (Classical)	56375	99.3	12	6	6	100.0
Congenital Hypothyroidism (Classical)	56375	99.3	441	17	17	100.0
Galactosemia (Classical)	56375	99.3	91	1	1	100.0
Sickle Cell Disease	56375	99.3	331	3	3	100.0
Biotinidase Deficiency	56375	99.3	12	1	1	100.0
Congenital Adrenal Hyperplasia	56375	99.3	100	5	5	100.0
Homocystinuria	56375	99.3	52	0	0	

Maple Syrup Urine Disease	56375	99.3	8	0	0	
beta-ketothiolase deficiency	56375	99.3	0	0	0	
Tyrosinemia Type I	56375	99.3	70	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	56375	99.3	8	2	2	100.0
Argininosuccinic Acidemia	56375	99.3	0	0	0	
Citrullinemia	56375	99.3	0	0	0	
Isovaleric Acidemia	56375	99.3	9	0	0	
Propionic Acidemia	56375	99.3	35	0	0	
Carnitine Uptake Defect	56375	99.3	144	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	56375	99.3	21	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	56375	99.3	35	0	0	
Multiple Carboxylase Deficiency	56375	99.3	0	0	0	
Trifunctional Protein Deficiency	56375	99.3	0	0	0	
Glutaric Acidemia Type I	56375	99.3	15	2	2	100.0
Sickle Cell Anemia (SS-Disease)	56375	99.3	3	3	3	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	56375	99.3	100	5	5	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	56375	99.3	12	12	12	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	56375	99.3	0	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	56375	99.3	0	0	0	
Methylmalonic Acidemia	56375	99.3	35	0	0	

(Mutase Deficiency)						
S-Beta Thalassemia	56375	99.3	0	0	0	
Hearing Screening	55718	98.1	782	71	52	73.2
Short Chain Acyl-CoA Dehydrogenase Deficiency	56375	99.3	8	1	1	100.0
Carnitine Palmitoyl Transferase-1 Deficiency	56375	99.3	2	2	2	100.0
Diet Monitoring Pregnant Women	6	0.0	70	6	6	100.0
Diet Monitoring 0-18 years	84	0.1	801	84	84	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	2005	2006	2007	2008	2009
Annual Performance Objective	63.7	65	65	52	55.1
Annual Indicator	63.7	63.7	55.1	55.1	55.1
Numerator					
Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	55.1	55.1	55.1	56	56

Notes - 2009

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

Notes - 2008

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

Notes - 2007

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

a. Last Year's Accomplishments

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

The CSHCN Bureau continued to employ a part-time family advocate to work directly with parents and family organizations in providing them with resource and advocacy information. She provided a parent's perspective and input to all of the new grants or projects developed including the MCH Block grant. The family advocate also recruited and trained other family leaders to serve as mentors for families through projects and programs for children with special health care needs (CSHCN) in the state. Family leaders were recruited to support families of children with autism spectrum disorders (ASD) and other developmental disabilities. Compensation to parent leaders for enhanced family involvement activities continued to develop and grow.

CSHCN collaborated in efforts to support the MCH funded Family-to-Family Health Information Center (F2FHIC). The Center provides vital information and support to families of CSHCN, provides information, training, and guidance regarding the needs of CSHCN to health care and other professionals, and develops and implements strategies for essential and effective family/professional partnerships. Other initiatives included outreach, training, and information dissemination on home and community based services and supports and as well as helping families assess their potential eligibility for needed services. The family advocate coordinator worked with state and national partners in assessing the sustainability of the F2FHIC.

Through a variety of mechanisms the CSHCN family advocate coordinator provided information and support to families of CSHCN to help them in making informed decisions and receiving quality health care, maximizing treatment choices, and improving health outcomes for their individual children and families.

Parents were trained and/or supported by LINCS (Liaisons for Individual Needing Coordinated Services) for families in their local home and community. The family advocate coordinator provided advocacy and resource information to professional partners and families attending the rural CSHCN clinics.

CSHCN also partnered with the F2FHIC and Utah Parent Center to support the Annual Family Links conferences held in the Wasatch Front, Southwest and Southeast Utah including the Navajo Nation. The family advocate coordinator was part of the planning committee to help address the needs of and provide health care and related information for families of CSHCN and the professional partners attending the conference. Presentations were provided on health care funding resources, emergency preparedness, medical home and community resources.

The family advocate coordinator, families of children with ASD and the Utah Parent Center planned and held a conference for families of children newly diagnosed with an ASD. The conference was titled "Autism Rocks" and was focused on helping parents navigate through the emotional aspects as well as information and resources to address the needs of their child and family. Caring for the caregiver and partnering with health care providers were the main emphasis of the conference. Over 200 individuals participated with a high percentage of fathers in attendance.

A survey to query families with CSHCN throughout the state was developed and initiated. The survey questions were developed with parent participation to help guide the MCH five year needs assessment but more importantly gather specific information about what the families' perspectives were. Collaboration with many family support groups and disability organizations made the survey a success. Approximately 1000 parents responded to the survey including those in rural areas and those whose primary language is Spanish. The data are being analyzed to help guide the development of information, education and supports that families are requesting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A Family Advocate as paid staff providing family involvement, leadership, support and resources				X
2. Recruitment of families to participate on activities with compensation				X
3. Collaborated with the Utah Family to Family Information Center on MCHB outcomes and the sustainability of the F2FHIC				X
4. Parents involved with itinerate clinics to support families in rural areas	X			
5. Presentations about significant information and resources to key stakeholders				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The family-advocate coordinator provides information to other Title V programs about the effectiveness of family/consumer participation in their programs and projects. The recommendation to compensate families for their time and expertise is continually reinforced and modeled through various MCH funded projects, such as parents of children with ASD being recruited and compensated to provide input related to building effective medical homes, mechanisms for early screening and educating dental providers about their children.

The family advocate coordinator also currently directs the Utah Family Voices Family-to-Family Health Information and Information Center (F2FHIC) in collaboration with the Utah Parent Center (UPC). Various efforts and enhanced partnerships are being developed to help sustain and grow the F2FHIC as an essential resource to families of CSHCN.

Family involvement and expertise continue to be key. Information collected from families across the state about health related issues help facilitate and coordinate the needs that are important to families at the grass-roots level. The expertise gathered will be infused in the Utah Regional Leadership Education in Neurodevelopment Disabilities (URLEND) program, the 2nd year pediatric medical residents and other health care professions' education.

c. Plan for the Coming Year

The family advocate coordinator will develop a Utah family involvement and leadership (UFIL) program which will expand the efforts in providing information to other MCH programs about the effectiveness of family participation in programs and projects. Collaboration with existing health related state boards, committees and councils to have family, youth and young adult representation will be increased. The recommendation to compensate participants for their time and expertise will continually be reinforced and modeled.

Family expertise will continue to be infused in the URLEND programs in partnership with Utah State University and the University of Utah. Coordinated family experiences for the CSHCN rotation for 2nd year pediatric medical residents at the University of Utah will continue to grow. The partnership with the faculty of the various health care disciplines will provide a mechanism to educate about family-centered care components in core curricula.

The family advocate coordinator will provide technical assistance to the F2FHIC about outcomes for CSHCN. The collaboration will help provide support to an increased number of families with children and youth as well as young adults with special needs in accessing health and related services across the lifespan.

Data gathered from a statewide survey targeted to parents of CSHCN will be assessed by the UFIL program about the challenges identified in the survey. An interagency family support committee will be developed to address the issues and needs identified as well as to facilitate and coordinate possible solutions or supports.

Outreach to Medical Homes and CSHCN clinics in urban and rural communities across the state will include site visits, surveys and focus groups to gain knowledge from parents at the grass-roots level. Activities will also include building local family leadership and providing family support, advocacy and information. Modules for the family section of the Medical Home portal will be enhanced and expanded. The portal will continue to serve as a clearinghouse of credible resources and information for families, physicians and professionals statewide.

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	2005	2006	2007	2008	2009
Annual Performance Objective	55.9	60	60	49	52.2
Annual Indicator	55.9	55.9	52.2	52.2	52.2
Numerator					
Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	52.2	52.2	52.2	55	55

Notes - 2009

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

Notes - 2008

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

Notes - 2007

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

a. Last Year's Accomplishments

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

The activities for the Medical Home project (MH) included year one activities of the Utah's Autism Spectrum Disorder/Developmental Disabilities Systems Development Project.

Utah implemented an early intervention pilot program (using CDC's Act Early/Know the Signs materials) in three urban and rural counties to help community-based human service providers and educators recognize early signs of autism and refer children for diagnostic and treatment services. In addition, preschool special education teachers were trained in the Act Early/Know the Signs materials and piloted ASD developmental checklists and screening tools in selected preschool and kindergarten classrooms.

The Utah Chapter of National Family Voices (UFV) trained five family resource navigators to work with providers and provide support, link parents to community resources, and assist parents in making informed decisions. The project trained and provided modest stipends to parent advocates in medical home practice teams.

Utah expanded the existing medical home network that addresses the needs of children with autism spectrum disorders/developmental disability (ASD/DD) and their families. In collaboration with the "Utah Pediatric Partnership for Improving Health Care Quality" (UPIQ) the Medical Home (MH) project provided training and support to 6 practice teams to improve early screening, diagnosis, and treatment, and six dental home practice teams. Using a "learning collaborative" approach, each team included a physician (or dentist), parent advocate, and care coordinator.

In year two of the MCH ASD grant to coordinate services for children with autism through the medical home a learning session was held on 6-12-2009 for 6 new practices. Support for the practices continued with email resource outreach and site visits with a structured interview at each site and results of their progress were established. The MH coordinator published three columns in the Utah Chapter of the American Academy of Pediatrics (UAAP) and published two MH newsletters that were sent to every pediatrician and family practitioner in the state. Support for Parent Partners (PP) continued through the CSHCN parent partner and PP business cards were given to each practice to facilitate communication between families and the practice PP.

The grant advisory committee met once to provide input on the recruitment of family medicine practices, utilizing parent partners more effectively in the offices and completed a user study of the autism module at www.medicalhomeportal.org. The CSHCN consultant group was kept informed of current activities of the bureau and given an opportunity to provide feedback at the quarterly executive committee meetings.

Collaboration with Family Voices, Utah State University, University of Utah, and Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) regarding CSHCN projects, medical and nursing school curricula and the medical home website continued. Medical students met with the CSHCN parent partner to gain a perspective from families with CSHCN. URLEND trainees provided consultation and technical assistance to the practices involved in the CSHCN medical home trainings along with families of CSHCN. The medical home website was redesigned to make the pages more user friendly and the staff of CSHCN gave feedback and suggestions. The CSHCN MH coordinator reassigned all the resources to appropriate categories

on the site.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. One Learning Session for 6 new Medical Homes on early screening for autism.				X
2. Advisory committee met once to provide input on LS curriculum and sustainability of grant activities.				X
3. Four topic oriented phone conferences to medical homes.				X
4. Four topic oriented phone conferences to dental practices.				X
5. Two Medical Home newsletters (topics "Early Screening for Autism in the Medical Home" and the "Medical Home Portal") sent to all pediatricians and family practitioners in Utah.				X
6. Collaboration with Medical and Nursing school curriculum to include the medical home model of care and parent perspectives of caring for CSHCN.				X
7. Three columns published in the AAP's local chapter newsletter and sent to the family practice organization on medical home activities in the state.				X
8. Site visits to physician practices establishing the MH model of care.				X
9.				
10.				

b. Current Activities

The advisory group met in January 2010 and brainstormed ideas on more effective roles for parent partners in the medical home, recruitment of family medicine practices and participated in a Medical Home website user study.

Each practice identified a core medical home team that participated in the 6 month project and learning session. Prior to the learning session project staff presented an introductory session on setting up a medical home within their office and followed up with the teams.

In addition 6 dental practices participated in a dental home and autism learning session in February 2010. Site visits were conducted in March and June. Each medical/dental home received a packet with diagnosis information, screening tools and resources. Currently the staff is recruiting eleven more medical practices to participate in a peer mentored learning session. A medical home training for the new teams is scheduled for June 2010.

Given the large rural and frontier portions of the state UPIQ will design a half day learning collaborative curriculum for in-office training on Medical Home 101, ASD/DD screening, diagnosis and referral for practices was delivered by project staff and supported by peer mentors at eleven sites during the spring of 2010.

In 2010 project staff completed a series of videos directed at parents of newly diagnosed children with autism. Staff continues to distribute Medical Home Newsletters and contribute to the Medical Home Corner column in the UAAP newsletter.

c. Plan for the Coming Year

Following the Dental Medical Home/Autism Learning session in early 2010 two site visits will be conducted to provide support to the practices towards their goal of providing a dental home for children with autism and to collect data.

Year three will only involve medical, not dental home practices, and will be a peer mentoring model rather than the full Learning Collaborative model of the previous years. New medical home practices will identify a parent partner who will participate on the medical home team providing input on office processes and acting as a support person to other parents. The office team will then identify 3-6 parents for a focus group with the goal of obtaining parent perspective of the office practices and moving the medical home group towards providing a more family-centered practice.

The plan is to present the videos throughout the state in 2010 and 2011 to families with trained family navigators in attendance during the presentations to assist families in locating resources and answer questions.

Physicians from the initial project are being recruited to mentor the new practices and will participate in the learning session and two follow-up visits. Two visits with the new practices and project staff are also scheduled later in 2010. The four visits will take place between July and October 2010.

Site visits are planned to our previously trained medical homes using a structured interview with their teams to facilitate team discussion and collect data to guide our continuing efforts at supporting and sustaining medical homes.

To outreach to all health care practitioners, plans include four articles a year to the American Academy of Pediatrics Utah (AAP) Chapter and Utah Family Practice (FP) organization newsletters. A semi-annual medical home topic oriented newsletter with community resources will be written and disseminated to all pediatricians and family practitioners in the state and posted to the medical home website. Contributions of resources and health information to the website (www.medhomeportal.org) and participation on the portal team will continue. The team plans to expand the portal to include other states' resources making the information more relevant nationally.

Those pediatric and family practice offices interested in implementing the medical home model of care not involved in our grant projects will be trained and supported by the medical home coordinator and a CSHCN parent partner.

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	2005	2006	2007	2008	2009
Annual Performance Objective	57.2	59	59	59	59.5
Annual Indicator	57.2	57.2	59.5	59.5	59.5
Numerator					
Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	59.5	59.5	59.5	59.5	60

Notes - 2009

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

Notes - 2008

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

Notes - 2007

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 59.5 and the Annual Indicator was 59.5.

Bureau programs assisted families in obtaining health care coverage by providing outreach to potentially eligible Medicaid, CHIP and SSI families. Numerous outreach methods were used including face-to-face encounters at statewide CSHCN clinics, on-line applications through UtahClicks, posting eligibility information on the Medical Home web-portal and providing space for an on-site Medicaid and CHIP eligibility worker. Open enrollment for CHIP continued throughout the year. Families were encouraged to apply for UPP (Utah's Premium Partnership for Health Insurance) to help pay a portion of their monthly health insurance premium through their employer's health insurance plan or COBRA coverage.

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

Through Medicaid's Waiver for Technology Dependent/Medically Fragile Children, 133 families had access to Medicaid and waiver services which provided the support needed to keep their child safe at home and in the community. CSHCN provided the day-to-day administration, case management and service authorization for this waiver program.

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

CSHCN provided membership and consultation to Medicaid on their EPSDT Expanded Services and Prior Authorization Committee. The education and recommendations on service coverage for

children with special health care needs are important for families to help them obtain the medical services and to support their children need.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided Medicaid, CHIP and SSI outreach to potentially eligible families of 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 UtahClicks.		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 up to 21 years of age through the EPSDT Expanded Services and Prior Authorization Committee.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Outreach activities are being conducted to identify children who may qualify for public funding of health care. Outreach efforts are implemented statewide through CSHCN clinics, case management programs, on-line information and application systems and an on-site eligibility worker at the CSHCN clinic/administrative office. SSI eligible children who are not yet enrolled in Medicaid are being identified and letters are sent informing families of their potential eligibility for Medicaid and CSHCN clinical programs.

The Bureau collaborates with hospitals and community organizations to help cover the cost of medical services for children who do not have access to public or private health insurance. CSHCN works collaboratively with Utah's Family-to-Family Health Information Center to respond to the needs of families through direct family-to-family support and information on public and private health insurance.

CSHCN is providing the day-to-day administration for Medicaid's Technology Dependent Waiver program. The waiver program assists families in coordinating medical benefits between 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.

CSHCN is monitoring forthcoming initiatives that affect health care coverage and will be proactive in supporting creative approaches that aim to reduce the financial strain on families.

c. Plan for the Coming Year

Financing health care services for children and youth with special health care needs will continue to be an important function of the CSHCN Bureau in meeting the needs of children and their families. Outreach efforts to identify children who may be eligible for public funding of health care

will be a high priority. Educating families on available programs, eligibility requirements and application processes will occur through CSHCN's statewide clinics, the Med Home web-portal and Bureau web-site. An on-site Medicaid eligibility worker will be available to process Medicaid and CHIP applications received in person during CSHCN clinics and from CSHCN staff referring children throughout the state. Open enrollment for CHIP will continue throughout this year. A database will be used to identify SSI eligible children who are not yet enrolled in Medicaid. Letters will be sent out in English and Spanish informing identified families of their potential Medicaid and CSHCN program eligibility.

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

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

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

CSHCN will work collaboratively with Utah's Family-to-Family Health Information Center to respond to the needs of families through direct family-to-family support and information on public and private health insurance. CSHCN will monitor 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	2005	2006	2007	2008	2009
Annual Performance Objective	79.1	82	82	82	86.2
Annual Indicator	79.1	79.1	86.2	86.2	86.2
Numerator					
Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	86.2	86.2	86.2	87	87

Notes - 2009

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

Notes - 2008

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

Notes - 2007

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

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 86.2 and the Annual Indicator was 86.2.

Children with Special Health Care Needs (CSHCN) staff worked closely with the Utah Collaborative Medical Home Program, Utah State University and Utah Family Voices on efforts to enhance access, collaboration, and efficient and effective care coordination between community agencies, health care providers and families. A new referral form and process to gain input and information from primary and community providers on service access and communications efficiencies was initiated on a statewide basis. An on-going update and revision of the CSHCN website were maintained to allow for easier use and navigation.

CSHCN provided access to community-based specialty care through statewide satellite case management and itinerant clinics. Specialists travel to the rural areas in Utah to provide evaluations, diagnostic services and follow-up. Specialty areas included the following: developmental pediatrics, psychology, speech pathology, genetics, neurology, occupational/physical therapy, audiology, orthopedics, cranio-facial and cardiology.

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 4300 children in the foster care system. FHC worked with Utah Medicaid to improve Health Status Outcome Measures for children.

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 three sites for approximately 1600 infants and toddlers who have graduated from newborn intensive care units and who meet certain program eligibility criteria, mainly that they were born at very low birth weight.. The Baby Watch Early Intervention Program (BWEIP) provided services for over 6300 infants and toddlers with disabilities and their families through 15 local programs statewide. BWEIP provided training and technical assistance to providers. BWEIP continued its effective use of the statewide database, Baby and Toddler Online Tracking System (BTOTS), which allows the program to monitor family and child outcomes in relation to BWEIP interventions. CSHCN worked

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

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

CSHCN has continued a strategic planning/needs assessment effort aimed at strengthening our ability to serve our populations, despite current budget challenges. Champions InC. from Utah State University, along with Utah Family Voices and the Utah Collaborative Medical Home Program are continuing to work closely with CSHCN staff and programs on this planning/assessment process. CSHCN continues to provide access to community-based specialty care through statewide satellite case management and traveling clinics. CSHCN will

provide case management to high-risk populations including children who are dependent on technology and enrolled in Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children (FHC). Bureau programs are evaluating the service delivery system to increase efficiency and assess changes needed in case management. and clinical services.

NFP continues to provide multidisciplinary clinics to NICU graduates and collaborates in University research projects for this population. They are completing the first version of a new clinical database.

BWEIP provides services statewide to infants and toddlers with disabilities and their families through 15 local programs.

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

c. Plan for the Coming Year

A joint strategic planning and needs assessment effort between CSHCN and Champions InC. from Utah State University will continue to develop and implement strategies to support children with special needs in the state, targeting the needs of this population and community in an efficient manner. On-going flat or reduced 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, and possibly combining or eliminating clinics.

CSHCN will provide access to community-based specialty care through statewide satellite case management and itinerant clinics. Specialists will travel to the rural areas in Utah to provide diagnostic 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 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 Collaborative Medical Home Program, Family Voices, care coordination services and the clinics will augment community clinical services, case management and capacity building efforts to enhance a coordinated, community system of care. Utah's Family-to-Family Health Information and Education Center will provide parent-to-parent support and information on community resources and services. During this next year, the center will continue its focus on collaboration and sustainability by developing new family advocacy and interagency relationships with community-based organizations at the local, state and national level.

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

NFP will continue to partner with the University of Utah and other agencies to provide multidisciplinary clinics to NICU graduates. BWEIP will provide services statewide to infants and toddlers with disabilities and their families through 15 local programs. BWEIP educates and provide technical assistance to their network of providers.

Continued collaboration between CSHCN clinical entities and CHARM, UHIN and cHIE will focus on implementing and expanding data sharing and the future implementation of mandated use of electronic medical records.

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	2005	2006	2007	2008	2009
Annual Performance Objective				36	42.5
Annual Indicator	5.8	5.8	42.5	42.5	42.5
Numerator					
Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	42.5	42.5	42.5	44	44

Notes - 2009

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

Notes - 2008

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

Notes - 2007

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

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 42.5 and the Annual Indicator was 42.5.

In FY2009, CSHCN promoted and supported transition services for young adults, their families and medical providers. CSHCN employed a transition specialist who provided transition planning to young adults with disabilities and their families in Blanding, Moab, Montezuma Creek, Price, Ogden and Vernal clinics. These services are especially important, as rural Utah presents significant challenges for families in successful transition into adult services for their children. The transition specialist provided services to young adults with disabilities and their families at CSHCN bureau programs based in Salt Lake City. Both in rural sites and Salt Lake City the

transition specialist coordinated with local health department staff, health and mental health providers, and other state and local agencies.

In addition to onsite consultations and the Medical Home Portal, phone consultations and written and email correspondence were available to young adults, their families and their medical providers. The transition specialist was available to community agencies for assessment of needs and transition planning. The transition specialist maintained current resource information critical for young adults and their families for transition from pediatric services and programs to adult services and programs.

A Memorandum of Agreement with Work Ability Utah (WAU) has facilitated transition training opportunities at the rural clinic sites for medical providers. The first training was held in Blanding, UT in April 2009. Pre and post surveys were done to understand and address the specific needs of the community. Additional trainings were scheduled for rural clinic sites throughout the state including Moab, Richfield and Vernal for the upcoming year.

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

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

The Becoming Leaders for Tomorrow (BLT) Project funded by the Administration on Developmental Disabilities through CPD, maintained an advisory committee of young adults. The young adults provided input to the CSHCN Bureau staff regarding transition services and materials. The young adults also spoke at local, state, and national transition training events for providers, young adults and families. With funding from the Centers for Medicare & Medicaid Services (CMS) and in collaboration with Independent Living Research Utilization, the BLT young adults developed a Youth Leadership Toolkit with a training guidebook and videos for professionals, parents, and young adults. The Toolkits were distributed through Family Voices and other national disability organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided onsite transition services for young adults and their families at rural clinics and CSHCN bureau programs based in Salt Lake City. Additionally, telephone consultation, written and email correspondence, and other supports were available thro		X		
2. Telephone consultation, written and email correspondence were available to providers and community agencies for needs assessment and transition planning throughout the state.		X		
3. Transition training session presented in Blanding, Utah for medical providers. Additional trainings planned for the upcoming year.				X
4. Maintained current resource information for adult services and programs.				X
5. The BLT project advisory committee provided training and materials for providers, young adults and families. These				X

materials were developed in partnership with the young adults.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN employs a transition specialist who provides services to young adults with disabilities and their families. The transition specialist and Becoming Leaders for Tomorrow (BLT) project coordinator offer transition training to medical providers in rural sites including Blanding, Moab, Richfield and Vernal in collaboration with Work Ability Utah (WAU). Pre and post surveys are conducted provide an understanding of specific transition issues identified by each community. In collaboration with WAU and Utah State Office of Rehabilitation, a Representative Payee Training was presented for families, CSHCN staff and staff from other agencies and organizations. CSHCN collaborates with state and federal agencies and community programs.

CSHCN and BLT staff provided training and outreach on transition topics by presenting at conferences. CSHCN staff presented at the "Critical Issues" state mental health conference. BLT staff presented at the Family Links 2010 Statewide Conference and the Pacific Rim International Conference on Disabilities.

The transition specialist and other program staff contribute toward maintaining current resources for adult services and programs for use by young adults, their families and medical providers. This information is available through consultation, email, telephone contact, the Medical Home Portal, partner websites, medical providers, and community agencies.

c. Plan for the Coming Year

In FY2011, CSHCN transition specialist will continue to provide educational training opportunities for medical providers in rural locations. Pre and post surveys will continue to better understand and address transition issues and specific concerns of each community. By training the medical providers, they can provide information on transition for the young adults and their families' specific to the individual community. This is a collaborative effort with the Becoming Leaders for Tomorrow (BLT) Project and funded through a Memorandum of Agreement with Work Ability Utah.

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

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

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

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	80	80	80	85	82.5
Annual Indicator	74.1	80.4	78.5	78.1	78.1
Numerator					
Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	80	80	82.5	82.5	85

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 2008 National Immunization Survey (NIS) which is only available at the state level as a percentage.

Notes - 2008

Data reported are the most recent data available.

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

Notes - 2007

This measure does not have a numerator or denominator because it is taken from CDC's 2007 National Immunization Survey (NIS) which is only available at the state level as a percentage.

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 82.5% and the Annual Indicator was 78.1%.

The Utah Immunization Program (UIP) developed and implemented a comprehensive quality improvement program to assist providers in increasing immunization coverage levels using all aspects of the CDC AFIX strategy. The UPIQ (Utah Pediatric Partnership to Improve Health Care Quality) project conducted assessments at 10 clinics for Phase 2 and 10 repeat assessments for Phase 1. An AFIX policies and procedures manual was submitted to the CDC and provider relations staff were trained on its contents.

A VFC provider satisfaction survey was administered and 66.9 % of VFC providers rated their experience as excellent and 32.5% rated it as good. Provider representatives conducted AFIX site visits at 118 VFC clinics throughout the state.

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

Outreach, enrollment and training activities for USIIS were supported by the UIP to all USIIS users. The number of provider offices participating in USIIS increased 19% from July 2008 to June 2009. UIP continues to actively recruit provider participation in the immunization registry through a variety of activities. UIP supports USIIS users by providing training to individuals through one-on-one or group training and Helpdesk requests. UIP worked with USIIS and vital records staff to establish/accept new race and ethnicity codes from vital records birth certificate data. USIIS accepts codes as established by vital records which moved from using 5 codes to 15 codes. USIIS reloaded data from vital records for all children born in Utah from January 1998 to present to populate the database with race and ethnicity data previously missed. Additionally, 113 new and re- trainings were provided to USIIS providers throughout the state.

The statewide "Immunize by Two" public awareness campaign was suspended due to a loss of funding and a reduction in program funds. Available funding was distributed to local health departments during January -- December 2009 to continue a limited campaign at the local level. The UIP continued participation in the Hallmark Greeting Card Program. During April 2009, UIP collaborated with the Northern Utah Immunization Coalition (NUIC) to conduct their annual immunization conference in conjunction with National Infant Immunization Week (NIIW). Additional support was provided for the Greater Salt Lake Immunization Coalition (GSLIC) for their annual NIIW provider workshop. The NUIC conference and GSLIC workshop were marketed to providers in the Utah Chapter of the American Academy of Pediatrics and the Utah Medical Association. The UIP distributed information to local health departments, community health centers and community coalitions to promote NIIW, National Immunization Awareness Month.

All program materials were made available in English and Spanish. Constituents were informed about the results of the "2007 Qualitative Ethnic and Racial Health Project". The UIP promoted the VFC Program with articles in minority magazines and newspapers. An ad was placed in the Utah Hispanic Yellow Pages to promote the VFC Program and to provide immunization age appropriate information. The UIP collaborated with the Utah Indian Health Advisory Board to create culturally appropriate immunization schedule cards and an immunization brochure specifically directed toward Native Americans.

Care-A-Van administered 5,175 doses to 2,820 clients at 84 clinics before being discontinued due to budget cuts. The UIP promoted and supported the Immunization Express, a new mobile immunization clinic, operated by Community Nursing Services. This support stretched to minority organizations and communities through collaboration with grass roots minority organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. UPIQ project assessed 10 clinics for Phase 2 of the program and 10 clinics for Phase 1.				X
2. Provider reps conducted 188 AFIX site visits to VFC providers.			X	
3. VFC satisfaction survey revealed 99.4% of clinics rate their experience as excellent or good.	X			
4. Increase of 19% in USIIS providers.			X	
5. Increased from 5 to 15 race codes in USIIS.				X
6. Continued participation in the Hallmark Greeting Card Program.		X		
7. An ad was placed in the Utah Hispanic Yellow Pages to promote the VFC Program and to provide immunization age appropriate information.		X		
8. Care-A-Van responsibilities transferred to Community Nursing Services; 5,175 doses administered to 2,820 clients.	X			
9.				
10.				

b. Current Activities

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

The UIP and USIIS are continuing to develop a method to use USIIS to assess immunization coverage (general population, race/ethnicity and Medicaid) levels statewide, and regionally. USIIS has increased the number of children birth to 5 years with at least two vaccinations recorded in the registry to 65.7%. We have increased USIIS enrollment by 9%. USIIS now automatically accepts race/ethnicity data from vital records when updated weekly with birth certificate data. The electronic Immunization Reminder Service continues as an ongoing service to remind parents of timely immunizations.

To date provider representatives have completed about 100 assessments at VFC provider offices.

The Hallmark Greeting Card Program continues throughout 2010. During December 2009, a medical assistant curriculum, "Basics of Vaccination," was completed and distributed to various health and community agencies throughout the state. UIP collaborated with Indian Health to develop and distribute immunization schedules and an immunization brochure to Indian Health Centers throughout Utah. UIP is collaborating with WIC to develop an online educational program for their staff.

UIP works with Community Nursing Services to start the Immunization Express so clients who previously used the Care-A-Van would still receive mobile immunization services.

c. Plan for the Coming Year

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

The Utah Immunization Program (UIP) Provider Relations Staff will continue to implement the quality improvement program, AFIX. They will work towards the goal of 20% of providers receiving face to face feedback on their 4:3:1:3:3:1 immunization rates every year. AFIX will be

promoted to providers through VFC site visits, brochures, and participating in local conferences with the new AFIX display.

The UPIQ project will continue recruiting providers to participate in quality improvement activities. UIP will collaborate on the Adolescent 101 project with Select Health to gather data on 4:3:1:3:3:1 as well as adolescent data that is comparable and reportable by UIP to the CDC.

Data will be queried from the USIIS data base to determine coverage levels based on race/ethnicity and Medicaid status. All USIIS providers will be encouraged to complete a USIIS satisfaction survey with the results being used to increase utilization. The annual coverage report will be disseminated to UIP partners/ stakeholders and posted online.

As funding allows, the "Immunize by Two" public awareness campaign will continue with local health departments. The UIP will continue to participate in the Hallmark Greeting Card Program and continue the electronic Immunization Reminder Service. 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 and National Immunization Awareness Month.

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

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	2005	2006	2007	2008	2009
Annual Performance Objective	16	14.8	15.7	16.5	18.5
Annual Indicator	15.7	16.3	18.6	18.5	18.5
Numerator	917	981	1133	1122	1122
Denominator	58374	60026	61060	60796	60796
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	18.5	18.5	18.4	18.4	18.3

Notes - 2009

Data reported are the most recent data available.

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

Denominator: IBIS Population estimates for 2008

Notes - 2008

Data reported are the most recent data available.

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

Denominator: IBIS Population estimates for 2008

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Denominator: IBIS Population estimates for 2007

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 18.5 and the Annual Indicator was 18.5.

The Maternal and Child Health Bureau continued to oversee the Department of Health and Human Services, Administration for Children and Families, Title V federal funding for Abstinence-only Education Program. The Adolescent Health Coordinator carried out oversight and technical assistance to funded community-based projects, which promoted abstinence from sexual activity, tobacco, alcohol and other drugs among youth aged 9-19 years through a variety of methods that were sensitive to community needs. There were six funded projects. Five targeted 9-14 year olds among all ethnicities and one targeted both 9-14 year olds among all ethnicities and 15-19 year old Hispanics. Many of these projects partnered with school districts to implement maturation and abstinence-only programming. Health care providers, service providers, religious and community leaders were targeted to encourage promotion of abstinence in their work with youth and parents. Each project had a parent component to encourage parents to regularly discuss abstinence with their children. On June 30, 2009, this funding source expired. Congress chose not to pass legislation that would extend the authority and funding for this program.

The Adolescent Health Coordinator continued to oversee the Utah Adolescent Health Network, which continued its focus on adolescent reproductive health issues. The network was comprised of two subcommittees. Those subcommittees were Teen Pregnancy Prevention (TPP) and STD Prevention. Both subcommittees continued to work on reaching the Utah State Teen Pregnancy Prevention Goal: By the year 2015, Utah will achieve a 20% decline in the pregnancy rate among girls between the ages of 15-19 (Baseline year 2003, 36.7 per 1,000 females). If Utah were to meet this goal, by the year 2015 the pregnancy rate among Utah girls between the ages of 15 -- 19 would be no more than 31.7 per 1,000 females. The rate for 2008 (most current data) is 39.4 pregnancies per 1,000 Utah females. Both subcommittees monitored, analyzed and released state data as they pertained to this goal. The Network also began working on a state report: Utah Adolescent Reproductive Health Report which will provide a snapshot of reproductive health issues pertaining to Utah adolescents.

The TPP subcommittee of the Utah Adolescent Health Network continued to utilize the Centers for Disease Control evaluated Parents Matter Program. This program is a parent intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction for parents of 9-12 year olds. With leftover funds from the pilot program award, the TPP subcommittee was able to provide an additional round of the Spanish language version of this program to a group of Latina moms. The program took place during November and December of 2008 and consisted of 5 two-hour sessions. Approximately 18 Latina women

participated in the program. The daughters of the women as well as some of their boyfriends participated in separate teen pregnancy prevention programming. Approximately 14 girls and 6 boys participated.

The Reproductive Health Program continued to provide contract oversight for the MCH Title V Funding contracted to the Teen Mother and Child Program at the University of Utah for the provision of supportive, age appropriate prenatal and pediatric care to teen mothers. Contract specifications included the prevention of repeat teen pregnancies and the development of strategies to reduce the increasing rate of repeat teen pregnancies. This funding ended June 30, 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oversight of ACF, Title V, Section 510 State Abstinence-only Education Programs.				X
2. Technical assistance to funded Abstinence projects.				X
3. Monitored, analyzed, and released Utah teen pregnancy and STD data.				X
4. Provided oversight of the Utah Adolescent Health Network (focus on adolescent reproductive health).				X
5. Began development of Utah Adolescent Reproductive Health Report.				X
6. Worked to reach the 2015 State Teen Pregnancy Prevention.			X	
7. Provided the Parents Matter Program to Latina moms.		X		
8. Provision of age appropriate prenatal and pediatric care to teen mothers.				X
9. Provided contract oversight for Teen Mother and Child Program.				X
10.				

b. Current Activities

The MCH Bureau no longer oversees the Title V federal funding for State Abstinence Education Program. As of June 30, 2009, this funding expired. Legislation was not passed by Congress to extend the authority and funding for this program.

The Adolescent Health Coordinator continues to oversee the Utah Adolescent Health Network, which focuses on teen pregnancy and STD prevention. The Network continues to monitor and share state data as they pertain to these two health areas. The Network is currently developing a Utah Adolescent Reproductive Health Report. This report will include data and resources pertaining to teen pregnancy and STDs among Utah's adolescent population.

The Utah Adolescent Health Network is also preparing to apply for the upcoming funding from the U.S. Department of Health and Human Services Office of Adolescent Health. The funding will be for evidence-based and promising programs that reduce teen pregnancy. The funding announcement will likely be released in spring 2010.

The Maternal and Infant Health Program continues to work and strengthen ties with the Utah State Office of Education and the Utah Parent Teacher Association. We continue to collaborate to develop tools and methods for educating students, teachers, and policy makers on the importance of scientifically based sex education. One of these tools, a booklet entitled "Life Planning for Teens" was completed this year. This tool continues to be distributed statewide.

c. Plan for the Coming Year

The Utah Department of Health, Maternal and Child Health Bureau, Maternal and Infant Health Program will apply for U.S. Department of Health and Human Services (HHS) funding for evidence-based and promising programs that reduce teen pregnancy by replicating programs with strong evidence of success. The Maternal and Infant Health Program plans to apply for funding that targets Latino teens and their parents the population with the highest teen birth rates in Utah.

The Adolescent Health Coordinator will continue to oversee the Utah Adolescent Health Network. The Network will reassess its goals, objectives, and activities, to assure the reproductive health needs of Utah adolescents are being met. The Network currently focuses on teen pregnancy and sexually transmitted disease (STD) prevention. The Adolescent Health Coordinator will continue to work on reaching the Utah State Teen Pregnancy Prevention Goal: By the year 2015, Utah will achieve a 20% decline in the pregnancy rate among girls between the ages of 15-19 (Baseline year, 2003). The Adolescent Health Coordinator will monitor and share state data as they pertain to this goal. The Network will publicize and distribute the Utah Adolescent Reproductive Health Report. This report includes data and resources pertaining to teen pregnancy and STDs among Utah's adolescent population.

The Teen Pregnancy Prevention subcommittee of the Utah Adolescent Health Network will continue to seek funding opportunities to utilize the Centers for Disease (CDC) evaluated Parents Matter program to plan and implement parenting programs within the community. This program is an evidence-based, parent intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction for parents of 9-12 year olds. The focus of this activity will be Hispanic families and the subcommittee will partner with Hispanic organizations to achieve this objective.

The Maternal and Infant Health Program will work with the Utah State Office of Education and the Utah Parent Teacher Association (PTA) to develop tools and methods for educating students, teachers, and policy makers on the importance of scientifically based sex education. The information booklet entitled "Life Planning for Teens" will continue to be distributed among Utah adolescents. This booklet provides information on relevant health topics for teens, such as a reproductive life plan and why it is important to develop one. The Maternal and Infant Health Program will provide a train the trainer training of presenters for the U.S. Health & Human Services "Parents Speak Up" program, a program supported and utilized by the Utah PTA. This training is based on the idea that parents are the best people to help their children make good decisions. The training provides information and tips on how to talk to children and teens about sexual behavior.

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	2005	2006	2007	2008	2009
Annual Performance Objective	52	50	45.1	45.1	45.1
Annual Indicator	49.9	45.1	45.1	45.1	45.1
Numerator	252	155	155	155	155
Denominator	505	344	344	344	344
Data Source				See footnote for source	See footnote for source

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	45.1	50	50	50	50

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Utah Oral Health Survey 2005, Oral Health Program, UDOH

a. Last Year's Accomplishments

The Performance Measure was achieved. The performance Objective was 45.1% and the Annual Indicator was 45.1%.

During FY09, the Oral Health Program (OHP) promoted sealants through screening and referral activities. The OHP supported direct delivery of sealants at the local health department level and promoted education/awareness programs among dental professionals, pediatricians and the public. The OHP concentrated on training Sealant for Smiles staff on screening and referral procedures for children attending high risk elementary schools in Salt Lake Valley, Davis, Summit and Tooele health departments. Referrals with information about low cost or no cost dental clinics are sent to parents of children identified as needing additional dental care. The Principal of the elementary schools and local health department personnel are also provided with a list of children with dental needs.

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 service to school children in Davis, Tooele, Summit and Salt Lake Counties. Nearly 6,000 children were screened and nearly 16,000 sealants were placed on children who are low-income, uninsured or enrolled in Medicaid/CHIP.

The OHP supported and provided technical assistance to sealant placement projects for low-income, uninsured, and Medicaid/CHIP insured children that are 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 health department and school personnel, volunteer dentists, dental hygienists, 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 placement to the public. Other activities included presentations and educational material on the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer

children for sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided technical assistance for local health department to form local Oral Health Task Forces and emphasize placement of dental sealants.				X
2. Used data from statewide survey of 6-8 year old children to develop strategies for direction efforts to reduce the percentage of children with untreated dental decay and increased the number of children with dental sealants.			X	
3. Supported and provided technical assistance to Sealants for Smiles for free sealants to low-income and underinsured first and second grade children in Salt Lake, Davis, Summit and Tooele Counties.				X
4. Supported the prevention and education activities of the Utah Oral Health Coalition in the promotion of dental sealants.				X
5. Supported the prevention and education activities of the Utah Oral Health Coalition in the promotion of dental sealants.				X
6. 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
7.				
8.				
9.				
10.				

b. Current Activities

The OHP is promoting dental screening, sealant and referral activities. The OHP is supporting direct delivery of sealants at the local health department level and promoting education/awareness programs among dental professionals, pediatricians and the public.

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

The OHP is supporting and providing technical assistance to other sealant placement projects for low-income, uninsured, and Medicaid/CHIP insured children coordinated and conducted by dental hygiene programs statewide.

Other activities include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

c. Plan for the Coming Year

The OHP will promote sealants through screening and referral activities. Plans are being developed to perform a statewide survey of 6-8 year old children this coming fiscal year. The

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

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

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

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

OHP is applying for a three-year CDC grant to fund State-based Oral Disease Prevention Program. The funding, if awarded to Utah, will provide us with the resources needed to promote oral health, prevention strategies, such as sealants, water fluoridation, etc. It would provide us with resources that we badly need to address oral health in the state.

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	2005	2006	2007	2008	2009
Annual Performance Objective	4.9	4.6	5.1	4.5	3.4
Annual Indicator	5.2	2.9	3.2	4.6	4.6
Numerator	35	20	23	33	33
Denominator	668784	686219	708557	723026	723026
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	4.3	4.2	4.1	4	4

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics Mortality database. UDOH 2007
 Denominator: IBIS Population estimates for 2007

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 4.5 and the Annual Indicator was 4.6.

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 249,490 people were reached through 1,622 events promoting motor vehicle safety. In addition, there were 35 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 53,446 individuals with by 454 activities at day care centers, schools, doctor offices, and businesses; distribution of over 2,139 child safety seats; conducting 48 car seat checkpoints; and educating the public through 23 media activities.

The pedestrian safety interventions included: pedestrian safety was promoted to 116,099 individuals through 125 events; Walk to School Day events were conducted at 82 schools and Green Ribbon Month events at 125 schools to increase awareness of pedestrian safety; coordinated with local law enforcement on pedestrian safety enforcement; educated the public through media activities; and, provided pedestrian safety information on the UDOH website. VIPP also coordinated the last year of the "Heads Up Utah" pedestrian safety media campaign with funding from the Utah Department of Transportation.

The bicycle safety interventions included: 192 community activities conducted reaching 23,045 individuals; and, distributed 2,299 bike helmets. The "Share the Road With Bicycles" DVD, available on the VIPP website, continued to be promoted to driver education classes.

VIPP remained the lead agency for Safe Kids Utah (SKU). SKU, through local 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.

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 as teens are the drivers in 27% of all MVC and 18% of all fatal crashes but only represented 7% of licensed drivers. Events (201) were conducted reaching over 32,908 individuals and 35 media events promoting teen

motor vehicle safety. A Utah Teen Driving Task Force continued to coordinate the efforts of several state, local, and private agencies working together on this issue. They conducted three press conferences on teen MVC and developed a second teen memorial booklet on teen motor vehicle-related deaths in 2008. 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 rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children was 4.52, thus meeting the annual performance measure.			X	
2. The Violence and Injury Prevention Program and local health departments reached over 249,490 people through 1,622 events promoting motor vehicle safety. In addition, there were 35 media events promoting motor vehicle safety.			X	
3. The Violence and Injury Prevention Program and local health departments promoted car seat use to over 53,446 individuals through conducting awareness activities at day care centers, schools, churches, doctors' offices, and businesses.			X	
4. The Violence and Injury Prevention Program and local health departments distributed over 2,139 car seats and 2,299 bicycle helmets.			X	
5. 125 schools participated in Green Ribbon Month, a statewide pedestrian safety campaign promoted by public health.			X	
6. The Violence and Injury Prevention Program remained the lead agency for Safe Kids Utah.			X	
7. The funding and training provided to local health departments for a statewide campaign to promote teen motor vehicle safety resulted in 258 events reaching over 32,908 people and 35 media events.			X	
8.				
9.				
10.				

b. Current Activities

VIPP continues collaboration with partners to implement strategies for reducing motor vehicle crash (MVC) deaths among children.

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

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

VIPP, as the lead agency for Safe Kids Utah, will oversee coalitions/chapters statewide. Reducing MVC injuries is a primary target area. Each coalition/chapter will coordinate interventions in their communities. The Safe Kids Utah website has been updated and allows Twitter.

VIPP is coordinating a bicycle/pedestrian safety campaign by promoting safety events, partnering

with other organizations, distributing educational materials, collecting data, working with media, coordinating bike rodeo trailer, making low cost helmets available, conducting and distributing results from bike helmet observation survey, and providing UDOH website information.

VIPP is coordinating a statewide campaign with all Utah LHDs aimed at reducing MVC deaths to teens (who have the highest death rates).

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.

Funding, training, and technical assistance to each LHD will be provided to conduct injury prevention interventions.

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, as lead agency for Safe Kids Utah (SKU), will oversee coalitions/chapters statewide. A primary goal is to reduce MV crash injuries and each coalition/chapter will coordinate interventions in their area. The SKU website will allow subscription to an electronic newsletter and increased use of social media.

VIPP will continue coordinating a pedestrian safety campaign by: promoting pedestrian safety events (Green Ribbon Month, Safe Routes to School, and Walk to School); partnering with Gold Medal Schools and community organizations; distributing educational materials: collecting and analyzing data; working with the media; coordinating with enforcement agencies; and providing information on the UDOH and partner websites.

Since teens are looked up to by siblings, VIPP will coordinate a bicycle safety campaign by working with the media, distributing educational materials, providing information on the UDOH website, collecting and analyzing data, scheduling the bike rodeo trailer, promoting bike safety events, seeking sources for low cost bike helmets, making helmets available through partners, conducting observation survey on bike helmet use, and distributing survey results and recommendations to improve helmet use.

VIPP will continue to coordinate a campaign with all LHDs aimed at reducing deaths to teens, 15-19 years of age, from MVC. Multifaceted interventions will include: education; mobilizing partnerships to solve traffic safety problems; partnering with law enforcement; and installing seatbelt reminder signs in communities.

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	2005	2006	2007	2008	2009
Annual Performance Objective		53	50	56	60.5
Annual Indicator	52.4	49.9	55.6	60.4	69.5
Numerator					

Denominator					
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	69.6	69.7	69.8	69.9	70

Notes - 2009

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

Notes - 2008

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

Notes - 2007

The data reported are from the National Immunization Survey. 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 60.5 and the Annual Indicator was 69.5.

Provisional data from the Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services National Immunization Survey indicated that Utah's breastfeeding rates were above the national average. The Healthy People 2010 breastfeeding objective is for 50% of infants continuing to breastfeed at 6 months of age. Utah has met and exceeded this goal. Nationally, 43.4% of infants are breastfeeding at 6 months.

The CDC also measured how breastfeeding is being protected, promoted and supported in each state with nine additional process measures: birth facility support, professional support, mother-to-mother support, state legislation, and public infrastructure (public facilities and services). The average national score in 2009 was 63. Utah's score was just below this average at 61. The three areas where Utah's rankings fell short were in the number of International Board Certified Lactation Consultants (IBCLCs) per 1,000 live births, the number of La Leche League groups per 1,000 live births, and no state legislation mandating employer lactation support.

A variety of planned activities related to breastfeeding promotion and support occurred in 2009. The WeeCare pregnancy program continued to educate and provide postpartum breastfeeding support to over 1,000 women. The Pregnancy Risk Assessment Monitoring System (PRAMS) included questions on breastfeeding which provided important data on initiation, continuation and exclusivity rates. The Maternal and Infant Health Program (formerly known as the Reproductive Health Program) continued to post a variety of breastfeeding resources on its website.

The Utah Breastfeeding Coalition (UBC) had an active year including sponsoring the 4th Annual Breastfeeding Cafe, a continuing education event titled "Relactation in Times of Disaster", and

promoted the Business Case for Breastfeeding for a second year. A Master's in Public Health student from Brigham Young University completed a practicum experience which led to the dissemination of the Business Case for Breastfeeding to 35 Utah businesses and a poster and paper will be presented at the Third National State and Tribal Breastfeeding Coalition Conference. A new partnership with the Utah Chapter of the American Academy of Pediatrics is being pursued.

The WIC program in 2009 rolled out a new food package that supports breastfeeding by providing additional foods to nursing mothers. Part of the rollout entailed staff education on supporting, assessing and counseling breastfeeding mothers. A 45 hour lactation course was held and attended by 80 people, primarily dietitians, nurses and WIC staff. World Breastfeeding Week was observed with educational outreach to professionals and the community on the importance of breastfeeding and maintaining breastfeeding during times of disaster. WIC invested in its educational resource library with updated textbooks and resource materials for healthcare professionals. WIC educational materials were purchased for dissemination to participants. In 2009, three WIC staff achieved certification as IBCLCs. WIC collaborates with community health centers, hospitals, and other public health programs in regards to improving breastfeeding policies and practices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. New WIC food package increasing foods for nursing mothers.		X		
2. Utah Breastfeeding Coalition sponsored the 4th annual Breastfeeding Cafe in Salt Lake City downtown public library.				X
3. Dissemination of the Business Case for Breastfeeding to over 35 Utah businesses.				X
4. Educational materials posted and dispersed through the WeeCare pregnancy program and the Women and Infant Health Program, and the WIC program.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities to educate and support women, families, employers, and healthcare providers will continue. Utah representatives attended the 3rd Annual State and Tribal Breastfeeding Coalition Conference for networking, education, and advocacy training. The UBC conference in January was attended by over 80 professionals and students. The position of the American Academy of Pediatrics Breastfeeding Chair in Utah was filled and collaborative activities are being planned. Additional training on the Business Case for Breastfeeding is planned. A goal is to disseminate it to at least 10 more businesses. The UBC will outreach during the August Breastfeeding Café event.

House Bill 252 "Workplace Accommodation of Breastfeeding" was endorsed by the Utah Department of Health, which developed a legislative fact sheet. The bill did not pass.

The WIC program continues to implement the new food rules limiting formula issuance and increasing breastfeeding assessment and counseling. The 45 hour lactation course will be offered online. The WIC Breastfeeding Peer Counselor Program will expand direct service hours. The

annual training will be provided in May 2010. WIC will fiscally support and encourage staff to sit for the 2010 IBCLC exam. All staff will be trained on a new national breastfeeding curriculum "Glow and Grow". The authors will present 3 two-day trainings. WIC is developing system requirements and reporting features for its new computer system that is still be tested.

c. Plan for the Coming Year

The UBC has several plans to promote breastfeeding in Utah. The yearly month-long Breastfeeding Café, an outreach event at the downtown public library, will be held in August. Additional ongoing plans are to obtain non profit 501 (c) 3 status, to increase outreach and participation in the Coalition throughout the state and widen stakeholder membership, and to further develop the UBC website. The Coalition will also continue to collaborate with the United States Breastfeeding Committee and the National State Breastfeeding Coalitions. Bi-monthly teleconferences are planned. The Worksite Lactation Taskforce will collaborate with local businesses on the implementation of the new workplace accommodations for the nursing mothers' statute Section 4207 of the Patient Protection and Affordable Care Act (also known as Health Care Reform). The statute states that employers shall provide breastfeeding employees with "reasonable break time" and a private, non-bathroom place to express breast milk during the workday, up until the child's first birthday.

The WIC program will offer several staff training opportunities and support staff members that are eligible to sit for the IBCLC certification exam. Each clinic will receive updated educational materials for staff development, and materials to promote breastfeeding during special events such as World Breastfeeding Week. The WIC program also plans to increase collaboration with organizations such as Utah Nutrition Council, Utah Dietetic Association, March of Dimes, Physical Activity, Nutrition and Obesity Program (PANO), the Center for Multicultural Health United States Lactation Consultant Association, and the American Academy of Pediatrics which can work together to better promote, protect and support breastfeeding.

The Pregnancy Risk Assessment Monitoring System (PRAMS) will evaluate 2009 survey breastfeeding data. New questions were added on reasons for discontinuing breastfeeding and age when solids were introduced. These data will help gain insights into the breastfeeding experiences of Utah mothers and will guide interventions. The Maternal and Infant Health Program will continue to support breastfeeding education through multiple breastfeeding related articles on the website. The WeeCare Program will continue to educate and promote breastfeeding duration of at least six months through interactions with women throughout pregnancy and during the first six months after birth. A breastfeeding guidebook and a booklet on returning to work or school will be included in mailed pregnancy materials, as well as a wide variety of breastfeeding information will be made available on the WeeCare blog www.pehpweecare.blogspot.com/.

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	2005	2006	2007	2008	2009
Annual Performance Objective	97.5	97.5	97.9	97.5	97.9
Annual Indicator	97.9	98.0	97.9	98.1	98.1
Numerator	51478	53454	55113	55705	55705
Denominator	52563	54532	56320	56788	56788
Data Source				See	See footnote

				footnote for source	for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	98.1	98.1	98.2	98.3	98.4

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, 2008

Notes - 2008

Data reported are the most recent data available.
 Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database
 Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2008

Notes - 2007

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database
 Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2007

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 97.9% and the Annual Indicator was 98.1%.

Universal newborn hearing screening is done at all 42 Utah birthing facilities and the pediatric specialty hospital. Utah had 56,788 births in 2008. Over ninety-eight percent (98.1%) of infants were screened for hearing loss. The inpatient pass rate was 95.1% increasing to 98.5% with outpatient results. Homebirth screening rates increased from 23.2% in 2007 to 35.8% in 2008. Four hundred forty-six (446) newborns were referred for diagnostic evaluation. Seventy-five (75) infants were identified with permanent hearing loss. Approximately 2% of Utah's 2008 newborns have not returned for outpatient or diagnostic testing, have screening results not yet reported to the State, or did not receive an initial newborn hearing screen. These data suggest that targeted efforts must be increased to help meet national 1-3-6 EHDl goals.

Utah EHDl's focus was to decrease the number of infants lost to hearing screening follow-up or documentation. Utah hospitals submitted updated protocols to the state EHDl office. Submissions were reviewed and evaluated for compliance to Utah guidelines, National Initiative for Children's Healthcare Quality (NICHQ) quality improvement recommendations and Joint Committee on Infant Hearing (JCIH) recommendations. Each facility was assessed, barriers and issues were identified, and action plans were initiated to address program needs. A refresher workshop was held for the Homebirth Hearing project. A HRSA Loss to Follow-up grant award allowed the purchase of six infant hearing screening devices for homebirth lay midwives. In collaboration with Utah's Fostering Healthy Children Program, documentation of hearing results improved to over 85% of children birth to 3 in foster care. A poster presentation highlighted this project at the 2009 EHDl Conference.

The HiTrack 4 data tracking system was upgraded and improved EHDI reporting and data sharing goals. Twelve hospitals have converted to HiTrack 4 since April 2008. Software enhancements were made based on user feedback. Monthly distribution of state HiTrack reports enabled timely data corrections and earlier tracking. Sites testing web-based HiTrack encountered access, up-load, and record update problems at the state level, so the web version has not been made available to hospitals. The linkage between Vital Statistics and HiTrack through CHARM was used to report maternal education, race, and ethnicity per MCHB and CDC objectives.

The "Age of Identification of Hearing Loss and Age of First Hearing Aid Fitting" project is nearly complete; a report will be made to the Utah Newborn Hearing Committee (NBHSC). Results will be shared with audiologists who diagnosis infant hearing loss; activities to decrease the age of identification and hearing aid fitting will be recommended. A pediatric audiology services survey was distributed statewide and is now being compiled. Free services were researched and only five audiology offices offer free or reduced cost screening services. A statewide training conference was held highlighting loss to follow-up objectives and data issues. A completed needs assessment on Utah Hearing Aid Loaner Banks was presented to the NBHSC in August 2009. A subcommittee will address recommendations.

A Family-to-Family Action Plan was updated in October 2008. State EHDI, Early Intervention (EI), the Parent Infant Program, and URLEND staff created goals to improve family-to-family support, advocacy, and collaboration with appropriate community resources. A parent resource notebook developed in collaboration with Utah State University Communicative Disorders program was printed June 30, 2009. Distribution to diagnostic sites and to parents of infants with newly diagnosed hearing loss started immediately.

A fax-back strategy as recommended by NICHQ is in the beta-test phase. A physician information form is faxed to the baby's physician/Medical Home when a baby fails inpatient screening. Outcomes of this process will be reviewed in next progress report. A fax-back follow-up form has been successfully implemented with five hospitals and EI. When an infant does not pass inpatient screening, the EI specialist calls the family to reinforce the need to complete outpatient testing. Reports from parents and EI have been very positive. This process will be refined and expanded to include informing the Medical Home and other caregiver professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessed updated Utah hospital program protocols; initiated action plans to address needs and barriers.				X
2. Held in service for Homebirth Hearing Project				X
3. Initiated NICHQ fax back improvement projects				X
4. Completed surveys / needs assessments focused on parent audiology resources, age of diagnosis/hearing aid fitting, and Utah loaner hearing aid banks.				X
5. Updated Family-to Family Support Action Plan Oct 2008.				X
6. Developed & began distribution of Parent Resource notebook.			X	
7. Held statewide EHDI conference; addressed loss to follow-up objectives and data & tracking issues.				X
8. Upgraded HiTrack; improved EHDI reporting and added CDC hearing data reporting guidelines.				X
9. Continued the Fostering Healthy Children Hearing Project to document/track hearing results for foster care kids 0-3.				X

10.				
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b. Current Activities

On-going activities include: 1) Evaluate effectiveness of hospital screening programs. Improve program success with standardized educational information, improved counseling approaches to families, scheduling follow-up activities, and reporting results. Review annual progress, identify barriers and issues and develop plans to address program needs. Emphasize NICHQ quality improvement activities. 2) Complete targeted site visits to hospitals with high referral rates and low diagnostic completion rates. 3) Increase the percent of hospitals using HiTrack 4. 4) Implement activities to decrease the number of infants over three months without definitive diagnosis. 5) Increase activities to reduce the number of infants who "missed" newborn hearing screening. Design a needs assessment for PCP'S to support hearing screening. 6) Expand the Homebirth Hearing project to six additional lay midwives. 7) Increase linkage to appropriate intervention services, including referrals, counseling and connection to a Medical Home. Pilot a "fax-back" process with audiologists and PCPs. Improve family-to-family support, advocacy, and collaboration with appropriate community resources. 8) Develop an educational pod cast (with CME credit) for pediatricians that highlights JCIH 2007 changes. Increase EHDI presentations by the Utah EHDI Chapter Champion. Update EHDI modules for the Utah MedHome portal.

c. Plan for the Coming Year

A number of activities are planned that will support the national 1-3-6 EHDI goals. Our focus will be on scheduling follow-up and intervention activities in a more timely way, documenting follow-up results, increasing homebirth screenings, improving counseling approaches, and distributing parent resource materials. Each year progress is reviewed, barriers and emerging issues are identified and plans are developed to address program needs. EHDI staff will continue targeted site visits to hospitals with high referral rates and low diagnostic completion rates. A Loss to Follow-up Coordinator will be hired with supplemental HRSA funds to decrease the number of infants lost to follow-up and documentation. Regional and statewide training sessions and appropriate one-on-one technical assistance will be scheduled with screening program staff. The potential benefit of using "Go-To-Meeting" for rural and frontier training and assistance will be researched.

The Utah EHDI Team and the Office of Vital Records (OVR) will continue the Birth Certificate Alert project that was delayed in the prior grant year due to access/linkage issues for 2009 birth data. This project links the EHDI data system and the Birth Certificate (BC) application process through the Child Health Advanced Records Management (CHARM) data system (on-line and at the state OVR office only), and provides a printed alert message to families when a BC application link generates a "missed screening" or "needs follow-up" message. Follow up rates for rescreens have improved to nearly 70%. Additional regional BC application sites will be linked to the alert project this year.

Activities aimed at decreasing the number of infants missed or lost to follow-up will be increased with hospitals and audiologists. The Homebirth/Lay Midwife Hearing project will be expanded; supplemental Loss-to-Follow-up funding has five screening units budgeted for FY11. Information for Medical Home providers will be updated information to the Hearing Screening Module on the MedHome portal, development of an annual Newborn Hearing and Follow-up report to primary providers, and with additional educational presentations by the EHDI AAP Chapter Champion.

Enhancements to the HiTrack4 data system will allow increased emphasis on achieving performance standards. HiTrack's 1-3-6 Milestone reports will become evaluation tools between state EHDI and hospital programs. All of Utah hospitals will convert to the upgraded HiTrack 4.5 system by June 2011. Increased efforts/collaborations with stakeholders will decrease the numbers of babies lost to documentation. Upgrades to the system server will be purchased/installed to enable audiologists reporting into state HiTrack through a web portal. Three diagnostic audiologists will beta-test the link. Development of the Utah School for the Deaf Parent Infant Program data system with electronic linkage to HiTrack via CHARM will be

completed.

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	2005	2006	2007	2008	2009
Annual Performance Objective	8.1	8.6	10.3	9.1	9.1
Annual Indicator	8.5	10.3	9.2	8.4	8.4
Numerator	67000	83200	76734	71700	71700
Denominator	788452	804569	834070	857680	857680
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	8.3	8.3	8.2	8.2	8

Notes - 2009

Data reported are the most recent data available.

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

Denominator: IBIS Population estimates 2008

Notes - 2008

Data reported are the most recent data available.

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

Denominator: IBIS Population estimates 2008

Notes - 2007

Numerator: The proportion of children with no insurance calculated using the data from the Utah Healthcare Access Survey, 2007.

Denominator: IBIS Population estimates 2007

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 9.1 and the Annual Indicator was 8.5.

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Additional funding to maintain open enrollment in CHIP.				X
2. Increased number of children enrolled in CHIP and Medicaid.			X	
3. Successful media campaigns to promote the open enrollment.			X	
4. Monitored coverage rates for children in the state.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the current year with a number of staff vacancies, we have not had the resources to work on increasing the number of children with insurance. The numbers of families seeking health insurance for their children have increased steadily from approximately 155,000 children enrolled in Medicaid and CHIP in March 2009 compared to more than 181, 600 in March 2010.

The Department staffs a legislative health care reform workgroup to address needs in the state. We have continued our efforts to support UtahClicks so that families in need can apply for certain services online.

We do ask programs, such as WIC, to ensure that families are referred to CHIP or Medicaid.

c. Plan for the Coming Year

It is hoped that the current hiring freeze will lift for the beginning of the state fiscal year, July 1st so that we can begin to recruit to fill vacant positions that will enable us to assign this important Performance Measure to track and collaborate with partners to promote the importance of families and health care coverage. We hope that with the new home visiting funding for programs that one of the ways we can promote insurance for children would be through home visitors assisting parents in applying for eligible services.

We plan to collaborate with the Center for Multicultural Health and the CHIP Program to promote outreach activities to increase CHIP enrollment among racial and ethnic minority populations.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		21.6	21.6	21.6	21.8

Annual Indicator	21.6	21.8	21.8	21.8	21.8
Numerator	6541	6558	6558	6558	6558
Denominator	30282	30083	30083	30083	30083
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	21.8	21.7	21.7	21.5	21.5

Notes - 2009

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

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

Notes - 2008

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

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

Notes - 2007

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

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

a. Last Year's Accomplishments

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

The Utah WIC Program continued to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) and the Food Stamp/SNAP Food Sense or SNAPEd Program by referring all WIC children at risk of overweight and overweight to these programs' healthy lifestyle classes. The EFNEP and Food Sense program directors estimated that, in 2009, 20 healthy lifestyle lessons were taught in WIC clinics and approximately 2,100 WIC participants were referred to these programs.

The results of the 2008 WIC Participant Satisfaction Survey were used to plan the types of healthy food options for the WIC food packages which were implemented in 6/2009. The results indicated that a majority (85%) of WIC participants preferred fresh fruits and vegetables over canned or frozen forms. And 58% preferred whole wheat bread and whole grain cereal over other whole grain products. Canned beans were preferred over dry beans by 75% of participants.

The Utah WIC Healthy Living Survey was administered in the Ogden WIC clinic which serves a population with a high prevalence of overweight and obesity. The purpose of this survey was to determine WIC participants' access to healthy foods and physical activity resources. Overall, the majority of respondents reported that they had access to healthy foods and physical activity opportunities. Also, 83.9% of the English and 70.2% of the Spanish-speaking participants reported doing some kind of physical activity 3 or more days per week. And, 96.1% of English and 81.9% of Spanish-speaking participants reported "Yes" to the question "Are there grocery stores near your household that offer healthy foods that you are able to buy?"

The results of the WIC Healthy Living Survey and the survey tool were shared with all Utah local WIC staff, for their consideration in administering it in their local districts. Unfortunately, none of the other local WIC districts decided to implement the survey.

The one day Value Enhanced Nutrition Assessment (VENA) interactive training was successfully conducted in September, 2008 at the statewide WIC Conference. Critical thinking and rapport building skills involved in the VENA approach to nutrition assessment are essential for conducting sensitive, participant focused counseling surrounding healthy eating, physical activity and maintaining healthy body weights and lifestyles for the entire family. Pre and post VENA training surveys were conducted with all attendees. The response rate to these surveys was 72.3%. The survey results showed an increase in the average respondent rating of their comfort level with VENA between the pre and post-training surveys. While only 65.5% rated themselves in the high comfort 3-4 level with the VENA process at the time of the pre-training survey, 91.8% did so at the time of the post-training survey. And 8.9% rated their level of comfort with VENA as low at the time of the pre-training survey, compared to only 1.2% at the time of the post-training survey.

In addition, the Utah WIC Program participated in the National WIC Association Sesame Street Workshop campaign on healthy habits for children. Healthy Habits for Life: Get Healthy Now kits were disseminated to all local WIC clinics for distribution to every family enrolled in the Utah WIC program. These kits contained a DVD and activities on how to eat, play and learn to grow healthy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC children at risk of overweight and overweight were referred to the healthy weight /lifestyle classes offered by SNAPEd or Food Sense and EFNEP.		X		
2. The 2008 WIC Participant Satisfaction Survey was analyzed and results were used in planning healthier WIC food packages.			X	
3. A community needs assessment tool, WIC Healthy Living Survey, was administered, analyzed and shared with other local WIC districts				X
4. One day VENA training on critical thinking and rapport building was successfully conducted with all WIC health professionals.				X
5. Sesame Street Workshop Healthy Habits campaign kits were disseminated to all local WIC districts.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The Utah WIC Program continues to collaborate with the Expanded Food and Nutrition Education Program (EFNEP) and the Food Stamp/SNAP Food Sense or SNAPEd Program by referring all WIC children at risk of overweight and overweight to these programs' healthy lifestyle classes.

Goal setting at each WIC certification visit continues to help children achieve a healthy body weight. The Help Me Be Healthy educational series for children aged 1 year through 4 years has been updated. Physical activity cards entitled, Baby Play, Toddler Play and Child Play, were updated and are now available for all local WIC clinics.

As the new WIC food packages are being issued, the local WIC staff use new educational materials that emphasize the importance of breastfeeding, healthy eating for the entire family and dietary fiber.

The 2010 Participant Satisfaction Survey (PSS) was implemented in April 2010. Self-paced Value Enhanced Nutrition Assessment (VENA) modules are available for all new local WIC staff to learn about this participant centered nutrition assessment process.

Finally, the Utah WIC Program continues to participate in the National WIC Association Sesame Street Workshop campaign on healthy habits for children. "Healthy Habits for Life: Get Healthy Now" kits are being distributed to every family enrolled in the WIC program. These kits contain a DVD and activities on how to eat, play and learn to grow healthy.

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/SNAP Food Sense (SNAPEd) Program by referring all WIC children at risk of overweight and overweight to these programs' healthy lifestyle classes. The EFNEP and Food Sense program directors have recently determined a plan for assessing the number of WIC participants who attend their classes. The number of WIC participants following through on referrals to these programs will be obtained. Also, these referral sources will be added to the current computer system for the WIC health professionals to indicate when they make these referrals.

The data from the Utah WIC Program Participant Satisfaction Survey (PSS) conducted in the spring of 2010 will be analyzed to assess participant perception of WIC services and their acceptance of the new, healthy food items. User acceptance training, testing and implementation of the USDA State Agency Model (SAM) computer WIC system entitled, VISION, will occur during 2010 - 2011. The VISION system incorporates the VENA process using a navigational tree structure which will facilitate a participant centered, open ended interview process during nutrition assessment.

USDA Nutrition Risk Revision 10 will be incorporated into the current WICNU computer system and the Utah WIC Policy and Procedure Manual. This revision updates risk factors related to weight gain during pregnancy and inappropriate nutrition practices for infants, children and women. Training on Nutrition Risk Revision 10, the logic model approach to program planning and WIC data reports from CDC will be offered for all local WIC staff in the fall of 2010. This training will facilitate a comprehensive nutrition needs assessment process that will benefit the local WIC staff in planning nutrition intervention strategies to help WIC participants achieve and maintain a healthy weight and lifestyle. Fit WIC Kids and other WIC Works Resource System

resources designed to combat childhood obesity will be reviewed and considered for incorporation into the Utah WIC Program. The updated physical activity series entitled, Baby Play, Toddler Play and Child Play will be distributed to all applicable WIC participants beginning July 1, 2010.

Breastfeeding has been associated with a reduced odds of pediatric overweight. It 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 will be offered for all WIC staff during the months of July, August, September and October of 2010.

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	2005	2006	2007	2008	2009
Annual Performance Objective		4.6	4.2	4.2	4
Annual Indicator	4.7	4.3	4.1	3.9	3.9
Numerator	2386	2228	2285	2188	2188
Denominator	50653	51517	55063	55605	55605
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	3.8	3.7	3.6	3.5	3.4

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

a. Last Year's Accomplishments

This Performance Measure was achieved. The Performance Objective was 4% and the Annual Indicator was 3.9%.

The Utah Department of Health's Tobacco Prevention and Control Program (TPCP) promoted the Quit Line as a resource for pregnant women using tobacco. Using economic stimulus funds, the TPCP was able to increase the number of counseling sessions available to pregnant women via the Quit Line. A pamphlet explaining the Quit Line was also developed. The TPCP also consulted with private providers through onsite office visits to determine the best means of implementing tobacco cessation information into each practice's specific work flow. Information promoting use of the TRUTH Network and the Quit Line fax referral system was provided at the time of the visits.

Local health departments (LHDs) throughout Utah offered tobacco cessation counseling through their own health promotion staff, home visiting programs or referral of pregnant tobacco users to the Utah Quit Line or QuitNet. The TPCP provided materials for the First Step Program to assist pregnant women in their cessation efforts. Many local health departments offered portions of the First Step Program. However, most LHDs were unable to offer the complete program that includes six one-on-one sessions as most women were unwilling/unable to attend all of them. However, Medicaid Health Program Representatives have been able to offer all sessions involved in the First Step Program to pregnant smokers enrolled in Medicaid as part of a variety of health promotion efforts they provide.

The WIC Program referred pregnant tobacco users to the Quit Line. To improve effectiveness in dealing with cessation efforts, the TPCP produced a video to train WIC personnel on Quit Line services.

The TPCP and Maternal and Infant Health Program (MIHP) collaborated as part of the Preconception Health Workgroup of the First Time Motherhood/New Parent Initiative Grant to develop strategies to target pregnant and parenting women regarding the importance of tobacco cessation before and during pregnancy and the need to remain quit following delivery. Baby wipes and changing pads were developed with cessation messages ("Quit Happens" and "The Greatest Change You'll Ever Make"). These will be distributed via the LHDs to their clients and from the LHDs to WIC offices, Medicaid enrollees and private health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expansion by the Tobacco Prevention and Control Program (TPCP) of the number of Quit Line counseling sessions available to pregnant smokers.		X		
2. Development by TPCP of a pamphlet for pregnant smokers describing Quit Line services.			X	
3. Utilization of the First Step Program by local health departments and Medicaid Health Program Representatives to assist pregnant women in their tobacco cessation efforts.		X		
4. Site visits by TPCP to private providers to assist them in means of incorporating tobacco cessation information into their routine office practice.		X		
5. Promotion of tobacco cessation activities by WIC along with development by TPCP of a training video to increase awareness among WIC personnel of Quit Line services.				X
6. Collaboration by TPCP and Maternal and Infant Health Program with the Preconception Health Workgroup of the First Time Motherhood/New Parent Initiative Grant in development of tobacco cessation messages targeting pregnant and parenting women.				X

7.				
8.				
9.				
10.				

b. Current Activities

The Tobacco Prevention and Control Program (TPCP) is preparing to distribute educational brochures and tobacco cessation tools--onesies, diaper wipes and changing pads--developed with the Preconception Health Workgroup of the First Time Motherhood/New Parent Initiative Grant via local health departments. Site visits to private providers' offices to consult regarding incorporation of tobacco cessation materials into office routines are continuing. Additional distribution sites for cessation messages are being explored.

Efforts to promote the TRUTH Network Tobacco Cessation Program that includes the Quit Line and Quit Line fax referral system are continuing with WIC, private providers and local health departments (LHDs).

The First Step Program is being phased out of LHDs as they are unable to retain pregnant women through the six-session course. Women are given general information at the LHDs and referred to the Quit Line for additional support in quitting. Medicaid Health Program Representatives continue utilizing the First Step Program in their health promotion efforts with pregnant women using tobacco.

The Maternal and Infant Health Program will place information on the effects of tobacco before, during and after pregnancy on their website along with links to resources to assist health care providers in counseling women regarding tobacco cessation.

c. Plan for the Coming Year

In an effort to continue to reduce the number of women reporting smoking in the last three months of pregnancy, the Tobacco Prevention and Control Program (TPCP) will continue to promote the TRUTH Network and the Quit Line fax referral system as the main focus of most tobacco cessation activities among local health departments, the WIC Program and private providers. TPCP will distribute cessation messages imprinted on baby wipes, onesies and changing pads targeting pregnant and parenting women which have been developed in collaboration with the Preconception Health Workgroup of the First Time Motherhood/New Parent Initiative Grant.

The Maternal and Infant Health Program (MIHP) will maintain information regarding the effects of tobacco before, during and after pregnancy along with links on tobacco cessation counseling for health care providers on the program's website. The Utah Indicator Based Information System for Public Health (IBIS-PH) "Smoking in the Third Trimester of Pregnancy" indicator will be updated as new data become available.

In July of 2010, a significant tax increase on cigarettes will be implemented in Utah. The MIHP will track the rate of third trimester smoking over the first six months following initiation of the tax (the only data available by July of 2011) to determine if there is a decrease in the percentage of women continuing to smoke during the third trimester of pregnancy. Additionally, the demographic profile of women reporting third trimester smoking in Pregnancy Risk Assessment Monitoring System surveys (PRAMS) will be reviewed to detect any shifts in at-risk populations.

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	2005	2006	2007	2008	2009
Annual Performance Objective	14.2	13.9	13.2	13.2	10.6
Annual Indicator	9.3	10.4	10.6	11.5	11.5
Numerator	18	22	23	25	25
Denominator	194147	212391	216313	216682	216682
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	11	11	11	11	11

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2007
 Denominator: IBIS Population estimates for 2007.

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 10.6 and the Annual Indicator was 11.5.

The former Division Director represented UDOH on the Suicide Prevention Council as they moved forward on the goals and activities outlined in the Utah State Suicide Prevention Plan. The UDOH supported outreach efforts through the Utah Suicide Prevention Council to promote suicide prevention with government and community partners.

Suicide prevention workshops were included in local mental health and suicide prevention conferences. Participant reviews from conferences have been used to provide direction in the development of future training to enhance the service delivery system for children, including youth at risk for suicide.

The Children's Mental Health Promotion Specialist collaborated with VIPP in obtaining data related to youth suicide and assists VIPP in completing updates to the State Strategic Plan for Injury and Violence Prevention. VIPP continued to provide information on the UDOH Internet site.

Public awareness about youth suicide risks and prevention efforts were addressed through participation in the Suicide Prevention Council, through information to the media and presentation to public and private organizations.

The Specialist provided consultation to the Child Fatality Review Committee related to youth suicide deaths in order to enhance the quality and quantity of data available on suicide so that they can be used for prevention purposes. Data collection is used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high-risk populations for interventions, and to assess the impact of prevention efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation on the Suicide Prevention Council				X
2. Mental Health conference planning and speaker sponsorship				X
3. Collaboration with Violence and Injury Prevention Program				X
4. Consultation to Child Fatality Review Committee				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Children's Mental Health Promotion Specialist resigned from the UDOH in January 2010 and due to a hiring freeze, we have not been able to fill that position. Other staff work on suicide prevention efforts through the Suicide Prevention Council.

c. Plan for the Coming Year

The Division will develop a plan to address the suicide rate increase with its partners. When we are able to fill the vacant positions, we will have a position set aside for school health. One of the responsibilities will be to participate in youth suicide prevention activities with partners and the Suicide Prevention Council. Until we have the resources, we will not have a plan to address this important issue.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	64	83	80	84	81
Annual Indicator	79.4	84.4	79.9	81.3	81.3
Numerator	424	475	460	469	469
Denominator	534	563	576	577	577
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	82	82.5	83	83.5	84

Notes - 2009

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

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals.

Notes - 2008

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

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals.

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals.

a. Last Year's Accomplishments

The Performance Measure was achieved. The performance objective was 81% and the annual indicator was 81.4%.

The percentage of very low birth weight (VLBW) infants delivered at tertiary care hospitals (high risk facilities equipped to care for high risk neonates) has improved, but is still behind the Healthy People 2010 goal that 90% of these infants deliver at high risk facilities. Reaching this goal is significant in that improved outcomes occur when infants are delivered in a facility offering the appropriate level of care. Furthermore, improved outcomes occur when an infant is delivered in the appropriate facility without the need to transport to a higher level facility.

In 2008, 577 infants weighing less than 1500 grams were born accounting for approximately 1% of all live births to Utah resident mothers. Of these infants, 469 were delivered at tertiary care hospitals and 107 were born at non-tertiary care hospitals.

A University of Utah Doctoral Nursing student developed her practicum project collaborating with the Utah Department of Health's Patient Safety Initiative and the Maternal and Infant Health Program's Perinatal Mortality Review Program on a Perinatal Quality Improvement Initiative. A presentation on the need for a statewide perinatal quality improvement collaborative was given via Webinar to an audience of clinical and hospital quality stakeholders.

A public health student started a practicum project with the Maternal & Infant Health Program to analyze the birthing hospital levels of care capacity. A survey was designed and administered to all delivering hospitals in Utah to define the levels of maternal and neonatal levels of care according the American Academy of Pediatrics Definitions of Facilities Based on Capabilities of Neonatal Care (2004) and the American College of Obstetricians and Gynecologists "Guidelines

for Perinatal Care" (2007).

The Maternal and Infant Health Program continued its efforts to learn from the Ohio Perinatal Quality Collaborative (OPQC) and other state collaboratives that have implemented Perinatal quality initiatives. In 2009 a scheduled conference call was cancelled with subsequent ongoing scheduling difficulties, however these efforts will continue in 2010.

The planned analysis of birth certificate data to identify VLBW infants who were not delivered in facilities appropriate for optimal care was not accomplished due to lack of resources. The survey of hospitals where delivery of VLBW infants occurred to ascertain whether they met the AAP guidelines for Level III care was not accomplished also due to a lack of resources. However, the public health student will work to complete these projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal Quality Initiative project and presentation being planned.				X
2. Hospital survey planned to determine maternal and neonatal levels of care.				X
3. Analysis of very low birth weight deliveries occurring outside of tertiary care centers planned.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The neonatal levels of care survey and analysis of extremely low and very low birth weight births occurring in non-tertiary care neonatal intensive care units (NICU's) was done. Ten hospitals self-designated as Level III. Four met the American Academy of Pediatrics (AAP) recommendation that NICU's have a neonatologist continuously available. The other hospitals have neonatologists on call. Discussion of hospital standards and AAP recommendations will be planned.

The Perinatal Mortality Review (PMR) Program continues to identify interventions to prevent future deaths.

The Utah Department of Health's (UDOH) Division of Family Health and Preparedness, partnered with community leaders to apply for a Health and Human Services "Patient Safety and Medical Liability Reform" demonstration grant. A community perinatal learning collaborative for patient safety measures, the publication of trends in perinatal clinical measures, and adoption of clinical guidelines as standards to be translated into clinical decision support tools are components. We are awaiting award announcement.

A University of Utah Doctoral Nursing student and the UDOH Patient Safety Initiative and PMR Program presented a webinar "Perinatal Quality Improvement Initiative". The national momentum to improve the quality of maternity care in the US, a priority area for quality improvement due to the high number of preventable morbidities and mortalities, was discussed.

c. Plan for the Coming Year

Utah will strive to meet the goal that 90% of very low birth weight (VLBW) infants be delivered at facilities appropriate for their care.

Emphasis will continue to be put on preconception care, and education that optimal pregnancy spacing, optimal pre-pregnancy weight, the appropriate treatment of chronic diseases, tobacco cessation, and treatment of periodontal disease all have a role in the prevention of very low birth weight. Early and continuous prenatal care including thorough formal risk assessments, education on danger signs and the importance of fetal kick counts help with early recognition of problems, earlier interventions, and improved pregnancy outcomes. Risk factors for poor outcomes will continue to be mitigated through education and referrals to appropriate services. These risk factors include pregnancy history, exposure to infections, use of medicines and exposure to chemicals in the environment, alcohol or drug use, poor medical care, chronic health problems and smoking as well as socioeconomic factors.

Services such as Baby Watch Early Intervention, the Children's Health Insurance Program, Bureau of Children with Special Health Care Needs Programs, the Utah Neonatal Follow-up Program, and the Women, Infants and Children Program will be promoted to help these children live a more normal healthy life.

The hospital levels of care data and analysis of the location of very low birth weight infants will illuminate where emphasis should be placed in order to increase the numbers of very low birth weight being delivered at the appropriate level facility. These results will be disseminated, perhaps via a webinar with a discussion of the AAP recommendation that neonatologists be onsite at Level 111 NICU's and the findings that most Level 3 hospitals in Utah have neonatologists on call.

If the UDOH is a recipient of the three year demonstration grant "Patient Safety and Medical Liability Reform", the Domain Knowledge/Patient Safety Working Group will be recruiting practitioners into the Utah Perinatal Learning Community Collaborative who will review and adopt perinatal guidelines which will be translated into decision support algorithms. They will select relevant perinatal measures and develop statewide disclosure and informed consent protocols.

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	2005	2006	2007	2008	2009
Annual Performance Objective	78.6	78.2	79	78.6	79
Annual Indicator	78.8	79.0	79.4	79.1	79.1
Numerator	40587	42237	43728	43977	43977
Denominator	51517	53475	55063	55605	55605
Data Source				See footnote for source	See footnote for source
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	79.1	79.1	79.1	79.2	79.2

Notes - 2009

Data reported are the most recent data available.

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

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

Notes - 2008

Data reported are the most recent data available.

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

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 78.8% and the Annual Indicator was 79.1%.

Baby Your Baby continued to air PSAs that included the message about early and continuous prenatal care and financial assistance. The PSAs ran in both English and Spanish. Baby Your Baby ads focusing on obtaining financial assistance for pregnant women were aired on television for the full fiscal year but radio spots only ran through November 2008. The program had planned to implement a Native American Outreach campaign, but this was not accomplished during the reporting period.

The BYB program continued to accept Presumptive Eligibility applications via phone. The Utah Clicks on-line eligibility application system was supported by staff. Training of local health department staff and other Presumptive Eligibility site staff on use of the Utah Clicks system was conducted. In FY 2009, 7,679 Baby Your Baby applications were made on UtahClicks, an increase of almost 1,800 applications from the year before.

A MOA was signed with the Ft. Duchesne Indian Health Clinic to become a PE site and offer outreach to pregnant women on the Ute Indian Reservation.

The Division continued its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers.

RHP staff worked with the March of Dimes Teddy Bear Den to promote their activities among UDOH partners and encourage enrollment among eligible women. The Teddy Bear Den rewards enrolled women for positive practices during pregnancy, including first trimester prenatal care entry.

Department of Health staff worked to publish a series of Health Disparities Summaries that focused on race and ethnicity. Significant disparities in prenatal care adequacy were found in three racial groups examined (Black, Pacific Islander, and Native American) and also in Hispanic women. For each of these groups, prenatal care adequacy rates were significantly lower than rates for the white population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to take Baby Your Baby applications via telephone and on-line.		X		
2. Continued to contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women with no insurance.	X			
3. Continued to air Baby Your Baby PSAs on television and radio.			X	
4. Signed memorandum of agreement with the Ft. Duchesne Indian Health Clinic to become a Presumptive Eligibility site.		X		
5. Published Health Disparities Summaries highlighting prenatal care utilization.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY2010, Baby Your Baby has continued to air television PSAs that include messages about early prenatal care and financial assistance. BYB staff worked with the Utah Indian Health Advisory Board to develop a keepsake book for Native American women. The BYB program continues to accept Presumptive Eligibility applications via phone. The MIHP continues to facilitate use of the UtahClicks on-line application system. MIHP staff will continue its work with the March of Dimes Teddy Bear Den to promote their activities among UDOH partners and encourage enrollment among eligible women.

The MIHP is developing courses for women attending "Your Parole Requires Extensive Preparation" (YPREP) courses. Courses will include information on prenatal care and family planning as appropriate. MIHP staff has presented to female youth in custody, when they discussed the importance of prenatal care and financial resources.

The MIHP signed a MOU with the Text4Baby campaign. The MIHP will promote the Text4Baby program via its website and other outreach activities.

The Division continues its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers.

c. Plan for the Coming Year

The Baby Your Baby program will continue to focus on women receiving early prenatal care and financial assistance. BYB program staff will be working on new scripts to continue the messages of early and adequate prenatal care. The PSAs will play on English and Spanish radio and TV throughout Utah. The newly developed BYB keepsake for Native American women will be distributed to tribes around the state.

Baby Your Baby will continue to accept applications via phone and online for Presumptive Eligibility in Salt Lake County. Baby Your Baby applications will be accepted online and in person throughout the rest of the state. Women who use the BYB hotline but do not qualify for Presumptive Eligibility will be referred to community health centers and other sliding fee clinics throughout the state for early and adequate prenatal care. The MIHP will also continue to facilitate use of the UtahClicks on-line BYB eligibility application system to women via various

websites.

The Division will continue its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers.

The MIHP is working to develop courses for women attending "Your Parole Requires Extensive Preparation" (YPREP) courses. These courses for women approaching release from prison will include information on prenatal care, including information on where to apply for financial assistance. MIHP staff and interested partners will continue to present to female youth in locked custody regarding the importance of prenatal care and financial resources.

A recent analysis of Utah PRAMS data found that homeless women had significantly higher rates of inadequate prenatal care. The MIHP will explore potential partners and strategies to encourage homeless women to obtain early and continuous prenatal care.

The MIHP will work as a partner for the national Healthy Mothers, Healthy Babies coalition's Text4Baby campaign. The MIHP will promote the Text4Baby program via its website and other outreach activities.

D. State Performance Measures

State Performance Measure 1: *The percent of women of reproductive age (18-44) who are uninsured.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		14	17.2	16	16
Annual Indicator	15.3	16.1	13.8	14.9	14.9
Numerator	78617	98370	86630	83775	82280
Denominator	513839	609150	626848	560742	553699
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	15	14	13	13	

Notes - 2009

Numerator: The proportion of women with no insurance calculated using the data from the Utah Behavioral Risk Factor Surveillance System, 2008

Denominator: IBIS Population estimates 2008

This is a new data source for this objective.

Notes - 2008

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

Denominator: IBIS Population estimates 2008

Notes - 2007

Numerator: The proportion of women with no insurance calculated using the data from the Utah Healthcare Access Survey, 2007

Denominator: IBIS Population estimates 2007

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 16% and the Annual Indicator was 14.9%

The Maternal and Infant Health Program (MIHP), formerly the Reproductive Health Program, continued work toward gaining approval for an 1115 Research and Demonstration Waiver for family planning services. Supportive data have been analyzed and provided to various stakeholder partners upon request. The MIHP collaborated with the Maternal and Child Health Bureau's Data Resources Program to analyze and study Medicaid data related to closely spaced pregnancies and their outcomes in order to make the case for the potential cost savings the state could realize with implementation of a family planning waiver.

The MIHP continued to promote the Primary Care Network (PCN) and Utah's Premium Partnership for Health Insurance (UPP) among women of reproductive age through advertisement on the program's website and health fairs. The MIHP continued work to increase enrollment into Medicaid for pregnant women who qualify for presumptive eligibility (PE) by promoting the UtahClicks online electronic application system through the program's website, and at health fairs. The number PE prenatal Medicaid applications submitted via UtahClicks increased from 6,843 in 2008 to 7,711 in 2009.

Lastly, the MIHP has continued to monitor the rate of Utah women of reproductive age who are uninsured and partner with advocates for health care reform to assure that this important target group is included in the reform agenda.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Maternal and Infant Health Program (MIHP) continued work toward gaining approval for an 1115 Research and Demonstration Waiver for Family Planning Services.			X	
2. The MIHP partnered with the Utah Chapter of the MOD on increasing the minimum federal poverty level (FPL) at which women can qualify for prenatal Medicaid.		X		
3. The MIHP continued to promote the Primary Care Network (PCN) and Utah's Premium Partnership for Health Insurance (UPP) among women of reproductive age.		X		
4. The MIHP continued work to increase enrollment into Medicaid for pregnant women who qualify for presumptive eligibility (PE) by promoting the Utah Clicks online electronic application system.			X	
5. The MIHP has continued to monitor the rate of Utah women of reproductive age who are uninsured and partner with advocates for healthcare reform to assure that this important target group is included in the reform agenda.			X	
6.				
7.				
8.				
9.				

10.				
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b. Current Activities

The Maternal and Infant Health Program (MIHP) has been collaborating with the Utah Health Policy Project (UHPP), a non-profit agency that serves as a resource for the public, community leaders, businesses, health care providers and policy makers interested in strengthening the health care system through decreasing the numbers of uninsured and addressing rising health care costs. MIHP has provided pertinent data and consultation to UHPP so that they could work to assure that insurance coverage for women of reproductive age is on Utah's health care reform agenda.

During the 2010 Legislative Session, one representative sponsored legislation to mandate that UDOH develop a 1115 family planning waiver. This is a first in Utah history! The bill did not pass, however staff were very involved in providing data as available. The MIHP worked with several partners to provide data and information for this bill. The bill sparked a great deal of interest in UDOH in terms of provision of data and information from a program perspective.

The MIHP provided information to the Utah Chapter of the March of Dimes (MOD) on increasing the minimum federal poverty level (FPL) at which women can qualify for prenatal Medicaid. Since Utah state legislative approval is required to increase the income eligibility level in order to increase the number of women who can qualify for prenatal Medicaid, the MOD decided that in the current economic shortfall, requests for appropriations are not favorable.

c. Plan for the Coming Year

This performance measure is being discontinued.

State Performance Measure 2: *The proportion of pregnancies that result in a live birth that are intended.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	66.4	68.7	67.1	65.9	69.3
Annual Indicator	66.1	65.8	69.1	67.0	67.0
Numerator	34053	35187	38070	37255	37255
Denominator	51517	53475	55063	55605	55605
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	69.5	69.7	69.9	70.1	

Notes - 2009

Numerator: PRAMS weighted data, 2008

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

Notes - 2008

Data reported are the most recent data available.

Numerator: PRAMS weighted data, 2008

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

Notes - 2007

Numerator: PRAMS weighted data, 2007.

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 69.3 and the Annual Indicator was 67.

Over the past five years, 2004 through 2008, the annual indicator has remained essentially unchanged varying only from a high of 69.8 intended pregnancies in 2007 and 2008 to a low of 65.8 in 2006. PRAMS data on unintended pregnancy were reviewed and revealed no significant changes in the demographics of women reporting unintended pregnancies or in the reasons for not using contraception.

During FY09, six programs within the UDOH including the Maternal and Infant Health Program (formerly the Reproductive Health Program) were awarded a two-year, one million dollar First Time Motherhood/New Parent Initiative Grant. As a result, the main focus of efforts to reduce unintended pregnancy centered on the activities of the Maternal and Infant Health Program's (MIHP) participation in the Preconception Health Workgroup of the First Time Motherhood/New Parent Initiative Grant. Through this grant, a teen reproductive/life course planning tool for use with male and female teens ("Plan Your Health/Live Your Life") was produced, focus tested and printed using as a basis previously developed materials on healthy lifestyles for female teens entitled "You're a Busy Teen". Specific information on contraception and contraceptive resources could not be included due to state laws. However, the tool encourages teens to plan their lives including preparing and planning for pregnancy at the appropriate time. Work also started on development of a more refined reproductive life plan tool for adult women that will include material on contraceptive methods and resources.

An article on natural family planning (NFP) was published by the MIHP in the Utah Chapter of the American College of Obstetricians and Gynecologists' newsletter entitled "Natural Family Planning -- It's Not Your Mother's Rhythm Method!" in an effort to encourage more providers to offer information on this method of contraception. The article also contains links to more information and resources for provider education on the topic as well as appropriate billing codes to enhanced reimbursement for NFP services. In-services on the Standard Days Method(r) of NFP were provided to one urban health department and another for a rural community health clinic. An offer was made to provide an in-service on the Standard Days Method(r) for staff of a large Wasatch Front community health center (CHC) system which was not accepted possibly, in part, due to the ability of that agency to provide their own educational programs. No further requests for in-services on NFP were received despite outreach to the local health departments and CHCs around the state. Due to the H1N1 pandemic that utilized the majority of the resources of local health departments during the last portion of FY09, NFP was not promoted among those agencies as intended.

No further progress was made toward submitting an 1115 waiver to extend family planning services beyond the postpartum period for women on Prenatal Medicaid. The major stumbling block was the concern by Medicaid regarding budget neutrality of such a program especially in the initial years of the waiver.

The MIHP website maintained information on NFP, the menstrual cycle and the risk of pregnancy with unprotected sex. Resources for low cost family planning services and a link to information on the various methods of family planning were also maintained on the program's website along with the older versions of the teen and adult reproductive life plans.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Awarded in collaboration with five other UDOH partners a two-year, one million dollar First Time Motherhood/New Parent Initiative Grant.				X
2. Developed, focus tested and printed the new reproductive life plan for female and male teens – “Plan Your Health/Live Your Life”.			X	
3. Provided in services on the Standard Days Method® of natural family planning to one urban health department and one rural community health clinic.			X	
4. Published an article on natural family planning in the Utah Chapter of the American College of Obstetricians and Gynecologists’ newsletter.			X	
5. Maintained information on family planning resources, methods, natural family planning and reproductive life plans on the Maternal and Infant Health Program’s website.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MIHP participated with the State Office of Education, Salt Lake School District and Planned Parenthood Association in AMCHP’s Adolescent Preconception Health Action Learning Collaborative Process. The team presented the concept of preconception health/life planning to a summit of middle and high school health teachers.

The MIHP is highly involved in the First Time Motherhood/New Parent Initiative Grant that developed and focus tested teen and adult life planning tools. Tool promotion begins June 2010 with TV and radio ads to push viewers to a website with information on female physiology, contraception and reproductive/life course planning.

Two legislative bills, one to mandate an 1115 Waiver and another to increase human sexuality information in schools, failed in the 2010 Legislative Session. These attempts provided opportunities to acquaint lawmakers with family planning access issues and opened dialogue between PTA, Planned Parenthood and UDOH to develop materials about human sexuality and contraception.

No interest in NFP in-services was expressed by LHDs due to the H1N1 pandemic. Reproductive life planning tools are available on the MIHP website and information on family planning resources has been updated. Funding for printing materials was not available. The MIHP participated in two health fairs and distributed materials on pregnancy planning/spacing.

c. Plan for the Coming Year

This performance measure is being discontinued.

State Performance Measure 3: *The percent of women who are at a normal weight prior to pregnancy.*

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		56	56.5	56	56.3
Annual Indicator	56.3	55.9	55.5	54.4	54.4
Numerator	28995	29898	30555	30266	30266
Denominator	51517	53475	55063	55605	55605
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	56.6	56.9	57.2	57.5	

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 56.3% and the Annual Indicator was 54.4%

Utah Vital Records data indicate that the percentage of women who were at a normal Body Mass Index (BMI) prior to pregnancy continues to decline. In 2008, only 54.4% of women were at a normal BMI, a full percent lower than 2007.

To increase the percentage of women with a healthy weight prior to pregnancy, the Maternal and Infant Health Program (MIHP), formerly the Reproductive Health Program implemented strategies to increase awareness among women of childbearing ages and health care providers of the association between poor pregnancy outcomes and abnormal weight prior to pregnancy.

The UDOH was awarded CDC funding for obesity prevention. The UDOH established the Physical Activity and Nutrition (PANO) program and hired a program director in July 2008. Staff in the MCH Bureau participated in prevention efforts coordinated by this new program to ensure that women of reproductive age were included in interventions. Staff from the MIHP and WIC continued to participate on the Department's Healthy Weight Workgroup, a group charged with coordinating obesity activities in the department. MCH staff also worked to incorporate reproductive health issues on the Department's obesity web page.

The MIHP participated in HRSA's Office of Women's Health national evaluation of the Bright Futures for Women and Health and Wellness Physical Activity and Nutrition curriculum in two University of Utah clinics staffed by certified nurse midwives. Data were collected from providers and clients during both postpartum and well woman visits to test the best timing for the intervention.

Staff from MCH developed and disseminated materials on healthy postpartum weight loss. The WIC program continued the postpartum course on "Returning to your prepregnancy weight". This

course helps women to enter their next pregnancy at a healthy weight.

A one day training entitled VENA (Value Enhanced Nutrition Assessment), which focused on critical thinking and rapport building was provided for all WIC health professionals at the Utah State WIC Conference in September 2008. A pre and post training survey was administered and while only 65.5% rated themselves in a high 3-4 comfort level with the VENA process at the time of the pre-training survey, 91.8% did so at the time of the post-training survey.

An indicator on pre-pregnancy obesity was developed and published on the UDOH Indicator Based Inquiry System. This indicator presents data on trends of obesity prior to pregnancy as well as demographics of those with higher rates.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Physical Activity and Nutrition program in the Utah Department of Health.				X
2. Continued to work with the UDOH's Healthy Weight Workgroup, incorporating reproductive health into obesity prevention efforts.				X
3. Continued evaluation of the Bright Futures for Women's Health and Wellness Physical Activity and Nutrition curriculum.				X
4. Continued WIC course on "Returning to Your Prepregnancy Weight".			X	
5. Provided Value Enhanced Nutrition Assessment course at the State WIC conference.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Utah continues to participate in a national evaluation of the "My Bright Future" program and materials. Utah's evaluation was conducted at University of Utah clinics. The materials are given at well women and postpartum clinic visits. Data collection has been completed and analysis is in progress.

The WIC program continued the postpartum course on "Returning to your prepregnancy weight". This course will be especially helpful for women to enter their next pregnancy at a healthy weight.

The UDOH was awarded a preconception health grant that works to promote optimal health prior to pregnancy. Formative research was begun. A campaign kickoff will be held in June 2010 and will include messages on healthy weight and physical activity.

The Physical Activity and Nutrition (PANO) program has worked to develop the Utah Nutrition and Physical Activity plan. This plan includes strategies to work with health care providers to counsel their clients on BMI, physical activity and nutrition. MIHP staff plan to participate in the Annual Physical Activity, Nutrition & Obesity State Plan Forum to see how the program can participate in efforts regarding women of reproductive age.

MIHP staff has updated the IBIS indicator on pre-pregnancy obesity with 2008 data.

c. Plan for the Coming Year

This performance measure is being discontinued.

State Performance Measure 4: *The percent of pregnant women with appropriate weight gain who deliver live born infants.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		33.9	34.1	34.3	34.5
Annual Indicator	33.2	33.0	33.1	32.5	32.5
Numerator	17119	17639	18228	18065	18065
Denominator	51517	53475	55063	55605	55605
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	34.7	34.9	35.1	35.3	

Notes - 2009

Data reported are the most recent data available.

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

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

Notes - 2008

Data reported are the most recent data available.

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

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 34.5% and the Annual Indicator was 32.5%.

Vital records data for 2008 indicate that 32.5% of women gained an appropriate amount of weight, 13.8% gained too little and 49.6% gained too much weight. Data also show that women at risk for putting on too much weight during pregnancy were overweight before the pregnancy, as defined by Institute of Medicine guidelines. Efforts to increase the proportion of women with appropriate weight gain are closely related with appropriate prepregnancy weight (SPM 3) interventions.

A mailing on discussing weight gain with clients was sent out to all known prenatal care providers in the state. The mailing included a fact sheet on pregnancy weight gain, three patient education brochures that could be downloaded from the Maternal and Infant Health (MIHP) website and BMI specific weight gain grids/tables to encourage tracking of weight gain during pregnancy. The mailed packet also included education on the nutritional counseling benefit for pregnant women

enrolled with Medicaid and a referral list of registered dieticians who would see Medicaid patients.

In October, MIHP staff gave a presentation on pregnancy weight gain at the Utah Perinatal Association conference. This presentation encouraged providers to discuss weight and weight gain issues with their patients and highlighted tools available from the UDOH. In April, staff presented a table top display on pregnancy weight gain and distributed educational materials at the Childbirth Educator's annual conference.

New birth certificates were implemented in January 2009. The new standard birth certificate will have fields for pre-pregnancy weight and delivery weight. The addition of the new fields will allow staff to better measure gestational weight gain and reporting with the 2009 certificate may markedly change rates reported.

Throughout the State, WIC staff weighs pregnant women at each visit and discusses their weight gain with them. Women who are outside of their recommended weight gain receive counseling from WIC staff.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mailed packets to all prenatal care providers statewide on approaching pregnancy weight gain with clients.				X
2. Presented data on pregnancy weight gain at the Utah Perinatal conference and at the Utah Childbirth Educator's conference.				X
3. Worked with Vital Records staff to implement the 2003 revision of the birth certificate, which has new fields for measuring pregnancy weight gain.			X	
4. Weighed pregnant WIC clients at each visits and tracked pregnancy weight gain.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MIHP continues to educate providers and patients on the availability of nutritional counseling for pregnant women enrolled in Medicaid. The MIHP also continues to work with dieticians interested in providing counseling services, as well as maintaining a dietician referral list for providers wishing to refer a Medicaid client into nutrition counseling.

The MIHP and BYB programs will continue to educate women and health care providers on use of the BMI specific pregnancy weight gain charts. The charts were downloaded from the MIHP over 30,000 times in a one year period.

New guidelines on pregnancy weight gain were issued by the Institutes of Medicine (IOM) in May 2009. The weight gain grids and tables that were developed using the old recommendations were updated with the new guidelines. The MIHP was contacted by a physician who requested permission to use the weight gain grids for an iPhone application. The program will follow progress on this development.

WIC staff weighs pregnant women at each visit and discuss their weight gain with them. Women who are outside of their recommended weight gain receive counseling from WIC staff. The Utah WIC program successfully implemented the new WIC food package which adds fresh fruits, vegetables and whole grain breads and reduces the amount of milk, juice, cheese and eggs. WIC staff also worked with the USDA to incorporate the IOM guidelines for pregnancy weight gain to the nutrition risk factors portion of their new computer system.

c. Plan for the Coming Year

This performance measure is being discontinued.

State Performance Measure 5: *The proportion of women who deliver a live born infant reporting postpartum depression who seek help from a doctor, nurse or other health care worker.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		40	35	39	42.6
Annual Indicator	34.6	38.6	42.6	31.9	31.9
Numerator	2233	2754	2687	2134	2134
Denominator	6459	7134	6302	6698	6698
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	43	43.5	44	44.5	

Notes - 2009

Data reported are the most recent data available.

Numerator: PRAMS weighted data, 2008

Denominator: PRAMS weighted data, 2008

The questions used for this performance measure are as follows:

*Questions:

Since your new baby was born, how often have you felt down, depressed or hopeless? Always, Often, Sometimes, Rarely, Never

Since your new baby was born, how often have you had little interest or little pleasure in doing things? Always, Often, Sometimes, Rarely, Never

The number of women delivering a live infant who answer Always or Often to either question are counted as having reported postpartum depression which is the denominator.

Since your new baby was born, did you seek help for depression from a doctor, nurse or other health care worker?

Notes - 2008

Data reported are the most recent data available.

Numerator: PRAMS weighted data, 2008

Denominator: PRAMS weighted data, 2008

The questions used for this performance measure are as follows:

*Questions:

Since your new baby was born, how often have you felt down, depressed or hopeless? Always, Often, Sometimes, Rarely, Never

Since your new baby was born, how often have you had little interest or little pleasure in doing things? Always, Often, Sometimes, Rarely, Never

The number of women delivering a live infant who answer Always or Often to either question are counted as having reported postpartum depression which is the denominator.

Since your new baby was born, did you seek help for depression from a doctor, nurse or other health care worker?

Notes - 2007

Numerator: PRAMS weighted data, 2007.

Denominator: PRAMS weighted data, 2007.

The questions used for this performance measure are as follows:

*Questions:

Since your new baby was born, how often have you felt down, depressed or hopeless? Always, Often, Sometimes, Rarely, Never

Since your new baby was born, how often have you had little interest or little pleasure in doing things? Always, Often, Sometimes, Rarely, Never

The number of women delivering a live infant who answer Always or Often to either question are counted as having reported postpartum depression which is the denominator.

Since your new baby was born, did you seek help for depression from a doctor, nurse or other health care worker?

a. Last Year's Accomplishments

The Performance Measure was not achieved. The Performance Objective was 42.6% and the Annual Indicator was 31.9%.

To raise awareness of postpartum depression (PPD) among childbearing women and their partners, the Maternal and Infant Health Program contacted stakeholders who oversee postpartum discharge packets in hospitals to assure that PPD content is included. To continue that effort, during FY09, the Maternal and Infant Health Program (MIHP) was able to present Utah specific PPD research to childbirth educators at an in-service at a large urban hospital in Salt Lake City. Another presentation was provided by the MIHP to labor and delivery nursing staff at another large medical center on PPD. This presentation was recorded and placed on the center's internal web-based system for future viewing by those unable to attend. A copy of this video was given to the MIHP for use in other in-services to broader audiences.

To assist in diffusing PPD information, the Maternal Child Health Bureau's Mental Health Promotion Specialist was very active in coordinating PPD training for nurses, nursing directors and other health care providers via in-services and conferences. Presentations were made to pediatric providers on the need to screen mothers for depression and the impact of untreated maternal depression on child development.

Women eligible for Prenatal Medicaid lose coverage approximately two months following delivery which limits their ability to pay for mental health services. Medicaid provides each woman with a "termination of coverage" notice three to four months prior to loss of coverage. The MIHP worked with state Medicaid staff to include language in the termination notice to encourage women experiencing symptoms of PPD to seek help, if needed, prior to losing their Medicaid coverage.

During a previous fiscal year, focus groups were held with women who self-reported PPD. Among the participants' suggestions was the need for information regarding PPD to be emphasized in childbirth education classes. As a result, during FY09, contact was made to several childbirth education coordinators located in major hospitals in the Salt Lake City area to assure that their programs include information on PPD. The MIHP was going to provide Utah specific data on PPD obtained from PRAMS along with resources for childbirth educators to enhance their teaching materials. This was not accomplished due to lack of time. However, the information is available on the MIHP's website: www.health.utah.gov/mihp.

As in previous years, the Baby Your Baby Program continued distribution of its Baby Your Baby Keepsake. This health record/keepsake contains information on both depression during and after pregnancy and urges women experiencing symptoms of depression to seek help from a health care provider. During FY09, 31,286 Keepsakes were distributed to pregnant women throughout the state many of whom are enrolled in Prenatal Presumptive Eligibility and Prenatal Medicaid - both programs serve women at increased risk for depression.

The WeeCare Program, a component of MIHP, provides prenatal case management for women enrolled in PEHP, an insurance plan available to government employees. All pregnant women enrolling in WeeCare receive an initial packet of information which includes a handout on depression during pregnancy. At 32 weeks' gestation, WeeCare enrollees receive a second packet with information on PPD. WeeCare screens all enrollees for a history of PPD with a previous pregnancy and for depression during the current pregnancy. Women with a positive screen are provided additional written materials on depression and encouraged to talk to their health care provider. In FY09, 54 women enrolled in WeeCare reported a positive history of depression or current symptoms of depression.

The WeeCare staff also provides case management for high-risk, pregnant Medicaid enrollees residing in Salt Lake County. These women receive a booklet on prenatal care which includes information on depression during and after pregnancy. Women with a past history of PPD or with current symptoms of depression receive the same materials and referral resources as other WeeCare enrollees with a positive screen for depression.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted dissemination of information on PPD through inclusion of information on the condition in hospital postpartum discharge packets given to new mothers.			X	
2. Provided information on PPD through in services to childbirth educators, labor and delivery nursing staff and pediatricians.				X
3. Developed language for the Medicaid "termination of coverage" letter sent to Prenatal Medicaid enrollees to encourage seeking care for PPD prior to loss of coverage.			X	
4. Distributed Baby Your Baby Keepsakes containing information on recognition of and encouraging treatment for PPD to 31,286 pregnant Utah women.			X	
5. Provided screening, written materials and resources for depression during and after pregnancy for women enrolled in WeeCare and high-risk pregnant, Medicaid enrollees in Salt Lake County.		X		
6.				
7.				
8.				

9.				
10.				

b. Current Activities

In an effort to reduce the number of women who fail to seek care for their depressive symptoms, the MCHB Child Mental Health Coordinator served on the Office of Home Visiting Advisory Committee to act as a consultant for three counties implementing a Healthy Family America Home Visiting Program. Training was provided to home visitors on the prevalence of postpartum depression (PPD), screening for PPD and making appropriate referrals.

A grant application for a second round of funding from the Linking Actions for Unmet Needs in Children's Health (LAUNCH) Grant was submitted but not funded. The state's Early Childhood Comprehensive Systems Grant did fund pilot projects to improve early childhood mental health. Technical assistance was provided to train staff to screen children and women for mental illness in early care settings using validated mental health screening tools and to educate staff in linking at-risk children and families to resources.

The MIHP maintains information regarding postpartum depression and screening tools on their website and an indicator on PPD is available on IBIS data query system.

The PRAMS Program is currently collecting information regarding PPD using new, more specific questions. Analysis of these new data may begin in the fall of 2010.

c. Plan for the Coming Year

This performance measure is being discontinued.

State Performance Measure 6: *The percent of children who are at risk of overweight and overweight.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		24	22.5	22.5	21.5
Annual Indicator	24.0	22.5	22.5	21.5	21.5
Numerator	1020	968	968	887	887
Denominator	4250	4310	4310	4123	4123
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	21.5	21	21	20.5	

Notes - 2009

2008 Elementary Student Height/Weight Survey.
Data are based on a statewide weighted sample of schools in which 1st, 3rd and 5th grade students were screened for height and weight in 2008.

Notes - 2008

2008 Elementary Student Height/Weight Survey.
Data are based on a statewide weighted sample of schools in which 1st, 3rd and 5th grade students were screened for height and weight in 2008.

Notes - 2007

2006 Elementary Student Height/Weight Survey.

Data are based on a statewide weighted sample of schools in which 1st, 3rd and 5th grade students were screened for height and weight in 2006.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 21.5 and the Annual Indicator was 21.5.

In 2007, Heart Disease and Stroke Prevention Program (HDSPP) conducted an extensive study of height and weight of 1st, 3rd, and 5th graders in Utah from a set cohort of elementary schools throughout the state. The study started in 2003 and is administered during odd years. Data from the 2007 study and past administrations were summarized in a report released in the fall of 2008.

The HDSPP continued the implementation of the Gold Medal Schools program in additional elementary schools. The Gold Medal Schools Program increases opportunities for to students to eat healthfully, be active and stay tobacco free. Power-Up, a version of Gold Medal Schools for middle schools, was expanded into ten schools. Funding for Gold Medal Schools comes from state and federal sources. Unfortunately, grants from private sources expired during this reporting period.

The Physical Activity, Nutrition, and Obesity Program completed development of a comprehensive, state-wide, ten-year strategic plan: Utah Nutrition and Physical Activity Plan: 2010 - 2020. The Healthy Weight Workgroup, consisting of representatives from all Bureau of Health Promotion programs, as well as from the WIC and the Maternal and Infant Health programs, continued to meet to coordinate department activities and messages regarding physical activity, nutrition, and healthy weight. This group contributed to drafting the "Government" section of the strategic plan.

Staff supported implementation of the Unplug N' Play program, encouraging children to "unplug" from electronic media and participate in physical activity instead. Unplug N' Play was promoted on local radio stations and nearly 75 schools participated. A partnership with Utah League of Cities and Towns (ULCT) was developed and Physical Activity, Nutrition and Obesity Program (PANO) staff presented information at the ULCT annual convention where mayors and city council members learned about creating active community environments and safe routes to school.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyzed height and weight data from a sample of 1st, 3rd, and 5th graders in Utah and prepared report.			X	
2. Continued to support Gold Medal Schools in elementary schools.			X	
3. Expanded Gold Medal Schools Power-Up program to ten middle schools.			X	
4. Applied for and received CDC funding to establish a Physical Activity, Nutrition, and Obesity Program.				X
5. Coordinated numerous events to promote healthy weight among children and their families, including Unplug N' Play.			X	
6.				
7.				
8.				

9.				
10.				

b. Current Activities

The Division of Disease Control and Prevention and Division of Family Health and Preparedness are supporting efforts to collect data to measure the prevalence of "at risk of overweight" and "overweight" children, grades 1, 3 and 5. The Physical Activity, Nutrition, and Obesity Program (PANO) and local partners collect the height /weight data every other year. Data collection occurred in SFY2009. Results will be analyzed and reported in SFY2010.

The Department continues to support the Gold Medal Schools and Power-Up Programs in elementary schools and middle/junior high schools. Possible resources for program support and/or expansion will be sought from the Utah Legislature, Centers for Disease Control and Prevention, and private funding sources. Gold Medal Schools increases opportunities for students to eat healthy, be active, and stay tobacco free.

The Physical Activity, Nutrition, and Obesity Program will release the Utah Nutrition and Physical Activity Plan: 2010 - 2020 and with many partners, will coordinate plan implementation. The plan focuses on environmental and policy issues associated with physical activity, nutrition, and obesity, including varied topics such as safer routes to schools, provision of media messages and outreach materials on nutrition and physical activity, health care provider education, and exploration of data sources for assessing the weight of additional and special populations, among many others.

c. Plan for the Coming Year

This performance measure is being discontinued.

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	2005	2006	2007	2008	2009
Annual Performance Objective		28.2	28	25.9	25.9
Annual Indicator	28.2	28.2	25.9	25.9	26.1
Numerator	434	434	499	499	398
Denominator	1540	1540	1926	1926	1522
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	25.5	25.5	25	25	

Notes - 2009

Numerator: YRBS, 2009
Denominator: YRBS, 2009

Notes - 2008

Numerator: YRBS, 2007.
Denominator: YRBS, 2007.

Notes - 2007

Numerator: YRBS, 2007.
Denominator: YRBS, 2007.

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 25.9 and the Annual Indicator was 25.9.

The Children's Mental Health Promotion Specialist participated on the Utah Suicide Prevention Council by attending meetings and providing consultation as needed and served as the UDOH lead on youth suicide prevention efforts. Violence and Injury Prevention Program (VIPP) provided data collection and analysis.

Consultation and referral was provided to the Child Fatality Review Committee when requested on cases involving child death reviews, domestic abuse and child abuse. These efforts may have helped reduce future mental health problems faced by these children.

The Children's Mental Health Promotion Specialist participated in mental health, substance abuse, domestic violence, child abuse, and suicide prevention conference planning. She provided consultation to conference planners to insure that mental health providers are offered specialized training opportunities in an effort to build the capacity of the mental health system to address the screening, and treatment needs of children, youth and their families. Specific conferences included: Generations in adult mental health and substance abuse treatment, Critical Issues in Child and Adolescent Mental Health, and the Utah Child Abuse Prevention Conference.

Coordination efforts through the Department of Human Services including, the Utah Transformation for Children and Adolescent Network (UT-CAN) continued. These efforts were specific to improving the mental health care of all Utah children.

The UDOH participated in the Child Abuse and Neglect Council (CAN Council) and the Child Abuse and Prevention Interim Action Committee (CAPIAC), and provided consultation on prevention and treatment efforts for children related to domestic violence, child abuse, child neglect, and other violent crimes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation on Suicide Prevention Council				X
2. Conference planning and speaker sponsorship				X
3. Child Abuse and Neglect Council				X
4. Child Abuse Prevention Action Council				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Children's Mental Health Promotion Specialist along with the Deputy Director, Division of Family Health and Preparedness represents the Utah Department of Health on the Suicide Prevention Council. The council provides coordination of outreach efforts to promote suicide prevention. The Children's Mental Health Promotion Specialist resigned in January 2010. This

position may not be refilled with a mental health professional. At this point, we are awaiting approval to start recruitment for a number of key positions that have been on hold due to a hiring freeze.

The Specialist provided consultation on prevention and treatment efforts for children related to abuse through participation in; the Child Fatality Review Committee, Child Abuse and Neglect Council and the Child Abuse Prevention Committee.

The Children's Mental Health Promotion Specialist provided consultation to conferences planners to determine professional training needs to build system capacity to promote healthy mental development and provide the most appropriate level of care to children and youth. The department has been sponsoring national experts to come to Utah and present on topics related to children's mental health.

The children's mental health specialist provided consultation to the Title V agency to address mental health screening and prevention efforts, identify and coordinate prevention and screening efforts and review of existing data to determine strategies and priorities for future work.

c. Plan for the Coming Year

The Deputy Director of the Division will participate on the Utah Suicide Prevention Council by attending meetings and providing information as needed. VIPP will continue to provide data collection and analysis. Once we are able to hire a children's nurse health consultant, the main responsibilities for youth suicide will be handled through that position.

The Divisions' Medical Director over CSHCN/MCH/CD will attend and participate on the Child Fatality Review Committee related to child death review, domestic abuse and child abuse.

We hope to continue efforts to reduce youth suicide, but that will be dependent on resources.

State Performance Measure 8: *The percent of children six through nine years of age enrolled in Medicaid receiving a dental visit in the past year.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	48	49	49.5	51	52
Annual Indicator	48.8	48.6	51.2	51.4	52.6
Numerator	14127	13889	14920	15211	18550
Denominator	28943	28596	29135	29599	35280
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	53	54	55	56	

Notes - 2009

: Medicaid CMS 416, FFY2009
Denominator: Medicaid CMS 416, FFY2009

Notes - 2008

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

Notes - 2007

Numerator: Medicaid CMS 416, FFY2007
 Denominator: Medicaid CMS 416, FFY2007

a. Last Year's Accomplishments

The Performance Measure was achieved. The Performance Objective was 52% and the Annual Indicator was 52.6%.

During FY09, the Oral Health Program (OHP) worked closely with the Utah Oral Health Coalition to improve access to dental services and develop public awareness campaigns. We continued to emphasize the importance of dental care as part of overall health and the benefits of early and regular dental visits. The oral health education material and curriculum developed by the American Dental Association for grades 1-8 was posted on the OHP and the Utah State Office of Education (USOE) websites.

The OHP continued working with Dental Select's "Sealant for Smiles Program". In addition to providing dental sealants for first, second and sixth grade children in Title I schools in the Salt Lake County area, the program assisted in referring children for needed dental services. With Dental Select as its fiscal agent, Sealant for Smiles expanded into Summit, Tooele and Davis counties.

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

The OHP continued to work closely with the Utah Dental Association (UDA) and the Utah Oral Health Coalition (UOHC) 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.

Through efforts of UDOH, OHP, and UOHC Medicaid reimbursement rates for dental services for children were restored which helped in retaining and recruiting dental providers and thereby improving dental access.

The OHP planned to trend utilization data from the CMS Medicaid 416 report for the past 5 years. This would have helped to identify counties and local health departments which may need additional technical assistance to address access to dental care for children. This project has not been completed due to budget constraints.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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. Collaborated with Medicaid in enhancement of the CHEC Dental Case Management Project			X	
3. Worked with Utah Dental Association Access Committee in			X	

advocating and promoting early childhood caries prevention and intervention programs and the promotion of increased participation from dentists willing to treat Medicaid patients.				
4. Publicized the oral health curriculum which has been developed by the American Dental Association for school grades 1-8.				X
5. Supported UDOH, UDA and UOHC in advocating for restoring Medicaid reimbursement rates.				X
6. Collaborated with Sealants for Smiles in screening, sealant placement and referral for first, second and sixth grade Title I children.				X
7.				
8.				
9.				
10.				

b. Current Activities

The OHP is working closely with the UOHC to improve access to dental services and in the development of public awareness campaigns. The educational video "A Healthy Smile for a Healthy Baby" was distributed to dentists, physicians and other health care providers. We continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. The oral health education material and curriculum for grades 1-8 is on the OHP and USOE websites.

The OHP continues to work with Dental Select's "Sealant for Smiles Program" in providing dental sealants for first, second and sixth grade children in Title I schools in the Salt Lake, Davis, Summit and Tooele areas.

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

The OHP continues to work closely with the UDA and the UOHC 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.

Budget constraints have delayed the process and completion date of trending utilization data from the Medicaid 416 report for the past 5 years.

c. Plan for the Coming Year

This performance measure is being discontinued.

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	2005	2006	2007	2008	2009
Annual Performance Objective	13	12	12	12	12
Annual Indicator	11.9	11.5	11.1	10.6	10.4

Numerator	2493	2403	2371	2333	2305
Denominator	20871	20821	21362	21978	22080
Data Source				See footnote for source	See footnote for source
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	12	12	13	13	

Notes - 2009

Numerator: The number of children served in the rural area based on the Mega West billing system, 2009.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

Notes - 2008

Numerator: The number of children served in the rural area based on the Mega West billing system. 2008

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

Notes - 2007

Numerator: The number of children served in the rural area based on the Mega West billing system. 2007

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 12 and the Annual Indicator was 10.4.

Flat or decreasing state and federal funding and an increasing rural population continued to present challenges in maintaining service delivery and achieving the performance measure. However, the Bureau of Children with Special Health Care Needs (CSHCN) continued contractual agreements with local health departments and with Intermountain Healthcare to provide clinics at seven different sites throughout the state. Although some services were cut, close scrutiny of community needs and more efficient scheduling avoided major decreases in service delivery, despite cuts in funds and personnel. 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 Medical School were extended to provide consistent pediatric, sub-specialty evaluation services for children seen in these clinics as well.

The Bureau initiated the development and use of a referral form, available on-line, to be used to solidify closer coordination with primary providers. CSHCN was able to maintain its collaboration and integration with the statewide Medical Home effort and provided close contact and coordination with local primary care medical home providers surrounding optimal care for children. The new referral form process was also designed to facilitate enhanced contact and coordination between the rural clinics and pertinent CSHCN programs that serve the special

populations, which included Neonatal Follow-up Program, Hearing, Speech and Vision Services; Fostering Healthy Children and Baby Watch Early Intervention programs. CSHCN continued its agreement with Intermountain Healthcare, the primary health care system in the State, to allow for access to their electronic medical records system, providing greater coordination capacity for shared clients of our two agencies.

CSHCN continued its provision of long-distance clinical health care and community staffing using tele-health videoconferencing technology in place through the University of Utah Tele-health Network (UTN), thus, enhancing and supplementing services to rural children with special needs. CSHCN participated with UTN and other agencies and 3rd party payers to further explore barriers and discuss issues regarding reimbursement for services provided via the tele-health medium.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued contractual agreements to provide clinics at seven different rural sites.	X			
2. RN and office support provided clinic coordination, scheduling, management, chart maintenance, and follow-up for each clinic.		X		
3. 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
4. CSHCN continued to support and assist local clinics in coordination with the statewide Medical Home effort, other pertinent CSHCN programs, and care management efforts with local primary care providers.		X		
5. Initiated the use of referral form available on-line, to better facilitate communication and coordination with primary health providers.		X		
6. Continued an agreement to gain access to electronic medical records maintained by the primary health care system in the State.				X
7. Continued use of tele-health technology to provide long-distance care, coordination and staffing, optimizing the care for rural children with special needs.	X			
8. Participated in summit, in collaboration with Utah Tele-health Network (UTN) and other agencies, to discuss barriers and explore ways to secure better reimbursement for tele-health.				X
9.				
10.				

b. Current Activities

Despite significant cuts in state funding (\$1.5 million over the past few years), the CSHCN Bureau continues its efforts to provide optimal care and services to rural children with special health care needs through specialty clinics and tele-health technology. Exploration of increased tele-health reimbursement through a statewide summit continues.

CSHCN contracts with local health departments and other agencies to conduct itinerant clinics in seven sites in the state. CSHCN provides ongoing training and support on clinic and care coordination for contract staff, along with clinical database support. Close scrutiny of the need for, and provision of, clinical services continues to support changes leading to greater efficiency and cost-containment. To facilitate this, a strategic planning process and overall needs assessment

for CSHCN services was continued with Champions InC. from Utah State University.

Through the use of a new 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 care and access to resources for children. To ensure better care coordination, increased access to private electronic medical records was continued. Rural clinics continue to collaborate with other CSHCN programs and staff in rural Utah, including the Fostering Healthy Children, Hearing, Speech and Vision Services and Early Intervention programs.

c. Plan for the Coming Year

Flat federal funding and significant cuts in state funding, combined with an increase of population in some rural areas and an on-going shortage of pediatric sub-specialists, continue to present challenges in providing needed care for Utah's Special Needs Children. Regardless of these challenges, the Bureau of CSHCN will continue to contract with local health departments and other entities to conduct itinerant clinics in seven sites across the state. CSHCN will continue its needs assessment to evaluate, through recently initiated strategic planning, the need to maintain and bolster those sites with increasing populations, and to consider consolidation of clinic sites that only serve a small population of children. Through the 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 will support the Access and Megawest software databases used by each site to schedule clinics, collect patient data, chart tracking and maintenance, providing staff assistance and consultation as needed. Information and training on resources and clinical processes will be provided.

CSHCN will promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, and will work closely with local primary care medical home providers to further enhance our referral process and use of the referral form to better coordinate the care and access to resources for children. Additionally, rural nurses will continue to collaborate, and be assisted in doing so, with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children Program and the Hearing, Speech and Vision Services Program and Baby Watch Early Intervention programs. 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. These activities will supplement services to rural children with special needs using video-conference technology currently in place through the University of Utah Tele-health Network and also state and local health department sites. On-going advocacy for, and exploration of, reimbursement opportunities will continue through a joint effort by these agencies. Additionally, CSHCN will increase its efforts to collaborate with the CHARM, UHIN, cHIE and private EMR entities to move toward the use of mandated electronic medical records and efficient health information management.

E. Health Status Indicators

Introduction

Health Status Indicators are helpful in identifying problems and the trends over time. Program planning is guided by the data.

Provide information on the State's residents - The HSIs provide data that we review to determine whether we have a problem with a specific indicator or not, for a specific populations, such as mothers, children or adolescents. It helps us identify a specific issue for a specific population we serve.

Assist in directing public health efforts - The HSIs provide data for comparison with previous years' data to identify areas of need that may require new public health efforts, enhanced efforts or ones that we no longer need to continue. As an emerging issue arises, we can direct our efforts to the emerging issue as needed.

Serve as a surveillance or monitoring tool - The trends for a HSI allows us to review several years of data to determine whether we are making progress in the right direction or if we are needing to adapt public health efforts to improve the indicator. If progress is not happening, then we can examine the various factors related to the indicator that we might impact versus those we cannot.

Function as an evaluative measure. - Many of the HSIs relate to National Performance Measures and can be used to evaluate the effectiveness of our public health strategies. We can monitor the trends to note progress or regression, however, one has to be careful in drawing conclusions of cause and effect versus association between two factors.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.8	6.9	6.7	6.8	6.8
Numerator	3520	3710	3669	3784	3784
Denominator	51517	53475	55063	55605	55605
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.
 Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah has the distinction of being among the healthiest states in the country. Utah women of reproductive age have relatively low rates of tobacco use which is a strong risk factor for low birth weight. The predominate culture in Utah, members of the Mormon church, are discouraged from use of tobacco and alcohol and are encouraged to adopt healthy lifestyles. This, no doubt contributes to our comparatively low rates of low birth weight.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The largest percentage of low birth weight births fall into the category of late preterm births, those that occur between 34 and 36 weeks' gestation. The Maternal and Infant Health Program (MIHP) is in the process of analyzing birth certificate data to determine risk factors and demographic characteristics of women whose deliveries are considered late preterm births. Utah adopted the 2003 new national birth certificate starting with 2009 births, which will enable us to analyze these data more specifically. Prior to this version our birth certificate data did not stratify births by elective or indicated late preterm inductions which made this issue very difficult to understand. Based on these analyses, interventions will be developed to target women who are most likely to deliver late preterm births with education and resources and to work with providers to make them aware of the risk of poor outcomes.

c) Any interpretation of what the data mean?

The percent of live births weighing less than 2,500 grams in Utah has remained relatively stable over the past decade (1999-6.8%, 2008-6.8%). However, several subpopulations of Utah women have higher rates; for example, women in the 15-19 age category had a rate of 9.2% in 2008, compared to women 20 years of age and older (6.6%). In addition, Utah Hispanic women had a rate of 7.4% in 2008 compared to non-Hispanic women (6.7%). Lastly, women who reported very short interpregnancy intervals (0-6 months) had a rate of low birth weight births of 7.6% in 2008. There were no differences in low birth weight rates among women with interpregnancy intervals > 6 months and the general population however.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.2	5.4	5.3	5.2	5.2
Numerator	2595	2784	2812	2791	2791
Denominator	50017	51922	53510	53882	53882
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.

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

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

Notes - 2008

Data reported are the most recent data available.

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

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Please see HSI #01A, a.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status indicator?

The American College of Obstetricians and Gynecologists recommends the use of 17 alphahydroxyprogesterone (17P) beginning in the second trimester of a singleton pregnancy for women with a history of previous preterm birth. . The 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. The Medical Director of Molina Healthcare helped us to advocate making 17p a covered benefit for prenatal Medicaid enrollees. Intermountain Healthcare, the largest payer in the state of Utah, also made 17P a covered benefit for their pregnant enrollees.

A workgroup of partners has collaborated to develop educational materials to target women with a previous preterm birth about 17P. University Hospital's NICU is disseminating these materials to NICU parents and we are working with our Utah Medicaid program to screen women when they enroll in prenatal Medicaid on whether they have had a previous preterm birth and provide the materials if they have. The educational material briefly describes the need for 17P and encourages women to contact their provider to see if they are a candidate.

c) Any interpretation of what the data mean?

The percent of singleton live births weighing less than 2,500 grams in Utah has remained relatively stable over the past decade (1999-5.3%, 2008-5.2%).

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.0	1.1	1.0	1.0	1.0
Numerator	534	563	576	577	577
Denominator	51517	53475	55063	55605	55605
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
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Notes - 2009

Data reported are the most recent data available.

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

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

Notes - 2008

Data reported are the most recent data available.

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

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

While Utah has seen a slight decrease in the number of very low birth weight (VLBW) births over the past decade, we continue to have almost 600 such births a year. 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 "building block" request (legislative funding priority) for an interconception care 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 Departments final list of funding priorities due to budget shortfalls during the economic downturn.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Utah was granted First Time Motherhood/New Parent Initiative funding from HRSA's MCHB to implement a social marketing campaign about the importance of preconception health to healthy birth outcomes. The campaign, "Power Your Life, Power Your Health" kicked off in June 2010 with TV and radio advertisements, an interactive website and educational material. The centerpiece of the campaign is the website where women can enroll to receive free vitamins and access a reproductive life planning tool. It is hoped that addressing wellness and reducing risks prior to pregnancy will decrease our rates of VLBW and LBW in Utah.

c) Any interpretation of what the data mean?

The percent of live births weighing less than 1,500 grams in Utah has decreased slightly over the past decade (1999-1.1%, 2008-1.0%).

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.8	0.8	0.8	0.8	0.8
Numerator	389	403	428	436	436

Denominator	50017	51922	53510	53882	53882
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.

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

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

Notes - 2008

Data reported are the most recent data available.

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

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007.

Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH. 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Please see HSI #02A, a.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The previously mentioned interventions to promote the use of 17P are hoped to have an effect on the rates of VLBW births as well as the LBW births.

c) Any interpretation of what the data mean?

The percent of singleton live births weighing less than 1,500 grams in Utah has remained relatively stable over the past decade (1999-0.82%, 2008-0.81%).

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	10.0	7.1	7.6	7.6	7.6
Numerator	67	49	54	55	55
Denominator	668784	686219	708557	723026	723026
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

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

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2007
Denominator: IBIS Population estimates for 2007.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah has 14 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP) and annual educational efforts as well as any necessary changes in laws focus on preventing injuries among children ages birth-14 and their families.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Safe Kids is continually looking to attract new partners with similar goals for ages birth -14. Allied partners, outside of state/local government, have also been helpful when advocating for new laws and when bills are introduced in the legislature.

c) Any interpretation of what the data indicate?

Utah has experienced a steady decrease in the mortality rate of unintentional injuries to children since 2004. This decrease can be attributed to new laws and educational campaigns that are paying off. However, Utah also gathers ED data and this combined with hospitalization data continues to give partners a good understanding of where problems still exist. The VIPP also has produced a Small Area Injury Report that breaks data down further within local counties for leading causes of unintentional injuries.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.2	2.9	3.2	4.6	4.6
Numerator	35	20	23	33	33
Denominator	668784	686219	708557	723026	723026
Check this box if you cannot report the					

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

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2007
Denominator: IBIS Population estimates for 2007.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

See #03A above. Utah's effort, coordinated through the Violence and Injury Prevention Program, consists of annual child restraint educational activities and advocating for changes in laws to prevent MV-related fatalities as well as injuries for children ages birth -14.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Safe Kids is continually looking to attract new partners with similar goals for ages birth -14. Allied partners, outside of state/local government, have also proven to be helpful when advocating for new laws and when bills are introduced in the legislature.

c) Any interpretation of what the data indicate?

Utah has experienced a significant decrease in the mortality rate of children due to MV injuries since 2004. This decrease can also be attributed to new laws and educational campaigns about child car seats and booster seats that went into effect in 2008. However, Utah also gathers ED data which combined with hospitalization data continue to give partners a good understanding of where problems still exist. The VIPP has produced a Small Area Injury Report that breaks down data further within local counties for leading causes of MV related fatalities.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	16.6	18.8	18.5	13.2	13.2
Numerator	69	86	85	60	60

Denominator	416361	456465	459013	455836	455836
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

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

Notes - 2008

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

Notes - 2007

Numerator: Office of Vital Records and Statistics, Mortality database. UDOH. 2007
Denominator: IBIS Population estimates for 2007.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

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 four years.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The Utah Teen Driving Safety Task Force, 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 involved with reducing teen driving injuries as well as fatalities. All participating partners are operating using one slogan and outreach campaign.

c) Any interpretation of what the data indicate?

The number of licensed teenage drivers continues to grow in Utah. Despite this trend the non-fatal rate for MV injuries has remained relatively stable since 2005. Unfortunately the fatality rate for this same age group has seen little change.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	146.7	132.9	139.2	124.6	124.6

Numerator	981	912	986	901	901
Denominator	668784	686219	708557	723026	723026
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Notes - 2008

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Notes - 2007

Numerator: Hospital Discharge Database Injury Query Module, 2007
 Denominator: IBIS Population estimates for 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah continues to be one of the states with the highest number of young children per family. Unfortunately this trend lends itself to more non-fatal injuries despite the unintentional injury fatality rate decreasing since 2004 and remaining flat for the last two years. Work continues to address this trend with the Safe Kids Coalitions/Chapters around the state despite level funding over this same time period. Annual educational efforts and advocating for changes in laws continue to remain the focus for ages birth-14.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

Safe Kids is continually looking to attract new partners as well as funding to address the needs of those aged birth-14.

c) Any interpretation of what the data indicate?

The non-fatal rate of injuries among children has slightly increased since 2004 although the last two years the rate has remained at 41.4 per 100,000.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	39.6	36.7	41.4	33.3	33.3

Numerator	265	252	293	241	241
Denominator	668784	686219	708557	723026	723026
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Notes - 2008

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Notes - 2007

Numerator: Hospital Discharge Database Injury Query Module, 2007
 Denominator: IBIS Population estimates for 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Utah leads all states with the number of young children per family. This trend lends itself to more non-fatal injuries despite the unintentional fatal injury rate decreasing. Funding has also remained level or decreased for Safe Kids Coalitions/chapters and other traffic safety partners over the last six years.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The UDOH, Safe Kids, and other traffic safety partners are continuing to improve MV related safety. Efforts include moving toward a primary seatbelt law for all ages and defending threats to weaken the booster seat law.

c) Any interpretation of what the data indicate?

Utah has seen a slight increase in the non-fatal MV rate of injuries to children since 2004. The last two years this rate has stabilized along with a decreasing fatality rate. This can be attributed to new laws and campaigns on child car seats/booster seats for children up to 8 years of age that went into effect in 2008.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
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Annual Indicator	144.1	130.1	128.3	122.2	122.2
Numerator	600	594	589	557	557
Denominator	416361	456465	459013	455836	455836
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Notes - 2008

Data reported are the most recent data available.
 Numerator: Hospital Discharge Database Injury Query Module, 2008
 Denominator: IBIS Population estimates for 2008

Notes - 2007

Numerator: Hospital Discharge Database Injury Query Module, 2007
 Denominator: IBIS Population estimates for 2007

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

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 four years.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

The Utah Teen Driving Safety Task Force was formed in 2007 to better coordinate activities as well as resources of the many partners involved with reducing teen driving injuries as well as fatalities. All participating partners are operating under one slogan and outreach campaign.

c) Any interpretation of what the data indicate?

The non-fatal rate for MV injuries for those aged 15-24 has decreased significantly since 2004. The fatality rate for this same age group however has seen little change.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	10.9	11.2	12.4	12.9	13.4
Numerator	1066	1196	1412	1435	1451

Denominator	97390	107209	113614	110841	108205
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data reported are the most recent data available.
 Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2009
 Denominator: IBIS Population estimates for 2009

Notes - 2008

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2008.
 Denominator: IBIS Population estimates for 2008.

Notes - 2007

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2007.
 Denominator: IBIS Population estimates for 2007.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff and duties within the Bureau of Epidemiology have improved services. There is now a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community.

Centers for Disease Control funding for prevention, testing, treatment, and local health department support remains steady, and limited state funding for an STD awareness campaign continues.

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

This indicator assists UDOH programs in monitoring trends in rates which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Limited state funding provides the capacity to maintain an STD awareness campaign aimed at youth, parents and health care providers. This unique campaign creates additional opportunities for access to information and resources. Other changes in organization at the UDOH provide new opportunities for collaboration between programs. As programs continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections other programs and staff have already made, as well as strengthen our efforts to reach community-wide. These organizational shifts have also provided

unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c) Any interpretation of what the data indicate?

Data for 2009 indicate a chlamydia rate of 13.4 per 1,000 females aged 15 through 19 years old, a non-significant increase since 2008 when the rate was 12.9 per 1,000 females aged 15-19 years old. The 2009 case increase may be due to several reasons. A new database system, UT-NEDSS, was introduced at the beginning of 2009. Other explanations may include data management issues that have not been identified and chlamydia testing has increased.

This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.1	4.5	5.0	5.0	4.9
Numerator	1941	2183	2471	2567	2493
Denominator	474823	484264	496192	511628	510434
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data reported are the most recent data available.
 Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2009
 Denominator: IBIS Population estimates for 2009

Notes - 2008

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2008.
 Denominator: IBIS Population estimates for 2008.

Notes - 2007

Numerator: Bureau of Communicable Disease Control, Utah Department of Health, 2007
 Denominator: IBIS Population estimates for 2008.

Narrative:

a) What has influenced the program's ability to maintain and/or improve the Health Status Indicator?

See #05A

b) What efforts are being made by the program in developing new strategies for meeting the Health Status Indicator?

See #05A.

c) Any interpretation of what the data indicate?

Data for 2009 indicates a chlamydia rate of 4.9 per 1,000 females aged 20 through 44 years old a slight decrease from 5.0 per 1,000 females aged 20-44 years old in 2008.

See #05A.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	55605	51573	570	735	1054	828	0	845
Children 1 through 4	213311	191534	4358	3645	3916	1548	8310	0
Children 5 through 9	240628	217950	4593	3902	3998	2317	7868	0
Children 10 through 14	213268	194732	3786	3263	3315	2040	6132	0
Children 15 through 19	213463	195830	3339	3870	3516	2033	4875	0
Children 20 through 24	242945	226410	2845	3530	4262	1970	3928	0
Children 0 through 24	1179220	1078029	19491	18945	20061	10736	31113	845

Notes - 2011

Narrative:

This table shows the Utah population for infants and children (< 25 years) by age and race. Tracking this indicator allows us to monitor population size, demographic changes, and which sub-group is experiencing the most growth. This information helps in planning appropriate program activities and interventions.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	45761	9493	351
Children 1 through 4	176225	37086	0
Children 5 through 9	201195	39433	0
Children 10 through 14	181896	31372	0

Children 15 through 19	187329	26134	0
Children 20 through 24	218702	24243	0
Children 0 through 24	1011108	167761	351

Notes - 2011

Narrative:

Utah's Hispanic population increased from 9% in 2000 to 12% of the population in 2008. This represents an increase of 33%. Mexicans continue to be both the largest and fastest growing group of Hispanics in the state. MCH programs partner with various health programs and other state agencies to ensure linguistically and culturally appropriate services are available for this population.

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	32	29	1	2	0	0	0	0
Women 15 through 17	1104	1016	23	35	10	12	0	8
Women 18 through 19	2686	2376	42	72	31	48	0	117
Women 20 through 34	46639	43436	453	571	809	684	0	686
Women 35 or older	5144	4716	51	55	204	84	0	34
Women of all ages	55605	51573	570	735	1054	828	0	845

Notes - 2011

Narrative:

This table shows the resident births by maternal age and race. In 2008, there were a total of 55,605 births in Utah. This represents an eight percent increase in numbers from 2005 (51,517). The birth data allow us to analyze trends in birth rates as well as birth outcomes among different racial and ethnic groups. For example, the percentage of LBW was much higher among infants born to black women compared to infants born to white women (13.0% vs 6.7%).

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	12	20	0
Women 15 through 17	540	572	10

Women 18 through 19	1747	852	24
Women 20 through 34	39252	7094	266
Women 35 or older	4210	955	51
Women of all ages	45761	9493	351

Notes - 2011

Narrative:

The percentage of Utah births by Hispanic women have increased over the last few years. In 2008, Hispanic birth accounted for 17% of all births. Analyzing birth data shows that Hispanic females ages 15-19 continue to have the highest teen birth rate in Utah.

MCH programs and LHD have increased staff who are bilingual in order to meet the needs of the growing Spanish speaking population they serve. More materials and resources have been translated and made available for this high-risk sub-population.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Total deaths								
Infants 0 to 1	264	221	3	1	6	4	0	29
Children 1 through 4	57	49	1	1	1	1	0	4
Children 5 through 9	39	30	1	1	1	0	0	6
Children 10 through 14	38	33	0	1	2	1	0	1
Children 15 through 19	105	94	3	6	1	0	0	1
Children 20 through 24	172	148	1	5	3	2	0	13
Children 0 through 24	675	575	9	15	14	8	0	54

Notes - 2011

Narrative:

A total of 675 deaths occurred among infants and children (< 25 years of age) in Utah in 2008. The highest proportion of deaths was accounted by infants (39.1%) followed by children 20 -- 24 (25.6%). The infant mortality rate for 2008 was 4.7 per 1000 live births. The rate has declined from last year (5.2 per 1000 live births).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	195	54	13
Children 1 through 4	49	8	0
Children 5 through 9	31	8	0
Children 10 through 14	32	6	0
Children 15 through 19	93	12	0
Children 20 through 24	151	21	0
Children 0 through 24	551	109	13

Notes - 2011

Narrative:

Of the 763 deaths among children (birth through 24 years of age), Hispanic ethnicity accounted for 16.2% or 109 deaths. Hispanic children less than 25 years of age comprised only 14.2% of the Utah population in this age group.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	936275	851619	16646	15415	15799	8766	28030	0	2008
Percent in household headed by single parent	100.0	92.9	1.3	1.4	2.0	0.8	1.7	0.0	2008
Percent in TANF (Grant) families	100.0	67.0	4.8	4.1	1.3	0.7	0.1	22.0	2008
Number enrolled in Medicaid	194038	135827	2911	1746	3105	2134	0	48315	2008
Number enrolled in SCHIP	46588	44359	435	834	650	204	0	106	2008
Number living in foster home care	2818	2397	193	153	25	33	7	10	2009
Number enrolled in food stamp program	254361	221583	8461	9611	6149	3194	0	5363	2009
Number enrolled in WIC	78082	70518	2009	2060	1529	1966	0	0	2009

Rate (per 100,000) of juvenile crime arrests	8758.6	8781.7	18755.8	8437.2	10447.2	10447.2	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.3	2.6	4.6	7.1	2.0	3.3	0.0	0.0	2009

Notes - 2011

2008 data from IBIS Race / ethnicity Query Module

2008 Data from U.S. Census, Race proportions based on IBIS 2008 Race / ethnicity Query Module

2008 data from the Administration for Children and families website, Characteristics and Financial Circumstances of TANF Recipients FY2008 tables 8

2009 data from the 416 (0-20) report. Race / ethnicity proportions from the 2009 MCH Service Report (1-21) Difference is in the unknown category

2008 data from UDOH CHIP.

2010 data from DHS, Current Count Data

2010 data from UDOH WIC Program REPORT 1003.

2008 data from UBCI, Proportions based on IBIS Race / ethnicity Query Module

2009 data from USOE Data Assessment and Accountability, Single year Drop-out Rates

2010 data from DCFS, March 2009 to March 2010

Narrative:

These data allow MCH programs to be aware of how children (birth -- 24 years of age) of different racial & ethnic groups are enrolled in various state programs (WIC, TANF, CHIP, Medicaid, foster care) and determine the need for additional program activities. Enrollment in various state assistance programs may be considered a proxy measure for low income. Given the economic downturn, the enrollment in public assistance programs is likely to increase, which will strain public resources.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
Miscellaneous Data BY HISPANIC ETHNICITY				
All children 0 through 19	792757	134518	0	2008
Percent in household headed by single parent	88.0	22.0	0.0	2008

Percent in TANF (Grant) families	88.0	22.0	0.0	2008
Number enrolled in Medicaid	136021	58017	0	2009
Number enrolled in SCHIP	35677	10911	0	2008
Number living in foster home care	2231	587	0	2009
Number enrolled in food stamp program	229787	24574	0	2009
Number enrolled in WIC	47004	31036	0	2009
Rate (per 100,000) of juvenile crime arrests	7572.7	16370.6	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.3	6.9	0.0	2009

Notes - 2011

See 9a

Narrative:

These data allow MCH programs to be aware of how children (birth -- 24 years of age) of different racial & ethnic groups are enrolled in various state programs (WIC, TANF, CHIP, Medicaid, foster care) and determine the need for additional program activities. Enrollment in various state assistance programs may be considered a proxy measure for low income. Given the economic downturn, the enrollment in public assistance programs is likely to increase, which will strain public resources.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	716042
Living in urban areas	853381
Living in rural areas	41132
Living in frontier areas	41762
Total - all children 0 through 19	936275

Notes - 2011

Narrative:

Based on 2008 population estimate, a total of 939,708 children from birth through 19 years of age reside in Utah. The majority of children (90.8%) live in urban areas. Less than five percent (4.7%) of children live in rural areas, and the remaining 4.6 percent reside in frontier areas. The greatest shortage of health care professionals for the state is in rural and frontier areas. Only 16 of the state's 29 counties have an OB/GYN. Long-distance travel is prohibitive of obtaining adequate prenatal care.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2757779.0
Percent Below: 50% of poverty	2.3
100% of poverty	9.0
200% of poverty	30.7

Notes - 2011

Narrative:

According to 2008 Healthcare Access Survey, 9 percent of Utah residents were living at or below the 100% federal poverty level. Almost 31 percent were living at or below 200 percent of federal poverty level. With the economic recession, there is potential for the percentage of the population in poverty to surge. MCH programs will face challenges in allocating its limited funding and resources to ensure that the needs of the most vulnerable populations are met.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	936275.0
Percent Below: 50% of poverty	2.9
100% of poverty	11.2
200% of poverty	37.2

Notes - 2011

Narrative:

More than one in ten Utah children ages birth through 19 (11.2%) lives at or below 100% of the federal poverty level. Children may suffer the impact of the economic recession at both the public and individual level. Children in poverty may be less likely to have routine health care, proper nutrition, and opportunities for mental enrichment.

F. Other Program Activities

The State Title V agency is involved in many activities that address the needs of mothers and children in the state. With the reorganization of the Department, we have new opportunities to integrate programs that serve mothers and children, to explore new opportunities and to develop new relationships internally and externally. Many of the activities that we engage in have been described in other sections of the Annual Application and Report and the Five Year Needs Assessment documents.

We work closely with the Baby Your Baby Program to promote healthy pregnancies and well children. Through several federal grants, we have had the opportunity to build infrastructure in autism, birth defects, First-Time Motherhood, evidence based home visiting, genetics, leadership, and many others.

The Department's Center for Multicultural Health has been working with Title V programs to address health disparities among minority populations/communities living in Utah. The Center has expanded staff capacity to better understand different communities in our state which has been beneficial for us as well as the communities. We interface with the Department's Native American Liaison to discuss ways we can better meet the needs of the Native American populations.

In 2001, legislation was passed to allow a mother not wanting to keep her newborn baby to drop the baby off at a hospital with no questions asked. The Legislation was crafted to help reduce the possibility of infant death due to a mother "discarding" her baby in a dumpster or other places, often leading to the infant's death. The Adolescent Health Coordinator works with the sponsor of the bill and representatives of various agencies to track the progress in assisting women who feel they are not able to care for a baby. Several press conferences have been held, print materials and a hotline have been implemented to address this serious problem.

The Division participates on numerous advisory committees sponsored by other state agencies or private agencies to enable the Title V programs collaborate with vital external partners in their work. Examples include the Child Abuse Prevention Council, Child Care Licensing, and so on. In general the state title V agency has exerted concerted effort to increase its collaborative efforts with private providers, professional associations and its agency partners to address the health needs of mothers and children, including those with special health care needs.

As our data capacity has been enhanced, we have expanded our ability to "research" various issues impacting mothers and children in the state. For example, MCH staff is looking at prescription overdose deaths among women who had a pregnancy within the 12 months prior to death. We use data to identify problems and associated factors, strategies to address the issues and tracking to measure progress in our work. Expansion of data capacity has enabled programs to conduct surveys, compile data that are important in identifying a health issue and related factors.

G. Technical Assistance

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 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	5998100	4750695	6013898		6013353	
2. Unobligated Balance <i>(Line2, Form 2)</i>	538000	947733	567502		1424947	
3. State Funds <i>(Line3, Form 2)</i>	25386000	24210043	23484900		12431500	
4. Local MCH Funds <i>(Line4, Form 2)</i>	5462581	4337379	4548728		4337379	
5. Other Funds <i>(Line5, Form 2)</i>	13290400	13893638	13234300		11254500	
6. Program Income <i>(Line6, Form 2)</i>	8004900	8250418	8475400		6542100	
7. Subtotal	58679981	56389906	56324728		42003779	
8. Other Federal Funds <i>(Line10, Form 2)</i>	50546500	54207737	63537300		56604500	
9. Total <i>(Line11, Form 2)</i>	109226481	110597643	119862028		98608279	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	6668905	7019826	6691853		5894708	
b. Infants < 1 year old	7697311	7566958	7444465		6318827	
c. Children 1 to 22 years old	24377296	22427218	22621976		12667704	
d. Children with	15969690	15459717	15530885		15484711	

Special Healthcare Needs						
e. Others	2693579	2678724	2767349		664829	
f. Administration	1273200	1237463	1268200		973000	
g. SUBTOTAL	58679981	56389906	56324728		42003779	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	80200		80200		89500	
c. CISS	140000		140000		104100	
d. Abstinence Education	0		288000		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	34444400		44042500		45088500	
h. AIDS	0		0		0	
i. CDC	10104700		10275800		1382100	
j. Education	5013200		7177100		8432900	
k. Other						
See Notes	0		1533700		1507400	
See FY2009 Notes	764000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	11755921	10934802	11181494		10036795	
II. Enabling Services	18900392	20222005	19487351		18134409	
III. Population-Based Services	16518818	14534634	14772033		5575435	
IV. Infrastructure Building Services	11504850	10698465	10883850		8257140	
V. Federal-State Title V Block Grant Partnership Total	58679981	56389906	56324728		42003779	

A. Expenditures

Please see notes related to each Form.

B. Budget

The Division of Family Health and Preparedness (FHP) is organized to address specific maternal and child health needs through a partnership between State agencies and the public and private sector to form a coordinated statewide system of health care. FHP's Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year (July 1 -- June 30).

The amount of state funds that will be used to support Maternal and Child Health programs in

FY11 is shown in the budget documentation of the state application. We assure that the FY89 maintenance of effort level of State funding at a minimum will be maintained in FY11 [sec.505(a)(4)].

For each four federal dollars a minimum of three state dollars is specifically designated as match. FHP allocates a total of \$12,431,500 of state funds appropriated by the Legislature for MCH activities. A total of \$5,787,000 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of \$5,578,725. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and combined with other federal and private funding to expand and enhance MCH programs and activities. Programs including Pregnancy Riskline, Fostering Healthy Children, and Baby Watch/Early Intervention, benefit from this use of the state funds. FHP receives private funding which is used to enhance selected programs or projects such as WEE Care and Pregnancy Riskline. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities.

FHP assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

FHP will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

FHP will allocate funds under this title fairly among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. There are a number of program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as WIC, Newborn Screening, and Baby Watch/Early Intervention.

The Department negotiates contracts with each of the twelve local health departments encompassing many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and perinatal, sudden infant and childhood death tracking. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff provide local health departments specific data to assist them in determining community needs. Local health department staff and state staff jointly develop an annual plan to address these needs. Annual reports are required from each local health department to monitor MCH activity and document their achievement in impacting the health status indicators for their local MCH populations.

In FY11, the state budget for FHP was reduced by approximately \$1.4 million. Included in these cuts was a \$1 million reduction to the CSHCN Bureau budget. In addition to these budget cuts the Department underwent an internal re-organization this past year. Many of the programs within

the Division of Community and Family Health were transferred to the Division of Disease Control and Prevention. These programs included all of the Health Promotion Bureau, as well as the Immunization Program. This re-organization resulted in over \$15 million dollars of funding being transferred to the Division of Disease Control and Prevention. As shown in the FY11 budget, these transfers impact State Funds, Other Funds, and Program Income. These transfers also have significant impact on the budgets categories for Children 1 to 22 Years Old, Others, and Population Based Services. It is not known at this time if additional state budget cuts will be necessary in the upcoming year.

Despite the ongoing budget challenges, the Division continues to allocate all available resources (MCH Block Grant funds, state funding, Medicaid, other private and public grants, and local funds) to most effectively address the changing maternal and child health needs throughout the state.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section "New State Performance Measure Detail Sheets and Data."

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.