State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.4 Overview of the State

Since the submission of Utah's FY96 Annual Application with Needs Assessment, there have been some significant changes in the demographics of the State as well as in the health care systems. These are discussed in detail in the needs assessment section of the application. The following narrative highlights a few challenges that warrant our special attention in planning, implementing, and evaluating health care services for mothers, children, and families during the upcoming year.

Utah has the nation's youngest population and the highest fertility rate. The 1990 census shows 36 percent of Utahns are younger than 18. Census demographers estimate that in 1999, the state's population reached a little more than 2.1 million. The Governor's Office of Planning and Budget projects that by 2020, the state will reach 3.3 million people. As of July 1999, Utah was the eighth fastest growing state in the country. More than three-quarters of that growth will come from local births exceeding deaths. In 1998, Utah had the highest number of births in its history, 45,128 births. Although minority groups comprise less than 11 percent of the total population, several ethnic minority groups are growing quickly. While Utah continues to be predominately white, ethnic minorities make up a larger portion of the state's population. These factors all have an impact on the health care system's ability to adequately address the health care needs of the MCH population.

The 1996 Health Status Survey done in Utah showed 9.53% of the residents from birth through 85 years of age have no health insurance with 21.37% of Hispanics being uninsured. As these populations are expected to contribute to future community population growth, it can be expected that the uninsured rate among these residents will also increase.

As the lead agency in public health, the State Health Department is committed to reducing the numbers of mothers and children who are uninsured. State staff, along with many other partners, provided the leadership to implement a state model Children's Health Insurance Program to address the issue of uninsured children in Utah. Utah's CHIP plan was approved in August 1998 and as of June 30, 1999 11,823 children had been enrolled in the program. The state has worked diligently to establish effective enrollment processes to enroll more eligible children in this non-Medicaid State plan.

States are nearly four years into their welfare reform efforts and there are still many unanswered questions. Utah has imposed a lifetime limit of 36 months, with the possibility for clients to "buy" additional months. Utah's welfare program, known as the Family Employment Program (FEP), is administered by the Department of Workforce Services (DWS), which is a combination of five former state agencies. At this time, it is not known what happens to families as they leave the welfare rolls, whether these families have moved out of poverty or simply moved off welfare or, whether they have health insurance if they no longer are enrolled in the state Medicaid program. Around 1,000 Utah families reached their 36-month time limit on December 31, 1999, followed by an estimated 230-250 families each month thereafter.

Utah's Title V staff continually identifies areas and populations to seek out underserved MCH individuals in order to prioritize allocation of programs and resources. These on-going needs assessment activities aid us in determining the importance of competing factors upon the health service delivery environment in the State. Staff then goes on to develop plans, identify resources, and develop interventions to help support the MCH services to those who reside here. After a standard review of all the necessary structures that need to be in place to support the delivery of health services to the MCH population, the important health status measures are evaluated and the resources are directed towards those populations.

The staff also uses their expertise to identify and weigh those competing factors, which may limit the degree of accessibility or availability of MCH services across the state. This work is done in conjunction with all the other community organizations and individuals who are interested in this effort. The Division has plans to host a Child Health Summit in the spring of 2001 which will involve numerous representatives from primary care, MCH programs, Medicaid, CHIP, child advocates, and others with interest in access to care issues and/or racial and ethnic disparities in child health measures. The conference will address child health issues, what resources are needed to address these, and what needs to be done that isn't currently being done to promote a child health action plan in the state.

Utah MCH 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 Utah Project, have promoted this policy, many families still remain skeptical

about applying for any government programs for fear they will be reported to Immigration and Naturalization Services or that their immigration status will be affected.

Legislation or statutes which impacted Utah's Title V programs are covered in more depth in each of the appropriate section of this document. An ongoing challenge in Utah is 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 parental involvement and the State Health Department has worked, largely through the Abstinence-Only Education Program, to promote increased parental knowledge, skills and abilities to discuss these kinds of issues with their children in their homes.

1.5 The State Title V Agency

Utah's Title V programs, both MCH and CSHCN, are administered by the Division of Community and Family Health Services (CFHS) of the Utah Department of Health (DOH). In addition, the Division is the lead agency for Individuals with Disabilities Education Act (IDEA) – Part C and the State's Immunization and WIC programs. George W. Delavan, M.D., heads the Division of Community and Family Health Services. Dr. Delavan is a board-certified pediatrician with more than thirty years of experience in Maternal and Child Health. (Please see Section 5.3, Other Supporting Documents, for his C.V).

Organizational charts of the Department of Health and the Division of Community and Family Health Services are included. CFHS is organized into five bureaus, comprising twenty-seven different programs. Each program reports to one of five Bureau Directors. The division has approximately 250 full-time equivalents working to improve the health of Utah's citizens. The MCH programs and services are operating in an improved manner with the WIC and Immunization programs co-located within the MCH Bureau. On July 1st of this year, the Oral Health Program was relocated into the MCH Bureau, which will foster stronger relationships among related programs. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse who brings more than twenty-nine years of experience to this position.

The main office of CFHS is in Salt Lake City, at the Martha Hughes Cannon Health Building, 288 North 1460 West, which also is the main office of the DOH. Many of the clinical programs of the CSHCN Bureau, including the Part C Program, are situated at another location in

Salt Lake City adjacent to the University of Utah Health Sciences Center and Primary Children's Medical Center and approximately six miles east of the Division's main office. The CSHCN Bureau clinical building is a newly constructed site, with staff having taken occupancy November 1999. Satellite offices for clinical CSHCN Bureau programs are located in Ogden, Provo, Cedar City, St. George, and Vernal. The CSHCN Bureau is headed by Vera Frances Tait, M.D., a pediatric neurologist with 17 years of experience trained in rehabilitation.

The senior level management staff in charge of this entire Division brings a wealth of experience and a depth of training to their respective program areas. They have the opportunity to lead an expert staff in carrying out their mission.

1.5.1 State Agency Capacity

1.5.1.1 Organizational Capacity

See organizational chart on page 7.

1.5.1.2 Program Capacity

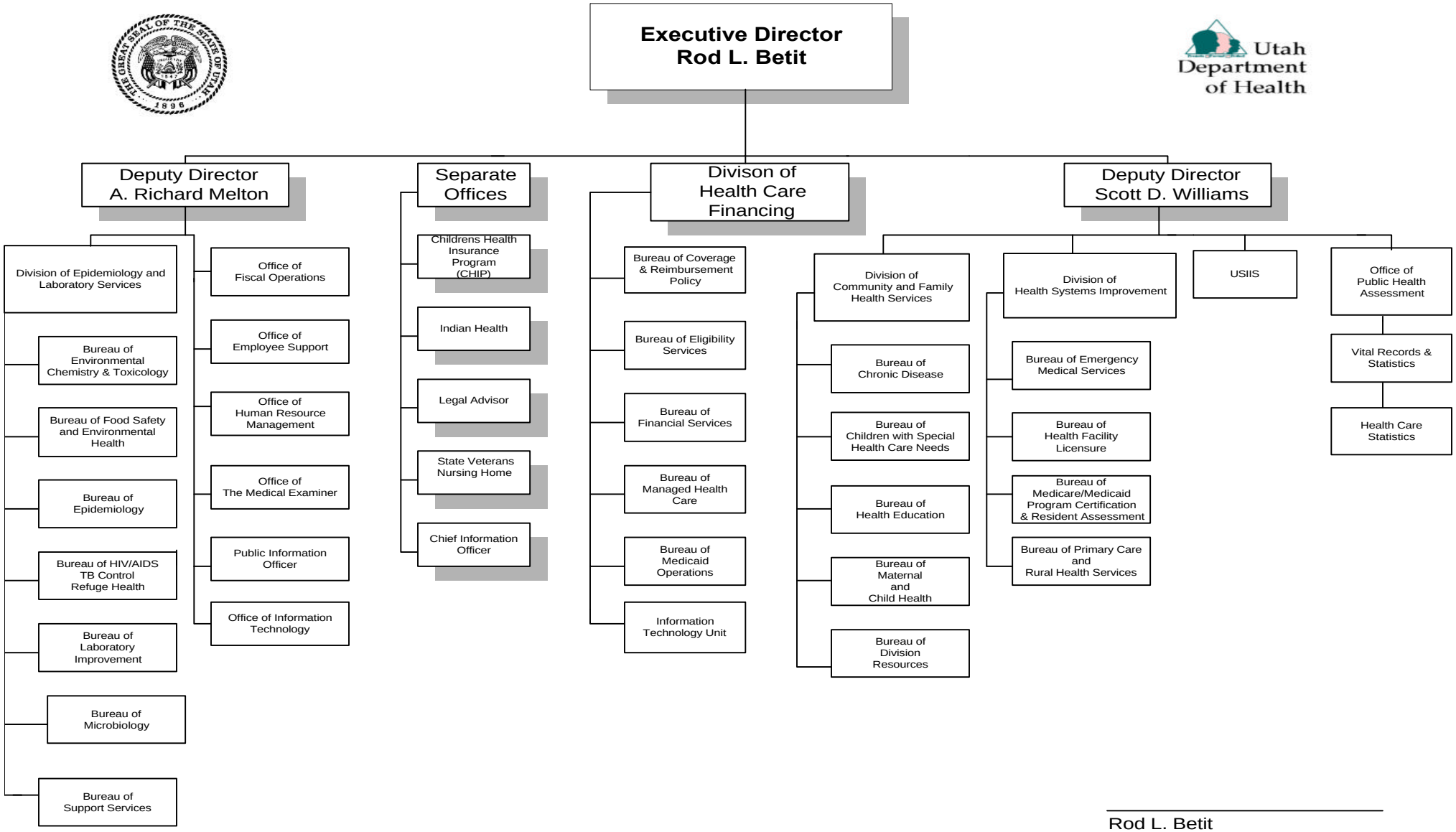
The program descriptions outlined in this year's application are all in place to provide the services of preventive and primary care to pregnant women, mothers, infants, and children as well as services for children with special health care needs.

Program or Service

Baby Your Baby Outreach Program – educates families throughout the state about the importance of early and regular prenatal and well-child care and where families may obtain such services. The program does this through television public service announcements and other programming, the Baby Your Baby Hotline, and through free educational materials such as the Baby Your Baby Health Keepsake, newsletters, and other incentives. The program staff provides presumptive eligibility for Medicaid to women in Salt Lake County who already have a health care provider who will accept Medicaid patients.

Pregnancy RiskLine – provides health care practitioners and the public with accurate and current information and high-risk counseling about the possible effects of maternal exposure to medications, drugs, chemicals, infections, and other diseases on a fetus and breastfed infant.

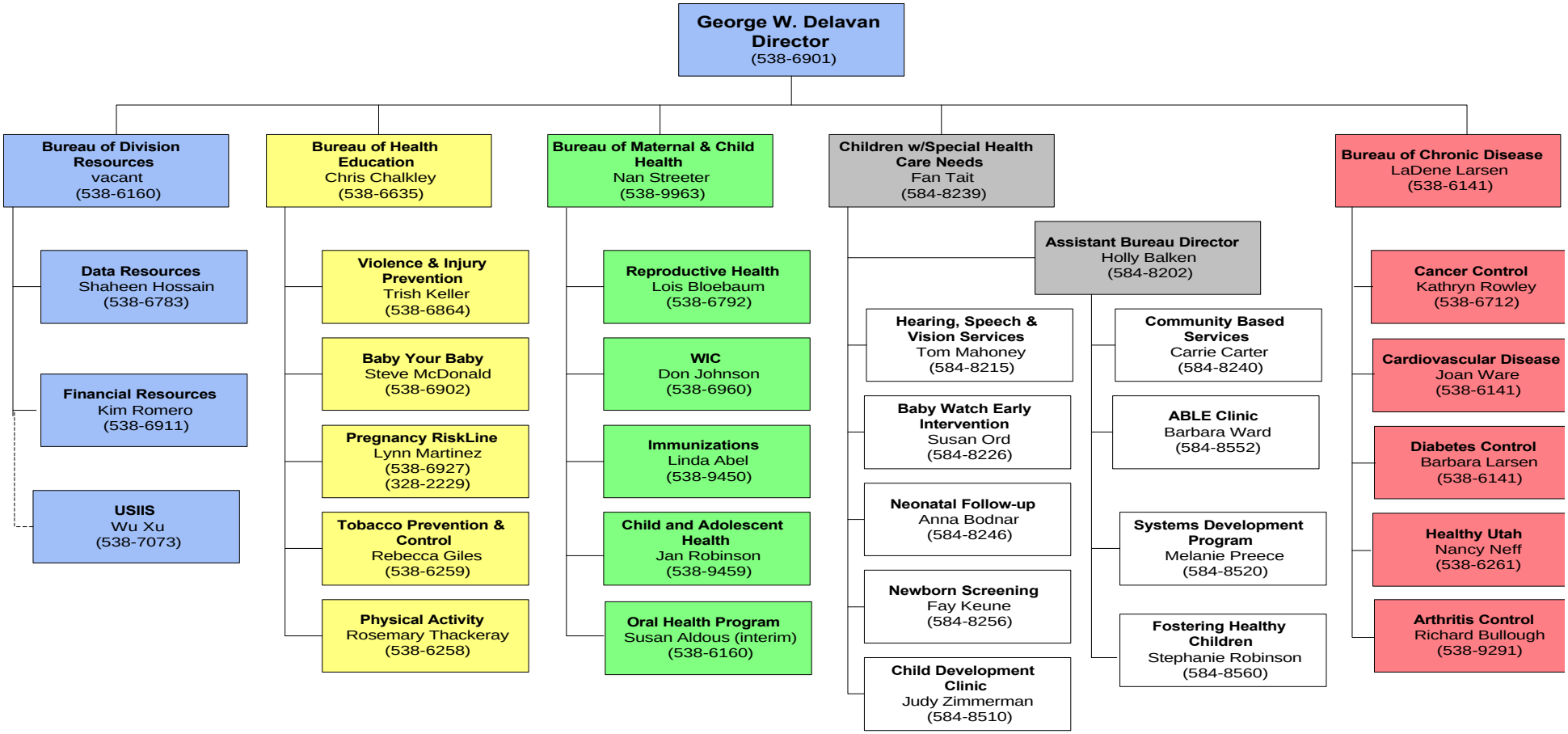
1.5.1.1 Organizational Structure



Rod L. Betit
Executive Director

Division of Community and Family Health Services

July 1, 2000



This information to improve the pregnancy outcome is provided over the telephone by way of a toll-free line throughout the state of Utah and in written follow-up to callers. Callers are not charged for these services.

Reproductive Health Program – focuses on the assurance of health care services to Utah women of childbearing age and their infants. The program oversees seven areas of reproductive health: federal abstinence-only education grant; prenatal care; family planning; case management for high-risk women; review of fetal, infant and maternal deaths; SIDS; and, the Utah PRAMS (Pregnancy Risk Assessment and Monitoring System) Project.

Sudden Infant Death Syndrome (SIDS) Program – provides information, grief counseling and follow-up services to families of SIDS victims, and promotes public awareness and understanding of ways to reduce the risk for SIDS, under the auspices of the Reproductive Health Program.

Newborn Screening Program – provides a statewide system for early identification and referral of newborns with any of three metabolic disorders that can produce mental retardation or death if not treated early. The disorders are: phenylketonuria, galactosemia, and congenital hypothyroidism. Hospitals are charged a fee of $27 for the testing kit.

Data Resources – provides objective information and data analyses for planning and evaluating maternal and child health services in Utah.

Violence and Injury Prevention Program (VIPP) – works to reduce the incidence of injury in the state of Utah, with a specific focus on youth injury prevention. This program has several components: school safety, suicide, bicycle safety, car restraint, etc. In addition, the program houses the Department's efforts to prevent rape and sexual assault and domestic violence.

Child and Adolescent Health Program – focuses on the assurance of health services to Utah's early childhood, school and adolescent populations by providing consultation to local health departments, school nurses and school districts, and others. The program also participates in the State Office of Education's Migrant Summer School Program, and the provision of technical assistance to local interagency teams providing services under the Families, Agencies, and Communities Together (FACT) Initiative. The program oversees five areas: a Head Start-

State Collaboration grant; a prenatal to five home visitation program, a Health and Safety in Child Care Program, school nursing, and adolescent health.

Oral Health Program – seeks to reduce the prevalence of tooth decay through screening, educational, and preventive services in conjunction with local health departments and others within the community. Screening services are provided free of charge. As a result of the most recent reorganization, the Oral Health Program has been incorporated into the Bureau of Maternal and Child Health. This allows for closer alignment in the Oral Health Program as they develop priorities for oral health in the state.

Hearing, Speech, and Vision Services Program – provides statewide screening, evaluation, and referral of infants and children with hearing, speech, and/or vision problems. Third party payers are billed for clinical services; the clients' portion after third party payment is billed on a sliding fee scale.

Neonatal Follow-up Program – provides statewide multidisciplinary services through three satellite offices to the very low birth weight graduates of Utah newborn intensive care units.

Child Development Clinic (CDC) – provides multidisciplinary clinical services for children birth to five years of age that have special health care needs. The program also offers consultative and case management services for children with multiple disabilities up to 18 years of age.

Community Based Services Program (CBS) – provides pediatric health care consultation and technical input for Early Periodic Screening Diagnosis and Treatment/Child Health Evaluation and Care (EPSDT/CHEC) children with special health needs. The program also provides care coordination to a target population of technology dependent children statewide through a Medicaid waiver.

Adaptive Behavior Learning Evaluation Program (ABLE) – the program improves the delivery of care to school-aged children who are at risk for or identified as having complex behavioral or learning disabilities as well as those with chronic physically disabling condition. The team works with families, schools and agencies and provides multidisciplinary diagnostic evaluations and school-based care coordination of services for children.

Fostering Healthy Children Program (FHCP) - assists the Utah Child Welfare agency in meeting the health care needs of children in foster care by co-locating nurses with DCFS case workers and providing medical case management.

BabyWatch Early Intervention Program (BWEIP) - provides early intervention and developmental interventions statewide for young children with developmental delays and/or disabilities from birth to age three. Children with delay in one or more of the following areas qualify for services: cognitive, motor, language/speech, psychosocial development, self-help, hearing, vision, or physical development/health. Services include multi-disciplinary evaluation and assessment; service coordination; specialty and therapy services such as nursing, physical therapy, occupational therapy, speech therapy, special instruction, family support and other related services that build on family strengths and child potential. Services are available statewide through local service delivery personnel. Early identification services, referral, and service coordination are available without cost to families.

Systems Development Program (SDP) - the services provided by this program include: neurology, cardiology, genetics, orthopedics, spina bifida, oro/facial, osteogenesis imperfecta, hemophilia and cystic fibrosis. Many of these services are provided statewide with CSHCN Bureau and local health department staff participating directly and in a supportive role.

1.5.1.3 Other Capacity

The division staff work on Title V programs in conjunction with multiple agencies across the state including local health departments (LHD), community health centers (CHC) and many other partners. LHDs and CHCs provide the local systems of care for our statewide MCH population. The division also has staff providing data analysis to aid the Division in its planning and evaluation tasks.

In addition, the parents of special needs children who are also staff members make a substantial contribution to our agency's capabilities to provide quality care to the state's children and families. The CSHCN Bureau also has a Family Voices parent who works on their program areas.

1.5.2 State Agency Coordination

The Division of Community and Family Health Services coordinates its efforts for the MCH populations with many other agencies in the state. In addition to the Department of Human Services, which serves the maternal and child population statewide, MCH staff work collaboratively with other state agencies such as the State Office of Education, the Justice, School for the Deaf and Blind, the Office of the Courts, Utah Highway Safety Office, to name a few. These efforts occur in conjunction with various efforts to improve the health of mothers, children and children with special needs.

A formal state agency coordination effort is the Families, Agencies, and Communities Together (FACT) Initiative. This initiative is an effort of five state agencies: Health, Education, Human Services, Workforce Services and Juvenile Justice. FACT has a steering committee composed of representatives of each of the five state agencies, as well as representatives from child advocacy organizations and other agencies serving children. This initiative has been funded by the state legislature for several years in order to promote better learning among Utah's children. The recognition that learning is impacted by other factors outside of education, such as illness, emotional and psychological stresses, economic stresses, etc. had enabled the state to develop local programs that address the needs of the child from a holistic perspective.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

2.2 Annual Number of Individuals Served

2.3 State Summary Profile

2.4 Progress on Annual Performance Measures

<u>Direct Health Care</u>

PM 1 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.

This performance measure was achieved. The FY99 Performance Objective was 19% and the actual Performance Indicator was 20.5%.

In FY99 CSHCN staff maintained a referral and information system with the Social Security Administration's Disability Determination Services (DDS). Approximately 548 DDS transmittals were received by CSHCN for children aged 16 years and younger, who were approved as having a disability. A CSHCN community health nurse evaluated the transmittals to provide Medicaid outreach and make other necessary referrals. Approximately 80% of families were contacted by phone or letter. Of state SSI beneficiaries less than 16 years old, 34% received rehabilitative services from the Children with Special Health Care Needs. CHSCN staff continued participation on the DDS Advisory Council to provide advocacy for children with disabilities and to strengthen ties with DDS.

CSHCN continued to develop a system to identify the SSI status of its patients by expanding the Megawest billing system to capture SSI data. CHSCN clinical teams received training to improve identification of potential SSI candidates. Several programs identified team members who were responsible for improving the identification of SSI and CHIP/Medicaid eligible children, for example, the Adaptive Behavior & Learning Evaluation (ABLE) program began tracking insurance and SSI benefits for all its clients. All SSI, Medicaid and CHIP eligible children were referred and followed until appropriate coverage was in place. All the children seen by the ABLE team were referred to a permanent medical home in their community.

CSHCN continued its support of two interagency agreements that clarified the responsibilities of agencies to children with special needs. A Memorandum of Agreement between CSHCN and Vocational Rehabilitation was implemented which identified agency responsibilities in collaborative service delivery as well as a referral process for children who are jointly served. CSHCN led in the development of a Memorandum of Agreement, which establishes agency responsibility for acquisition of Assistive Technology for persons with disabilities by the following state agencies: Education, Health Care Financing, Vocational Rehabilitation, Independent Living, and the Division of Services for Persons with Disabilities.

CSHCN and Shriners Hospitals for Children collaborated on a MCH SPRANS grant, Children's Healthcare Options Improved through Collaborative Efforts and Services (CHOICES),

to improve transitional services for Utah children with developmental motor disabilities beginning FFY98. Through this two-year project, 10-15 young adults per month, their families, friends and siblings participated in workshops to prepare them for the transition from adolescence into adulthood. Topics included: young adult mentoring, independent living, safety issues, sexuality issues, attendant care, support and advocacy, legal issues, assistive technology, Medicaid eligibility, proactive health care consumer training and development of transition plans by the young adults. Additionally CSHCN and Shriners Hospitals for Children staff provided community information fairs on Young Adult Transition planning with 25-30 agencies represented at each of four fairs with approximately 20 to 30 participants and their families attending. CHOICES staff also conducted the "Expeditions to the Top" transitions conference attended by over 500 young adults, parents, educators, health providers and vocational rehabilitation staff. Community board meetings were held monthly to provide a statewide forum for coordination of transition services to young adults. The project ends December 1999 with final analysis of the outcomes after project completion.

PM 2 The degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to clients.

This performance measure was achieved. The FY99 Performance Objective was 8 and the actual Performance Indicator was 8.

CSHCN and Medicaid continued the formal Administrative Case Management contract to assure that children with special needs eligible for Medicaid were referred appropriately. CSHCN staff made extraordinary efforts to refer children all over the state to eligibility workers to determine eligibility for Medicaid or CHIP. CSHCN staff assisted families to find appropriate medical health providers and services to meet their needs. Through administrative case management CSHCN provided education to families and providers about Medicaid eligibility and services. CSHCN staff also provided pediatric health care consultation and technical input for the EPSDT/CHEC program for children with special health care needs.

CSHCN staff administered Medicaid's Travis C. Waiver Program and provided intensive case management to a statewide targeted population of technology dependent children through a contract with Health Care Financing. A total of 55 children were served under this waiver in FY99 allowing recipients access to the usual Medicaid services as well as the additional waiver services. CSHCN successfully reached the program goal to keep medically complex children in the community by offering skilled nursing, respite, and case management and other essential services. CSHCN case managers referred children not meeting waiver eligibility requirements to other programs for which they may qualify.

CSHCN's Community Based Services, through contracts with 5 rural local health departments, provided care coordination to approximately 1750 children in 8 areas of the state. During FY99, the Ogden CSHCN Program was reorganized and is now staffed by CSHCN's Community Based Services Program through a team consisting of a social worker, nurse and support staff who provided care coordination to the children seen in clinics.

Local health department contracts provided care coordination teams, consisting of a nurse and clerical staff, in each of the 8 rural clinic sites by providing training and support to local public health nurses in their communities. Care coordination for CSHCN clinic children and assurance of completed follow-up care remained a high priority for the rural sites by developing comprehensive care plans. The rural case management team provided essential services to children with special needs and their families and provided outreach and education on CSHCN services and services of other programs for this population. The team coordinated with community providers and held interdisciplinary meetings focusing on solutions, including community resources and advocacy, for highly complex children and families.

CSHCN continued the Fostering Healthy Children Program (FHCP), a contractual collaboration with the DHS Division of Child and Family Services (DCFS), Utah's child welfare agency. The program ensured that children in foster care received health care services and that their health care needs were met. Outcome measures were developed and included physical health, dental, and mental health. Each child's status was evaluated within 5 days of removal from the home, at 30 days, and every 3 to 6 months thereafter depending upon their previous status. Baseline reports were generated with reasons for lack of improvement in health status (placement change, lack of follow up by foster parent, primary care provider not utilized, etc.). This

information was used by FHCP and DCFS to prioritize areas of focus to improve health care as well as monitor systems improvements.

CSHCN continued its Neonatal Follow-up Clinics for very low birth weight babies, graduates of Utah newborn intensive care units through three satellites, SLC, Ogden and Provo. The program also partnered with the staff of local hospitals (Columbia Regional Medical Center, McKay-Dee Hospital, and Utah Valley Regional Medical Center) to provide multidisciplinary services. No eligible baby was denied the full complement of screening services, nor was any eligible baby denied services due to family's inability to pay. NFP staff participated in hospital discharge planning to identify at-risk babies. In FY99, 152 clinics were held with 1700 high-risk children served through 8885 patient encounters. NFP provided regular feedback to all respective newborn intensive care units regarding the outcomes of their graduates, and worked closely with the statewide early intervention services and assessment summaries that were shared to provide continuity of care and reduce duplication of services. NFP partnered with University of Utah Hospital in two studies: prevention of cerebral palsy and the effect of prenatal steroids on high-risk infants' developmental outcome.

The CSHCN Child Development Clinic (CDC) provided 173 multi-disciplinary clinics for special health care needs children birth to five years of age; case management services to 580 children; and, completed a total of 2836 medical and/or developmental assessments. The program also offered consultative and case management services for children with multiple disabilities up to eighteen years of age. Of the children evaluated, 33% had a significant psychological/psychiatric diagnosis; 18% had a neurological disorder; 15% had a speech-language disorder; 14% had a genetic or congenital malformation; 8% had developmental delay; 6% had cognitive delays; 3% had been abused; and 2% had hearing loss. A Family and Child Needs Assessment form was completed on all clients with continued case management as needed. A continued focus of the program during last year was to promote access to mental health services for infants and toddlers through ongoing collaborative efforts with local mental health providers, early intervention programs, and foster programs.

Adaptive, Behavior, Learning, Evaluation (ABLE) program staff provided comprehensive evaluations and treatment planning for school-age children identified with medical disorders, learning disabilities, attention deficit disorder, or behavioral and adaptive functioning disorders.

Program staff traveled to various schools and to patients' homes to continue coordination of services for each child in the ABLE clinic and provide on-site evaluations for patients unable to travel to the clinic.

During FY99, ABLE program staff developed partnerships with 12 schools statewide to improve the delivery of care to children who are at-risk for or identified as having behavioral or learning disabilities. As part of the ABLE team partnership with the schools, each school was visited on a rotating basis by the team three times a year to consult with school staff on current ABLE clinic patients and new at-risk students identified by the schools.

As representatives of the state public health agency, members of the team attended meetings of local interagency council for Families, Agencies and Communities Together (FACT) staffings by the school district to assist in coordinating services with other agencies for identified at-risk students. The team physician and nurse participated on the Rapid Response Team (part of the FACT committee) to coordinate services for the most at-risk children in need of emergency services.

Hearing, Speech and Vision Services (HSVS) provided pediatric hearing, speech and photorefraction vision screening services throughout the state, with 1,868 patient evaluations and approximately 500 population-based screenings provided statewide. During FY99, photorefraction vision screening to detect conditions that lead to amblyopia was made available at all HSVS clinic sites. Children identified with a problem were referred to appropriate local services for continued management. HSVS clinical facilities were located in Salt Lake, Ogden, Cedar City, Price, and Vernal. Services were also available to CSHCN clinical programs and ten HSVS traveling clinic sites throughout rural Utah. Target populations included Native Americans; children enrolled in early intervention; Early Head Start or Head Start programs; infants that failed newborn screening; children with other physical and developmental conditions; and, children lacking alternative resources. Additionally, 2,200 educational encounters were provided through printed educational materials, in-services, and training sessions to parents and professionals.

In FY99, the Baby Watch Early Intervention Program (BWEIP) provided services to infants and toddlers with disabilities and their families through the efforts of 16 local programs and 2 statewide programs by a variety of personnel such as therapists, nurses, parents,

paraprofessionals, teachers, social workers, sensory and child development specialists, etc. Of personnel providing services throughout the State, more than 1/3 have completed their Early Intervention Credential and maintain the "highest requirements" in the State for licensure, certification, registration, etc. BWEIP continued to develop its in-service training and technical assistance capacities to insure that ongoing training was provided through one-on-one contacts, small group sessions, regional conferences, and statewide activities such as the annual Early Intervention/Preschool Conference.

Contracts with the University of Utah, Primary Children's Medical Center and private providers were updated and renewed for specialty services including neurology, cardiology, genetics and orthopedics, and multi-disciplinary clinics including spina bifida, orofacial, osteogenesis imperfecta, hemophilia and cystic fibrosis. Many of the services were provided statewide with CSHCN and local health department staff participating directly and in a supportive role. Various CSHCN staff, including a social worker, physical therapist, speech/language pathologist, registered nurse, licensed practical nurse and resource specialist participated as needed in these various specialty clinics.

The University of Utah Genetics Division conducted genetics evaluations for children living along the Wasatch Front. CSHCN also conducted genetics clinics at itinerant sites throughout the state based on need. Approximately 125 children and their families received genetic evaluation, testing and counseling not routinely covered by private health plans.

During FY99, CSHCN conducted 29 traveling pediatric orthopedic clinics, 18 Salt Lake City pediatric orthopedic clinics and, in conjunction with Shriners Hospitals for Children, 15 feeding clinics; 4 hand clinics; 4 spine clinics; and 4 osteogenesis imperfecta clinics. CSHCN staff provided physical and occupational therapy services to seven early intervention sites in the state as needed, covering Logan, Vernal, Roosevelt, Richfield, Price, Moab, and Blanding. (See Section 5.3) CSHCN also hired a part-time occupational therapist in Southeastern Utah to provide support to CSHCN traveling clinics and Baby Watch Early Intervention sites in this area of the state.

In FY99, there was an average of 188 active patients in Children's Healthcare Options Improved through Collaborative Efforts and Services (CHOICES). CSHCN received 450 referrals for clinics from Shriners Hospitals for Children, BWEIP and through the onsite

Medicaid/CHIP eligibility worker. CSHCN made approximately 45 referrals to Shriners Hospital for Children requiring care coordination. Shriners and CSHCN staff worked together to continue the Intermountain Collaborative Transition Center designed to more clearly define the unique needs of youth, ages 14-21, with disabilities and provide them with competencies to gain independence and resourcefulness as they approach adulthood.

SP 1 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.

This performance measure was achieved. The FY99 Performance Objective was 5.5% and the actual Performance Indicator was 6.9%.

CSHCN expanded telehealth to three rural areas, Richfield, Vernal and Moab, in collaboration with the University of Utah Division of Family and Preventive Medicine. Funding for the set-up of telehealth at the Richfield and Vernal sites and for nursing personnel came from a U.S. Department of Commerce grant, Telecommunications and Information Infrastructure Assistance Program (TIIAP), awarded to the University. CSHCN, in cooperation with two local health districts, established two remote nurse coordinator positions for the Richfield and Vernal sites to coordinate evaluations for children with special health care needs.

Local health department contracts provided case management and follow-up for special needs children in Vernal, Price, Richfield, Blanding, Moab, Provo, Cedar City, and St. George as described in PM2. The case management teams assisted children with special health care needs and families by providing resource information and clinic follow-up to ensure they received the necessary treatments and recommended services. CSHCN continued its travelling specialty clinics to these areas of the state with the local case managers being responsible to manage clinic operations. Community Based Services increased the independence of the rural itinerant clinic sites by transferring the responsibility of chart maintenance and scheduling to each site with provision of hardware and software and technical assistance. CSHCN continued to collaborate with rural providers that also serve children in these areas.

Physical and occupational therapists from CSHCN provided their expertise to children served in the early intervention program. Technical assistance from CSHCN was provided to a

rural area of the state for implementation of the Families, Agencies and Communities Together initiative, with community staffing in the local areas to provide consultation and promote collaboration with the local providers and schools. Efforts were made this past year to build relationships with rural mental health providers. Meetings were held with HCH Medicaid to identify problems with access and service provision in the Medicaid Pre-paid Mental Health Plans with resultant contract language amendments that include working with CSHCN staff on referrals, community staff meetings, and coordination of services. Medicaid also agreed to involve CSHCN staff in quality monitoring activities of the Pre-paid Mental Health Plans.

Hearing, Speech and Vision Services was instrumental in the installation of a sound booth in Montezuma Creek, Utah, in cooperation with the Utah Department of Health DREAMM (Developing Reservation-based Efforts Addressing Mortality and Morbidity) Grant for Native Americans and the San Juan County school system. The sound booth was functional in October of 1998 and, for the first time, allowed complete audiological testing in southeastern Utah.

Enabling Services

SP 2 Percent of cigarette smoking by teenagers aged 12-17 years.

This performance measure was achieved. The FY98 Performance Objective was 14.9% and the actual Performance Indicator was 14.9%.

A comprehensive training system for the youth-focused END (Ending Nicotine Dependence) Program was developed and implemented with 21 trainings conducted during FY99, including development of training manuals that were used consistently for trainings.

Compliance checks for youth access to tobacco products in retail establishments were conducted in all local health departments, with results that indicated youth successfully purchased tobacco products approximately 20% of the time.

The Utah Department of Health was the lead agency in developing a coordinating committee to guide implementation of the statewide Anti-Tobacco Media Campaign, along with the American Cancer Society; Utah Substance Abuse and Anti-Violence Coordinating Council; University of Utah/College of Health; Robert Wood Johnson Foundation; State Purchasing; and Davis, Utah, Weber/Morgan and Salt Lake Valley Health Departments. Youth focus groups were conducted throughout the state to determine direction and focus for the campaign, with a theme

of “THE TRUTH ABOUT SMOKING. GET IT!” Multi-media partnerships were developed during FY99, beginning with a $500,000 state appropriation which was partly used to hire a private advertising/marketing agency to develop multi media, negotiate airtime and strengthen promotional bonuses. Along with in-kind contributions and a Medicaid match the total campaign value increased to $1,951,468. Between TV and radio, the campaign message reached 86% - 96% of youth ages 9-18 between 23 to 44 times.

PM 3 The percent of CSHCN in the State who have a “medical/health home.”

This performance measure was achieved. The FY99 Performance Objective was 90% and the actual Performance Indicator was 90%. This percent is based on 1995 survey data of parents with children with special health care needs. There are no new data available.

In FY99 CSHCN continued to work with Intermountain Pediatric Society (IPS) Utah’s Chapter of American Academy of Pediatrics (AAP) to improve the provision of a medical home for special needs children in Utah. CSHCN staff worked closely with IPS to strengthen the role of the Special Health Needs Committee, consisting of CSHCN staff, pediatricians in private practices, academics and from outside the Salt Lake area through quarterly meetings and development of statewide goals. The committee developed and published a Medical Home Resource Brochure that was sent out to pediatricians and internal medicine physicians in Salt Lake County. The Special Health Needs Committee assisted in developing the training agenda for the yearly IPS Continuing Medical Education Session to support and train physicians in provision of high quality medical homes for special needs children. The committee applied for the American Academy of Pediatrics/Shriners Hospital for Children “Every Child Deserves a Medical Home Facilitator Training” grant.

In FY99, CSHCN continued to meet with the Utah State University Early Intervention Research Institute (EIRI) staff which was awarded the MCH grant for “Measuring and Monitoring” systems of care for CSHCN. CSHCN worked with the EIRI staff in developing a statewide assessment plan for children with special needs and their families. Through this effort, Community and Family Health Services submitted a State Systems Development Initiative grant

for funding of a statewide needs assessment for all children in Utah in FY00, with special attention to children with special health needs and their families.

Population Based Services

PM 6 The birth rate (per 1,000) for teenagers aged 15 through 17 years.
This performance measure was achieved. The FY98 Performance Objective was 24.7% and the actual Performance Indicator was 23.6%.

With federal abstinence education monies, eleven programs continued throughout the state to promote abstinence-only education among boys and girls between the ages of 9 and 14 years. The program stressed the importance of parental involvement and the promotion of sound decision-making, strong self-esteem and good refusal skills. These programs were provided through contracts with local health departments, school districts, and private non-profit agencies. The projects were located in various parts of the state, including Bear River, Emery, Garfield, Salt Lake, Sanpete, Tooele, and Wasatch counties, although some projects extended their programs beyond these geographic areas. Because the abstinence-only education program targets pre-adolescents and younger adolescents, it is not anticipated that it will have an impact on the birth rate among 15-17 year olds for a number of years. The Division began to update the Adolescent Pregnancy Report with current statistics and data, but it was not completed before the end of the fiscal year. The report will be completed during FY00 and posted on the Internet for easy and low cost access. A report of teen birth statistics was sent to each health district and was posted on the Internet with an average of nearly 200 visitors a month.

PM 9 Percentage of mothers who breastfeed their infants at hospital discharge.
This measure was achieved. The Performance Objective for FY98 was set for 82% initiation of breastfeeding. According to 1998 Mothers Survey conducted by Ross Products Division the actual proportion of Utah mothers who initiated breastfeeding was 82.8%.

The promotion of initial breastfeeding and longer breastfeeding duration during infancy was an activity that the Division continued to encourage during FY99 through collaboration with

the Breastfeeding Coalition and other activities to strengthen the promotion of breastfeeding among new mothers. Division staff was involved in the implementation of WIC National Breastfeeding Campaign, including media spots. WIC staff worked closely with local agencies to promote breastfeeding within their own communities. The Peer Counselor Program and Training Manual, recognized nationally to enhance services to WIC participants, was continued. WIC held two state trainings, available to WIC and non-WIC staff, while local agencies sponsored at least 10 others. Support for local peer counselors, representative of the population they served, was developed including greater emphasis on the needs of different ethnic groups in the state. WIC offered educational programs to support five new lactation educators in the state. Breastfeeding was also promoted through the SIDS program and in the Reproductive Health quarterly newsletter.

SP 6 The rate (per 10,000) of neural tube birth defects.

This performance measure was achieved. The FY98 Performance Objective was 6.6 and the actual Performance Indicator was 6.6.

The Folic Acid Educational Campaign Committee was active during FY99 with presentations to five local and national conferences to increase awareness of birth defects prevention with consumption of multivitamins with folic acid. Posters and brochures were also available for participants.

Several students have participated in promoting folic acid consumption by disseminating information to women under age 30 in one community and conducting a pilot study of teachers and students in six high schools in Salt Lake and Davis Counties to educate students about folic acid.

PM 7 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

This performance measure was achieved. The FY99 Performance Objective was 43% and the actual Performance Indicator was 43%.

In the last statewide survey (1996), this measure was 43%, greatly improved from 28% in 1987. The variation by local health district was remarkable, ranging from 14% in the Southwestern Utah District to 59% in the TriCounty District. Further analysis revealed low income, minority and migrant sub-populations had poor access to preventive services such as sealants.

As in previous years, through the Smile Factory, Oral Health staff conducted education, screenings and prevention activities in schools with children at high risk for dental caries. Educational materials and referral for treatment were sent home with children needing sealants. Of 1,100 eight year-olds screened in forty-five schools, 32.5% had sealants on at least one permanent molar, a decrease from 39.5% in 1998, due, in large part, to targeting schools with significantly more severe dental risk factors.

Members of several Native American tribes received oral health education, screening and referral at health fairs on reservations at Montezuma Creek, White Mesa, Cedar City, and Fort Duchesne. The Oral Health Program provided a dentist, dental hygienist, portable dental equipment, examination supplies and educational materials. Tribal health representatives followed up on treatment needs discovered in the screenings. Sealants were found in fewer than 5% of those screened.

PM 5 Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

PM5 was achieved. The FY98 Performance Objective was 75% and the actual Performance Indicator was 77% for completed immunizations.

SP 5 The percent of kindergarten through twelfth grade students who receive two doses of Measles, Mumps and Rubella (MMR) vaccine.

SP5 was achieved. The FY98 Performance Objective was 72% and the actual Performance Indicator was 72%.

PM5 and SP5 are related measures so reports on activities have been combined. The statewide media campaign, “Immunize by Two, It’s Up to You”, was sustained through 1999

with major corporate sponsorship which supported media outreach (print, television, and radio) and efforts for the Infant Immunization Week in April including a golf event. The pharmaceutical collaborative continued to meet to support outreach efforts statewide.

Utah's statewide Every Child by Two immunization task force, chaired by Utah's First Lady, continued to meet bimonthly to address: insurance coverage; access; education; publicity/marketing and provider participation. The statewide task force was further supported through continued efforts of two local coalitions (Northern Utah and Greater Salt Lake Area). The Access Committee, Utah Medical Association and the Immunization Program developed a physician education packet that was delivered to community physician offices in Northern Utah and Salt Lake County by the Utah Alliance, an organization made up of physician spouses. The toll-free immunization hotline was continued as an education/information resource to the public.

The Immunization Program used Clinic Assessment Software Application (CASA) to assess public and private providers' immunization rates in clinics in all local health departments and sixteen community health centers. Training was provided for Intermountain Hospital Corporation to support assessment of immunization rates in their private provider offices.

WIC linkage activities included all WIC clinics screening clients for immunization status and referring to immunization providers as needed. Several WIC clinics were co-located with immunization clinics to provide immunizations on site. The WIC/Immunization Registry Bridge was developed and the pre-Bridge evaluation of eight WIC clinics, in conjunction with the University of Utah, was completed in October 1998. The Bridge computer programming was completed and the ability to share immunization data was tested.

The schedule for the mobile immunization Care-A-Van, a joint effort of UDOH and Community Nursing Service with support from the Immunize By Two partners, targeted areas with low immunization levels or poor access to services by visiting underserved areas statewide and providing immunizations free-of-charge to children under two.

The Vaccines for Children (VFC) program continued to enroll Utah physicians as VFC providers for an overall total of 250 provider sites.

The Utah School Immunization Law has required two doses of a measles-containing vaccine (usually MMR) for kindergarten entry since the 1992-93 school year. Surveys revealed

that for the 1997-98 school year, approximately 72% of K-12 students statewide had received the second dose of MMR. The new Immunization Rules requiring a second dose of MMR for all students K-12 became effective July 1, 1999 for the 99/00 school year.

PM 8 The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

PM8 was not achieved. The FY98 Performance Objective was 7.8 and the actual Performance Indicator was 8.3.

SP 3 The percent of bicycle helmet use among bicyclists 5-12 years of age.

SP3 was not achieved. The FY98 Performance Objective was 16.0% and the actual Performance Indicator was 12.7%.

SP 4 The percent of use of vehicle safety restraints among child occupants under nine years of age.

SP4 was not achieved. The FY98 Performance Objective was 72% and the actual Performance Indicator was 68.7%.

PM8, SP3 and SP4 are related so report of actions has been combined. The Violence and Injury Prevention Program (VIPP) continued its collaboration with many state and local partners including: local health departments; Utah Highway Safety Office; Utah Safety Council; Utah Parent-Teachers Association; Primary Children's Medical Center; Utah SAFE KIDS Coalition; Coalition for Utah Traffic Safety; University of Utah's Intermountain Injury Control Research Center; Utah Automobile Association and others.

VIPP worked with community partners to provide data, background information and staff support to the Utah Traffic Safety Task Force, created by the 1998 Utah Legislature to investigate and prioritize traffic safety issues that might warrant legislative action. VIPP participated in a broad-based coalition to support a statewide campaign for a Standard Seat Belt Law by providing information to the Traffic Safety Task Force and legislators to assist them in drafting a bill, providing data, technical assistance and staff support for the coalition, assisting in the development of legislative fact sheets and news releases, and assisting local health

departments to develop local grass roots support. Although the bill was not passed into law, coalition representatives met to evaluate efforts and consider future strategies.

VIPP worked to reduce motor vehicle injuries through activities including: participation in the Youth Alcohol Coalition; collaboration with local law enforcement in the "Cops in Shops" program; serving on the Advisory Board of Primary Children's Medical Center's "Hold On To Dear Life" Campaign; supporting the Utah Safety Council's "Buckle Up for Love" campaign; working with Utah SAFE KIDS Coalition to conduct child car seat checks and to purchase and distribute free or low cost bike helmets; promoting pedestrian safety by distributing brochures, conducting media interviews, providing news articles, and continuing to make the Wary Walker Pedestrian curriculum and training available to kindergarten through third grade teachers.

VIPP collaborated with state and local partners in various efforts to increase the use of bike helmets among elementary school age children in Utah. VIPP collaborated with the Utah SAFE KIDS Coalition to promote bicycle helmet use by distributing bike safety brochures, conducting media interviews, contributing to articles for newspapers, providing bike safety information on the Utah Department of Health (UDOH) internet website; sponsoring SAFE KIDS Week and Gear Up Games; and purchasing and distribution of low cost bike helmets through local health departments and local Parent-Teachers Associations (PTAs).

VIPP contracted with all twelve local health departments to conduct a variety of motor vehicle injury prevention programs including: promoting bicycle helmet use and use of child car seats and seat belts; participation in a statewide campaign for a Standard Seat Belt Law in Utah; and, conducting pedestrian safety education for school age children and youth. Key elements of the bicycle helmet safety projects among elementary school age children ages 5-12 years included: child and parent education; participation of local schools and businesses; public education or media campaigns; and pre/post observation surveys of helmet use. Preliminary analysis of observation survey data indicated that bicycle helmet use among children in the target areas increased to 10%.

To increase use of safety restraints among children, VIPP, in collaboration with its partners, purchased and distributed low cost car seats through local health departments and provided funding, training and technical support to local health departments to promote child safety restraint use.

PM 4 Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies.

This performance measure was not achieved. The FY98 Performance Objective was 98.5% and the actual Performance Indicator was 98.4%. The reason for this measure was not achieved is use of occurrent births for CY96 and resident births for CY97.

Utah has consistently exceeded the Year 2000 objective of screening at least 95% of the newborns. We have chosen 97.5% as our minimum goal.

The Newborn Screening Program continued to coordinate the screening for PKU, congenital hypothyroidism, and galactosemia in the state for all newborns. Utah does not screen for hemoglobinopathies. All newborns with two abnormal screens were referred for evaluation and possible treatment. Allowances were made for duplicate screens on newborns who were adopted (in-state births not linked to the original first specimen and out-of-state births adopted by in-state families who were tested), transfused, etc.

Law passed in 1998 mandated that the Utah Insurance Commission establish minimum standards of coverage for the treatment of inborn errors of amino acid or urea cycle metabolism. Rule was established in 1999 establishing guidelines for billing and processing of claims for dietary products coverage. Newborn Screening staff educated families and insurance providers about the requirements in the law that allows for payment of dietary products.

PM 10 Percentage of newborns who have been screened for hearing impairment before hospital discharge.

This performance measure was achieved. The FY98 Performance Objective was 66% and the actual Performance Indicator was 78.8%.

The Newborn Hearing Screening Act of 1998 mandated hearing screening of all newborns before hospital discharge effective on July 1, 1999. Rules and Regulations for Newborn Hearing Screening became effective September 11, 1998. A contract with Utah State University/National Center for Hearing Assessment and Management (NCHAM) was developed that included

implementation, technical assistance and continuing support for newborn hearing screening programs in all Utah hospitals. In 1998, 78% of all infants live births received hearing screening before hospital discharge, with over three-quarters of all birthing hospitals providing newborn hearing screening.

The Newborn Hearing Screening Committee, mandated by legislative act, met three times during FY99. Upon the committee's recommendation, Hearing, Speech and Vision Services generated and distributed a statewide audiological survey and referral list, a primary care provider information packet, and educational and screening referral information to physicians, hospitals and Early Intervention sites throughout the state. Hospitals were required to submit a newborn hearing screening program and procedure summary to HSVS. Forms for documenting transferred babies and audiological diagnostic referrals from hospital programs were distributed to hospitals. HSVS worked with Office of Vital Records and Statistics to obtain monthly records of home births and infant deaths. HSVS and NCHAM coordinated three statewide trainings for newborn hearing screening programs and provided implementation training to the institutions required to begin screening on July 1, 1999. Regional HSVS offices provided diagnostic evaluations and follow-up services, concentrating in rural areas of the state where alternative services were unavailable. Audiological supervision was provided to seven rural newborn hearing screening programs by HSVS audiologists.

Medicaid continued to pay for code V5008, Infant Hearing Screening, in "fee for service" areas only, mostly to rural providers. Indications from hospital newborn hearing screening programs suggest the percentage of insurance payments for screening did increase.

Infrastructure Building

PM 15 Percent of very low birth weight live births.

This performance measure was achieved. The FY98 Performance Objective was 1.1% and the actual Performance Indicator was 1.0%.

PM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

This performance measure was achieved. The FY98 Performance Objective was 82.2% and the actual Performance Indicator was 86.5%.

PM15 and PM17 are related measures so the report for activities has been combined. Continued surveillance by the perinatal mortality review program (PMRP) identified factors that impacted infant deaths. For example, a number of mothers did not seek care when danger signs of pregnancy presented, such as rupture of membranes, or providers did not manage high-risk pregnancy conditions appropriately. A brochure on the danger signs of pregnancy ("I'm Worth It") was developed and distributed to prenatal health care providers. Education regarding PMRP findings was distributed to prenatal care providers via newsletter reports and the Internet.

The PMRP worked with regional perinatal centers in the state to acquaint them with problem areas in their regions to promote outreach education and encourage improved consultation with hospitals in their referral network. Prenatal health care provider education regarding appropriate assessment was included in the recommendations from the PMRP, which were published on the web and presented at the 1998 American Academy of Pediatrics District VIII Section on Neonatal/Perinatal Medicine Conference to perinatal and neonatal physicians along with mid-level providers from the intermountain western states.

During FY99, a report on low birth weight was started as part of Utah's Promise, the Governor's initiative for volunteer efforts for healthy families in the state. Because of the data analysis required to produce the report, it was not completed before the end of the fiscal year. The report was designed to present an in-depth analysis of low birth weight in Utah, including the geographic distribution, risk factors such as demographic variables, multiple gestations, history of previous low birth weight births, interpregnancy spacing, etc., as well as recommendations for health care providers, public health professionals, and women of childbearing age.

The Division had planned to develop and implement an intervention during FY99 to encourage delivery of very low birth weight infants at facilities equipped to handle high-risk births. However, this goal was not accomplished because the data analysis had not been completed.

Since not all very low birth weight births can be eliminated, it is critical that the appropriate facility be available to high-risk pregnant women. The Division tracked trends in the hospital of

birth for very low birth weight infants, with assistance from the Office of Vital Records and Statistics which for the first time included in its annual vital statistics report the numbers of very low birth weight babies born in individual hospitals in the state. Publication of this information allowed the Department to document sites of very low birth weight deliveries that may be inappropriate depending on individual circumstances.

The PMRP identified deaths of very low birth weight infants which could have been influenced by the type of hospital in which the mother delivered. The PMRP concluded that when the infant was not transported to a higher level facility, the decision not to transport was appropriate for the individual circumstances. In most instances of infant death when the decision not to transport was made, it was due to unavoidable circumstances, such as a precipitous labor, pre-viable fetus, or distance and weather problems that would have made the transport inappropriate.

PM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

This performance measure was achieved. The FY98 Performance Objective was 79.7% and the actual Performance Indicator was 79.7%.

In 1998, 79.7% of mothers delivering a live infant entered prenatal care in their first trimester of pregnancy, a decrease in early entry from the previous year of 82.9%. This decrease may reflect under-reporting due to a marked increase in the number of births for which entry into care was not recorded, representing an increase in non-reporting of 68.7%.

In an effort to target women entering prenatal care after the first trimester, data by health district were provided to the four districts with the highest percentages of women receiving late or no prenatal care. While teens and women of racial and ethnic minorities were over-represented, White women and women between the ages of 20-30 years comprised the majority of late entrants.

During FY99 three managed care organizations (MCO) contracting with the State Medicaid agency, Division of Health Care Financing (HCF), participated in quality assurance reviews carried out by HCF in conjunction with CFHS's Reproductive Health Program staff.

Each MCO was queried about providers delaying prenatal care until the second trimester, with each indicating that they were unaware of providers delaying clients' care. All MCOs were encouraged to start or maintain client and provider newsletters to include promotion of early prenatal care. Additionally, all MCOs were encouraged to develop/maintain active outreach programs to pregnant enrollees to promote early prenatal care.

The Baby Your Baby Program (BYB) produced a video on preconceptional care entitled "Before You Get Pregnant" with input from various Division staff, such as WIC, Pregnancy RiskLine, Reproductive Health, etc. This video, which discusses health practices that promote optimal pregnancy outcomes and urges early and continuous prenatal care, was distributed to approximately 500 private and public health care providers throughout Utah. Four new BYB television public service announcements were developed and aired that encouraged entry into prenatal care. The BYB Hotline received 16,350 calls and referred more than 7,000 women for prenatal care. Other BYB activities in FY99 included: distribution of the Health Keepsake book, creation of the BYB web page: www.babyyourbaby.org; production of a new brochure in English and Spanish; ads in Family Matters Magazine and the Spanish Yellow Pages; busboards and billboards in targeted areas of Salt Lake City and Ogden; announcements at selected Smith's grocery stores with BYB materials available at the stores' pharmacies; and distribution of BYB materials by program staff at various health fairs and conferences.

SP 7 The number of Internet reported MCH Performance and Outcome Measures with an interactive query capacity.

This performance measure was achieved. The FY99 Performance Objective was 8 performance and outcome measures and the actual Performance Indicator was 10 performance and outcome measures.

The Maternal and Child Health Information Internet-Query Module (MatCHIIM) contains modules on low birth weight, prenatal care, teen births, fertility, Cesarean section, infant mortality, and unintentional injury. Each module consists of five to eight measures that can be analyzed by a number of different characteristics of the mother, infant and/or health care. The modules all are up and running and available to the public.

SP 9 Percent of pregnant women with adequate weight gain who deliver live born infants.
This performance measure was not achieved. The FY98 Performance Objective was 81.4% and the actual Performance Indicator was 80.4%.

The Division promoted adequate weight gain during pregnancy through improved data collection. The WIC Program worked toward achieving adequate weight gain for its pregnant participants by individual counseling regarding recommended weight gain for pregnancy, following weight gain recommendations based on preconception body mass index (BMI). All pregnant women who had a BMI<18, low weight gain, or weight loss during pregnancy were categorized as high risk and were closely followed by a Registered Dietitian throughout pregnancy including weight tracking at each WIC visit. The PMRP tracked poor weight gain among women whose infants later died and reported these findings in its reports.

PM 12 Percent of children without health insurance.
This performance measure was not achieved. The FY98 Performance Objective was 8.0% and the actual Performance Indicator was 8.5%.

Utah's Children's Health Insurance Program (CHIP) began enrollment in August 1998 and since then has documented fairly steady enrollment of CHIP-eligible children. CFHS was integrally involved in the planning and early development of the Utah CHIP program through participation in meetings and development of the state plan and the initial planning of CHIP outreach and evaluation strategies. During FY99, CFHS staff continued participation in CHIP-related activities to facilitate the success of this program and to ensure that as many eligible children as possible were enrolled in the program and provided access to needed care.

During 1999, CFHS was successful in applying for a three-year Robert Wood Johnson Covering Kids Grant, which focuses on improving the effectiveness of outreach strategies for both CHIP and Medicaid eligible children with the ultimate goal to improve health status of Utah children through increased access to health insurance and care. The Project Coordinator was hired in July 1999, reporting directly to the CFHS Division Director. Although the Covering Kids

Utah Project is administered through the CFHS Division, project activities were planned and coordinated closely with Medicaid and CHIP programs, which are administered through separate divisions and/or offices within the Department.

The Baby Your Baby Program also worked closely with the CHIP Program administrator and a media consultant in the development of written information on CHIP for distribution to hotline callers. This collaborative effort was further expanded later in the year, when the BYB hotline operators began to send CHIP applications directly to callers requesting information and making referrals to nearby CHIP/Medicaid eligibility offices. MCH Bureau staff and consultants encouraged all local health departments to provide CHIP information, outreach and referral to clients receiving services through their various clinics.

At the beginning of CHIP, the projected enrollment goal for July 1, 1999 was 10,000. As of July 9, 1999, there were 10,179 children enrolled in the program. Although the precise impact of CHIP enrollment on the percent of uninsured children throughout the State is unknown, it seems likely that this percent has been reduced.

PM 13 Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

This measure was not achieved. The FY99 Performance Objective was 72% and the actual Performance Indicator was 69.9%.

Although they are separate programs, Utah CHIP and Medicaid shared eligibility workers which greatly improved coordination and ensured that children were enrolled in the appropriate program. Utah CHIP services were delivered through managed care contracts throughout the State. Utah Department of Health, Division of Health Care Financing staff performed eligibility determinations for CHIP and enrolled CHIP-eligible children in participating health plans. These staff were instructed to look first at Medicaid eligibility and then, if not eligible for Medicaid, at CHIP eligibility. Eligibility staff has been out-stationed at community sites, in addition to being housed in state agency offices where families apply for other benefits. During FY99, CSHCN and Medicaid shared the salary of an on-site Medicaid eligibility worker at 44 North Medical Drive, the CSHCN clinical site. CSHCN coordinated closely with the eligibility worker to facilitate

timely enrollment for disabled children, especially children applying for SSI, Technology Dependent Waiver, and children identified as very low birth weight.

The Memorandum of Agreement (MOA) continued between CFHS and the Division of Health Care Financing (HCF), the State Medicaid agency. MCH and CSHCN Bureau nursing staff continued to partner with the HCF Bureau of Managed Health Care staff to monitor MCOs contracted to provide services to Medicaid enrollees. Follow up was done with each MCO related to the previous year's findings with a focus on Maternal, EPSDT/CHEC and CSHCN services. MCH staff reviewed child health tracking systems and mechanisms to inform Medicaid clients of available services.

PM 16 The rate (per 100,000) of suicide deaths among youths 15-19.

This performance measure was achieved. The FY98 Performance Objective was 21.09 and the actual Performance Indicator was 15.4.

The Violence and Injury Prevention Program (VIPP) promoted awareness of youth suicide through professional and community presentations, media interviews and news articles. VIPP provided major support for the Youth Suicide Study which was designed to develop a profile of youth suicide victims, to understand patterns of contact and relationships between suicide victims and their community, and to evaluate these relationships and connections as potential points for intervention. Although the study hasn't yet been completed, preliminary findings indicated that 75% of youth suicide completers had contact or involvement with human services and/or the juvenile justice system.

Since the 1999 Utah Legislature passed a resolution that called for the development of a statewide plan to prevent teenage suicide and rehabilitate those who survive suicide attempts, VIPP facilitated formation of a Suicide Prevention Task Force. The task force included representatives from more than 25 organizations and agencies.

SP 8 The percent of child care providers who have taken the Utah Health Safety training course and receive a rating of zero deficiencies from the Bureau of Licensing. Not achieved due to lack of ability to measure.

Because data are unavailable, this measure was not quantifiable. Although a core training network for the Heath and Safety curriculum was established, the development of an adequate data collection and monitoring system to measure training effectiveness lagged behind. Numerous data collection and analysis challenges were encountered, not the least of which was development of a user-friendly and effective mechanism for state-level data collection on course participant completion. Also problematic was development of a practical means of comparing data from two different databases/data sources to cross reference a list of child care providers completing the course with another list of child care providers receiving a zero deficiency rating. During the second half of FY99, staff were actively involved in designing methods to improve training course tracking and resolving various data collection and analysis issues in collaboration with staff from the Bureau of Licensing.

Activities related to this performance measure were funded primarily by Utah's Health Systems Development in Child Care (HSDCC)/Community Integrated Service System grant in FY99. Grant-supported activities were carried out by the HSDCC Project Coordinator/Early Childhood Nurse Consultant hired for the project, in collaboration with the Child, Adolescent, and School Health Program Manager and other key agency partners. Activities and accomplishments during the year continued to build upon the previous year's achievements and focused primarily on establishing a training network for the newly developed Utah Health and Safety (H/S) Training Curriculum for Early Childhood Providers.

Utah's H/S curriculum, completed in March 1998, was the product of a broad-based interagency collaborative effort involving the State Office of Education; Utah's Head Start-State Collaboration Project; the Bureau of Licensing; the Office of Child Care; the BabyWatch Early Intervention Program; and local Head Start programs. From May through September 1998, the HSDCC Project Coordinator conducted train-the-trainer sessions at several locations throughout the State, wherein nurses from each of Utah's local health departments and Head Start/Early Head Start programs were trained on use of the curriculum.

Local implementation of Utah's five-module ten-hour H/S training course began in January 1999. CFHS made a small amount of MCH Block Grant funds available to eleven of the twelve local health departments (LHDs) through the Prenatal to 5 Nurse Home Visitation

contracts to assist in the costs of public health nursing time to teach the H/S training course locally. Local Child Care Resource and Referral (CCR&R) agencies began to collaborate with the LHDs in their areas by providing various coordination and support services for the training. The LHD nurses and their collaborating CCR&R partners comprise Utah's statewide core training "network" for the dissemination of the H/S training for child care providers.

PM 11 Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care.

This performance measure was not achieved. The FY99 Performance Objective was 92.5% and the actual Performance Indicator was 90.1%. CHIP outreach may not have been as effective as anticipated, indicating a need for more outreach. Data from the Utah 2000 Child Health Survey will provide better information on target groups for outreach.

Utah participated in the Tri-Regional MCH Conference for Improving Managed Care Organization Services (MCO) to children with special health needs. Through this project, each state in the region initiated a task force with MCH support to develop a work plan for issues that affect children with special health care needs enrolled in managed care plans. CSHCN staff worked with Health Care Financing staff to support the Utah Task Force for Children with Special Health Care Needs with representation from Department of Health (Health Care Financing and CFHS/CHSCN); consumers; MCOs; medical provider community; the Utah Chapter of the American Academy of Pediatrics; and, Family Voices. Areas of focus were: consumer satisfaction and education; identification of children with special needs; rate setting; case management; family support; and physician training on providing a medical home. The federal support has continued, and the committee has continued to meet.

CSHCN staff participated in a project of the Governor's Council for People with Disabilities on improving managed care. The committee visited numerous MCOs to gather information and develop recommendations for a final report.

PM 14 The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

This performance measure was achieved. The FY99 Performance Objective was a score of 12 documenting family participation and the actual Performance Indicator was a score of 12 documenting family participation.

The Utah Parent Center contract continued to help support the Family Voices Coordinator. Work completed included developing a database of children with special health care needs to allow information to be easily disseminated to families; establishment of a parent majority Family Voices Advisory Council to discuss project goals and interventions; and, identification of families willing to serve on committees in Medicaid and other organizations that serve children with special health care needs. The Family Voices Coordinator referred calls from families to the appropriate resources, advocated for children and families, and was involved with the Legislative Coalition. CSHCN staff assisted the Utah Parent Center in successfully developing a proposal for start-up of a Family Voices parent-to-parent network, and continued its involvement. CSHCN assisted Family Voices in developing other potential funding sources through Primary Children's Medical Center and other organizations to support the expansion of Family Voices.

CSHCN also contracted with Liaison to Individuals Needing Coordinated Services (LINCS), another family-based service provider in Utah, to provide case management consultation and expertise to families and children throughout the state with traveling clinics.

Two CSHCN staff members attended a national conference on cultural sensitivity, and subsequently provided a Bureau-wide training and information on cultural sensitivity, and developed relationships with other organizations with similar efforts.

The Baby Watch Early Intervention Program (BWEIP) was awarded an U.S. Department of Health and Human Services technical assistance grant, "Map to Inclusive Child Care Project". A Utah team of stakeholders determined state strategic goals and priorities in the areas of legislation, staff development, regulatory practices, and interagency collaboration to improve the provision of Utah child care for children with disabilities. Two specific events addressed the team's strategic goals: 1) provision of a train-the-trainer course on inclusive childcare for 100 persons in the state, and 2) development of six traveling displays including videos, books and other information about children with disabilities in child care settings.

2.5 Progress on Outcome Measures

OM1 The infant mortality rate per 1,000 live births.

This outcome measure was achieved. The FY98 Outcome Objective was 5.75 and the actual Outcome Indicator was 5.7.

OM2 The ratio of the black infant mortality rate to the white infant mortality rate.

This outcome measure was achieved. The FY98 Outcome Objective was 2.0 and the actual Outcome Indicator was 1.6.

OM3 The neonatal mortality rate per 1,000 live births.

This outcome measure was achieved. The FY98 Outcome Objective was 3.6 and the actual Outcome Indicator was 3.6.

OM4 The postneonatal mortality rate per 1,000 live births.

This outcome measure was achieved. The FY98 Outcome Objective was 2.2 and the actual Outcome Indicator was 2.1.

OM5 The perinatal mortality rate per 1,000 live births.

This outcome measure was achieved. The FY98 Outcome Objective was 8.5 and the actual Outcome Indicator was 8.1.

OM1 and OM5 are related so the report on activities has been combined. Four programs in the Division continued review of infant deaths through surveillance by cause of death, including the Birth Defect Network which reviews infant deaths with congenital anomalies; the Child Fatality Review Program which reviews unintentional and intentional injury deaths; the Perinatal Mortality Review Program which reviews infant deaths due to perinatal conditions; and the Sudden Infant Death Program which reviews SIDS deaths and those classified as “undetermined”. Each program collected data, conducted a review of each case, and identified potentially preventable risk factors amenable to intervention. The programs published a collaborative “newsletter” report on results of two years of data collection and death reviews which was distributed to prenatal and pediatric care providers throughout the state.

Due to the extremely small number of black infant deaths (2) in 1998, no specific activities were targeted for this group.

The majority of infant deaths reviewed by the Perinatal Mortality Review Program (PMRP) occurred during the neonatal period. The PMRP identified factors that may have contributed to these deaths and developed interventions to disseminate this information to the community, such as distribution of materials to promote appropriate management to prevent transmission of perinatal Group Beta Streptococcal infection to nurses, local health departments, community health centers, and, labor and delivery suites in Utah hospitals.

Postneonatal mortality was addressed primarily through the SIDS Program with emphasis on the Back to Sleep campaign and through the Child Fatality Review Committee. In-services to various health care professionals and day care providers based on a train-the-trainer philosophy were conducted to promote back sleeping and other sleeping safety issues to reduce the risk of SIDS. The SIDS website was expanded, additional educational materials were developed, and T-shirts with "This Side Up When I Sleep" were distributed to all Utah hospitals for about 10% of babies born in the state. Hospitals were encouraged to print their own T-shirts to promote back sleeping resulting in about 40% of Utah's hospitals indicating they were considering this intervention.

Analysis of SIDS data continued, especially for sleeping position at death. The SIDS rate reached its lowest in 1998 at 0.4 per 1,000 live births. Concurrently, deaths of undetermined cause and suffocation rose reaching the same rate as for SIDS, probably due to a diagnostic shift.

The Child Fatality Review Committee reviewed postneonatal deaths due to intentional or unintentional injuries; recommendations were included in the collaborative report.

The Perinatal Mortality Review Program (PMRP) continued its review of fetal deaths that occurred after 34 weeks' gestation. The committee identified possible contributing factors and developed interventions, such as public education to promote fetal movement counts via a flyer distributed to health care provider offices, and at health fairs and conferences, and publication of a report on two years of data analysis and recommendations for health care providers on the Reproductive Health Website (www.utahrhp.org); and, poster presentation of data and recommendations at the 1998 Conference for the American Academy of Pediatrics District VIII Section on Neonatal/Perinatal Medicine.

OM 6 The child death rate per 100,000 children aged 1-14.

This outcome measure was achieved. The FY98 Outcome Objective was 26.49 and the actual Outcome Indicator was 23.9.

The Violence and Injury Prevention Program (VIPP) collaborated with state and local partners to conduct prevention activities related to a wide range of childhood injuries. Prevention efforts addressed child car seat, seat belt, and bicycle helmet use; pedestrian safety; school and playground safety; poison prevention; child abuse prevention; and, youth violence prevention. Partners included local health departments; Highway Safety Office; Safety Council; Parent-Teachers Association (PTA); Primary Children's Medical Center; SAFE KIDS Coalition; Poison Control Center; School Boards Association; State Office of Education; State Office of Risk Management; Child Fatality Review Committee; Utah CODES Project; Utah Chapter of the American Academy of Pediatrics; State Fire Marshall; Attorney General's Office; Department of Human Services Child Protective Services; Utah Children; Bureau of Emergency Medical Services; Automobile Association of America; Regency Blue Cross/Blue Shield; and others.

Activities included supporting Buckle Up for Love and Hold on to Dear Life Campaigns; car seat inspections and training; free car seats for low income families and low cost car seat rentals; funding and staff support for the Youth Suicide Task Force and the Youth Suicide Study; coordination of the Cops in Shops Program; and, participation in statewide campaign for a standard seat belt law in Utah and others.

VIPP provided staff support for the Utah SAFE KIDS Coalition and promoted the development of two local coalitions and six local chapters. VIPP coordinated publication of the semi-annual Utah SAFE KIDS Newsletter with a distribution of 40,000 copies per issue. Coalition partners included many of those mentioned previously.

VIPP contracted with local health departments (LHDs) to provide injury prevention programs through local coordinators who conduct community public health injury prevention activities. VIPP conducted training of LHD injury prevention coordinators at periodic site visits, meetings of the Utah Local Association of Community Health Education Specialists, and semi-annual Injury Prevention Partnership Conferences. VIPP obtained and provided injury and

violence data to LHDs for use in local needs assessment and prevention planning and responded to requests for injury data from other agencies, programs, organizations and interested parties.

VIPP and LHD staff supported and participated in numerous community events and provided news stories, interviews and public service announcements in print, radio and television, as well as injury prevention training and presentations for community organizations, schools, health care providers, law enforcement, businesses and others.

VIPP provided staff support and funding for the interagency Child Fatality Review Committee (CFRC) including participation in the investigation of child fatalities and development of recommendations for prevention of child abuse deaths. Child fatality data were compiled and analyzed. A report of 1993-1995 child deaths was published with committee findings and recommendations. The CFRC Rapid Response Team, formed to review child abuse deaths and suspicious deaths of undetermined cause, met bi-weekly and provided consultation to local law enforcement and attorneys.

VIPP staff served on the Poison Control Center Advisory Board to investigate causes of accidental poisoning and make recommendations for prevention. VIPP also promoted poison prevention awareness by distributing brochures, and through media interviews and news articles.

VIPP worked to reduce youth violence by assisting elementary schools to implement the *Second Step* violence prevention program, including training elementary school faculty, staff and administrators.

SO1 Maternal Mortality rate per 100,000 live births.

This outcome measure was not achieved. The FY98 Outcome Objective was 25.0 and the actual Outcome Indicator was 26.5.

This outcome measure was selected to track the maternal mortality rate because the Department initiated a more sophisticated process for identifying pregnancy associated deaths by performing computer match of death certificates of women of childbearing age with birth and fetal death certificates to identify every woman who died during or within 12 months of pregnancy. After the match, a cursory review was conducted to determine if the deaths were pregnancy related, resulting in identification of 7 deaths in 1995, 10 deaths in 1996, 10 deaths in 1997 and 12

deaths in 1998. These numbers were higher than those reported as maternal deaths via death certificate recording. The Perinatal Mortality Review Program completed review and data analysis for the 1995-1997 pregnancy related deaths, which were presented as a poster at the annual 1999 Perinatal Medicine Conference.

Summary

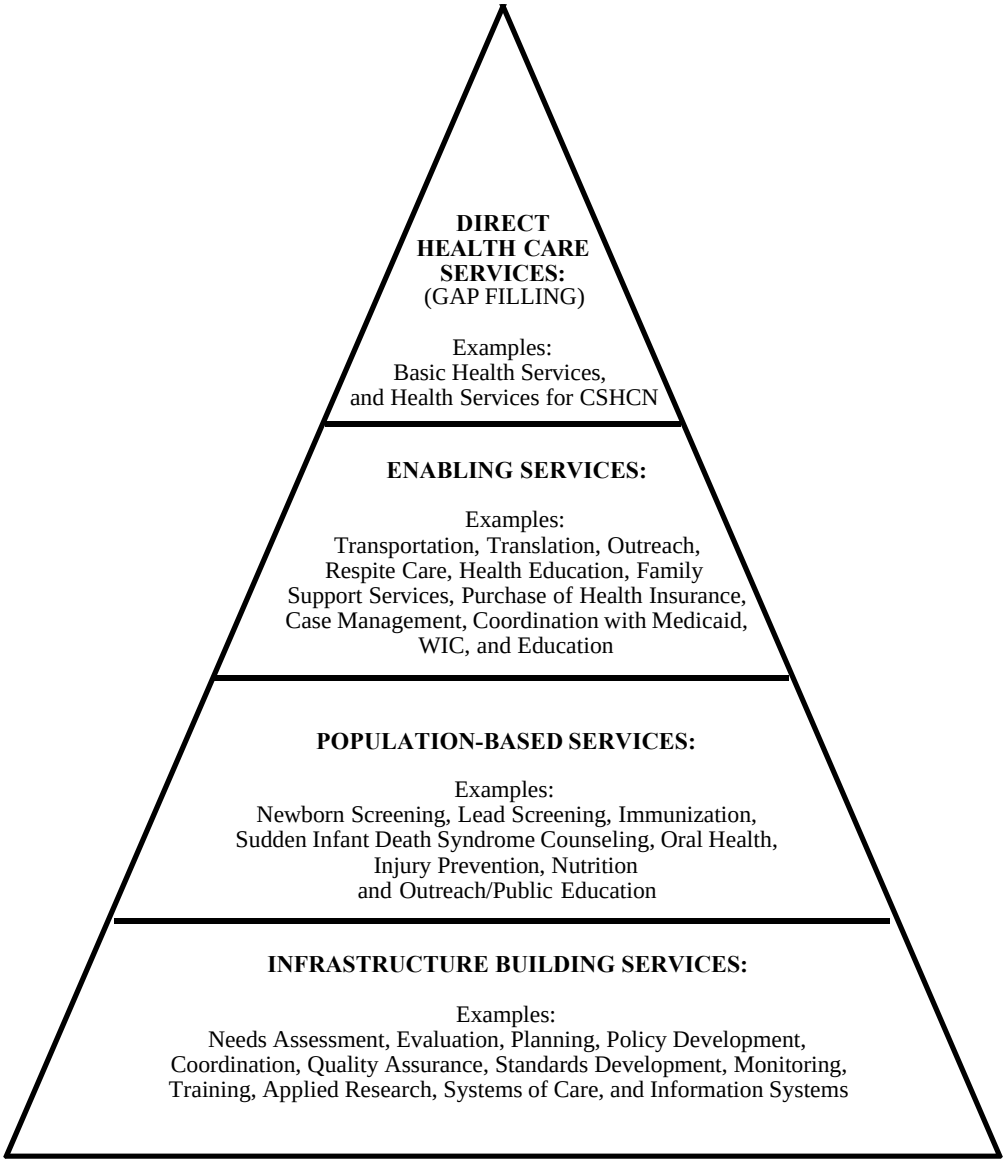
The activities described for the performance measures that occurred in FY99 impacted the outcome measures although to what extent, we don't know. Infant death rates have decreased over time and while we cannot take direct credit for this decline, we believe that some of our activities can certainly play a role in decreases in infant deaths. The Division's review of infant deaths that are potentially preventable has resulted in identification of factors that may have contributed to the death, as well as identification of provider and consumer recommendations that should impact better outcomes. These may include better consultation and referral among obstetrical providers for high-risk cases, or notification of a provider when danger signs of pregnancy arise.

In terms of the child death rate, these increased this year and we believe that this is due to an increase in motor vehicular and pedestrian accidents, in part, due to the massive road construction in the Salt Lake Valley. The activities addressing prevention of these kinds of deaths certainly have played a role in increasing awareness in the community of some of the dangers of road construction, especially for the children.

Maternal mortality rates increased, basically due to improved case finding. We believe that improved case finding will result in increased rates; but, with greater potential to identify all causes of deaths of women within a year of a live birth or fetal death, this will improve our ability to identify preventable causes, make recommendations for providers and consumers to hopefully reduce the rate in the future.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The needs assessment process for this year's MCH Block Grant Application included several different steps. The steps included: input from the MCH Advisory Committee; local health department nursing directors and health officers; a specialized effort to determine priority needs of children with special health care needs population; information from various sources, including MCH staff, multiple data sources; and, perhaps most critical, data from the Utah 2000 Child Health Survey. At this point, the needs assessment process is not complete because we feel we have only initiated the first step in the process, identification of priority health care needs among the three MCH populations. During the subsequent year, the process will continue as we obtain more detailed data from Utah's 2000 Child Health Survey and as we analyze allocation of funding to local health departments and other agencies, as well as within the MCH programs.

The first steps in the needs assessment process involved input from the MCH Advisory Committee membership. The MCH Advisory Committee is comprised of three subcommittees, one for each of the three MCH populations. MCH Advisory Committee and subcommittee membership includes broad representation from local health departments, community health centers, the dental and medical provider community, nursing, Head Start, Child Care Licensing, Medicaid, Utah Children's Health Insurance Program, the Utah Statewide Immunization Information System, Planned Parenthood Association of Utah, Family Voices, etc. as well as staff from various maternal and child health-related program areas within the Division of Community and Family Health Services.

Each subcommittee met separately to identify health issues of concern to them with emphasis on their area of focus. The process that each followed was a broad-based health outcome prioritization process adapted from the Pickett-Hanlon Method previously used by the Washington State Department of Health in their statewide five-year MCH needs assessment. As a starting point for discussion, the subcommittees reviewed health areas/issues outlined on the "Worksheet for Determining Priority of Health Areas" document which included a list of health

indicators for which the state is required to provide data for the annual MCH Block Grant and Report. (See Section 5.3 for the worksheet and instructions for the prioritization process.)

Subcommittee members were asked to identify additional health issues and/or needs among Utah's maternal and child populations that may not have been included in the list. After each subcommittee amended their list of health issues for their particular population, they began the second step in the prioritization process which was to score the issue as to its importance utilizing the tool and its process. The lists that each of the subcommittees generated included a mixture of health status indicators as well as health system issues. Division staff provided necessary data so that subcommittee members had enough information to score each identified issue and its impact on the population on which they were focusing.

Each subcommittee processed the scoring tool using different methods, with two averaging individual members' score for each identified issue and other developing a composite score based on consensus. Scores were recorded and issues rank ordered, with a final list of health issues from the three subcommittees.

The second step in the needs assessment process involved obtaining input from local health department leaders. Each local health department nursing director and health officer was asked to complete the same worksheets used by the MCH Advisory Committee. Scores from those returned were added in to the overall ranking of issues.

Since the final list of priorities included more than the 7 – 10 priorities requested, each subcommittee selected their top 3-4 issues from their lists. This mechanism allowed for equal emphasis on each of the three MCH populations. This process yielded 12 priority areas. Division staff met to process the list and came up with a model of priorities. The list included health system issues and some health issues which crossed all three target populations served with Title V funds. To address both health issues and health system issues, each population list was incorporated into a matrix. The matrix ensures that each health issue is addressed from the perspective of health systems issues. The final list included nine priority health areas, crossed by health systems issues. Subcommittees then met to complete the final process of identifying assets and gaps for each component of the matrix as it related to their focus area.

Because the Bureau of Children with Special Health Care Needs recognizes the importance of the development of a comprehensive system of care, staff has been involved with

the federally funded SPRANS grant to Utah State University Early Intervention Research Institute for "Monitoring and Measuring Community Based Integrated Systems of Care for CSHCN". Through this process a Participatory Action Research (PAR) team, comprised of key stakeholders in the public and private sectors, was formed, including representatives of child advocacy groups, pediatric provider community, and CSHCN staff. The group identified the service system continuum for Utah and elements of services for children with special needs currently being provided which included: 1) categorical services for specific diagnoses; 2) categorical services for all children with special health needs and at risk; 3) comprehensive system for children with special health care needs; and 4) universal system for all children, which are also available to children with special needs. The Participatory Action Research team outlined the historical and current state systems for CSHCN (Section 5.3 - Table 1), and organized current related services into the four categories of the MCH pyramid (See Section 5.3 for Table 2). Available data were analyzed to identify service gaps. The next step in the process was to analyze the data available so that the PAR team could see where there were service gaps. A subgroup of the PAR team developed a list of existing performance measures and evaluated current data sources.

Data from the Utah 2000 Child Health Survey has provided, for the first time ever, preliminary information about needs of children and children with special health care needs in Utah. While we only have very preliminary data from the survey, further data analysis and reports on specific topics, (such as insurance rates among the populations, children's medical home, children's problem with access to care, and services for children with special health care needs) are planned for the upcoming year. These data will provide MCH State and local staff with needed information to develop improved systems of care for children in the state. In the spring of 2001, the Division, along with its partners from Medicaid, CHIP, Primary Care Association will sponsor a Child Health Summit that will allow key stakeholders to develop a Utah Child Health Action Plan. This summit is being planned in conjunction with the federal technical assistance offered to states through Health Systems Resource for the purpose of developing comprehensive systems of care for children.

The next mechanism for the needs assessment process involved a systematic review of other sources of data, programs, services and gaps according to each level of service, as delineated by the Pyramid of Core Public Health Services delivered by MCH agencies. A more

detailed review of these sources of health care is included in needs assessment content areas of this document.

In retrospect, the needs assessment process used by the division would have been strengthened by obtaining more detailed input from community health centers, other community providers of care and from an expanded cadre of representatives of the three MCH populations. Some of this expanded solicitation of information will occur with other projects, such as focus group input from a CDC-funded grant for health care access among populations with disparate health outcomes, focus group input from a private grant funded to provide Medicaid services to families with young children and from the American Academy of Pediatrics/Intermountain Pediactric Society Medical Home training project for CSHCN.

Needs assessment is an ongoing process and this year's effort has produced invaluable information about the needs of Utah mothers, infants, children, adolescents and children with special health care needs, including adolescents with special health care needs, that the Division and others will be able to utilize in planning improved services and programs to better address the populations served through these funds.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

Introduction

In recent years Utah has ranked among the nation's healthiest states. Utah's population is younger and lives longer, has a higher fertility rate and more persons per household than the national average. Utah's Maternal and Child Health population is unique in that it is proportionally larger compared to the rest of the nation's MCH population. Therefore, Utah faces, and will continue to face constraints associated with serving a large young population.

Public health professionals in Utah are concerned about a rising percent of infants born with low birth weight, and pregnant women who receive inadequate prenatal care. They are also concerned about the large number of uninsured mothers, pregnant women, children, and infants. They are pleased, however, with declining rates of infant mortality and teen births. They are also pleased with the implementation of the State Children's Health Insurance Program (CHIP), which

began in 1998. Although enrollment rates need improvement, more and more people are becoming aware of this resource.

Utah has unique characteristics that affect, in many ways, the health and health care needs of the maternal and child population. The following narrative describes demographic characteristics of Utah's maternal and child populations in the State, including health problems, health service gaps, and strengths and weaknesses of the service system.

Demographics

Population size and distribution - By the year 2020, it is projected that Utah's population will have grown by almost 60% to over 3.3 million people. Utah's population reached just over 2,121,000 persons in 1999[1], an increase of 1.9% over the 1998 estimate. With the national population increasing by an estimated 0.9% during 1999, the pace of population growth in Utah continues to be roughly twice that of the nation. Utah is one of the fastest growing states in the nation.[2] From July 1998 to July 1999 Utah had the eighth largest growth rate in the nation.[3] In 1997, Utah's birth rate was 40% above the national average, while the death rate was about 17% below the national average.[4] In 1998, 45,128 women gave birth to live infants, and 497,782 women are of childbearing age (15-44). Utah has the highest fertility rate in the nation, 90.7 per 1,000 women ages 15 – 44 years of age (1998) compared to 66.0 nationally. In 1998, 27% of Utah's population was age 14 or younger, compared with 22% in the U.S.[5]

Race and ethnicity - One of every ten Utahns belongs to an ethnic or racial minority group. Most are Hispanic, Asian, Pacific Islander, American Indian, or African American. The African American, Asian, Pacific Islander, and Hispanic/Latino populations are growing more than twice as fast as the state population as a whole. [2] Utah's diverse racial and ethnic populations often have disparate health outcomes that must be addressed in order to close gaps in health status and overall well being. Disparities include higher infant mortality and low birth rates and lower immunization rates among certain racial and ethnic populations.

Family structure and household size – Utahns have larger households compared to the U.S. The average household size in Utah is 3.08 (1996), which is the highest in the nation. It also ranks far higher than the national average of 2.62 persons per household.[6] Approximately 45.5% of Utah's households have children compared to the national average of 34.1%. Utah households are much more likely to contain married couples with children (38.5%) than are households in the

U.S. (26.3%). Utah is higher than average in the proportion of children in the population and lower in the number of single parent households. Among single parent families, more are headed by females (82%) in Utah than those in the U.S. (78%). [2]

Income - Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger and the per capita income in Utah is significantly lower than in the U.S. overall. In Utah, the averages for 1997 and 1998 show a 7.1% increase in real median household income from $40,960 to $43,870. [7] Using a three-year average (1996-1998) Utah's median household income of 42,073 was the tenth highest among states. However, per capita income in 1998 was $21,096, ranking Utah eighth lowest in the United States. The percentage of the population living below the poverty level increased slightly from 8.3% for 1997 to 8.9%, however, these numbers are not statistically different. Utah's poverty rate is among the lowest in the U.S., ranking 2nd lowest at 8.5% for 1996-1998. The overall childhood poverty rate of 13.0% (93 - 97) compares favorably with the U.S. average of 20.2%. However, it is clear that children in three of Utah's ethnic and/or racial populations do not fare as well as the rest of Utah's children. More than one third of American Indian, Black/African American, and Hispanic children in Utah were live in poverty (37.1%, 36.6%, and 35.0% respectively).[8] Poverty is the single most important factor correlated with poorer access to health care.

Culture, religion and policy – Utah's predominant religion counsels against the use of tobacco and alcohol and consequently results in lower incidence of liver disease, alcoholism, and lung cancer. Utah is also characterized by its anti big-government sentiment, often making it difficult to obtain local funding for state agency programs. The Republican Party dominates local government, leading the legislature to preserve conservative public health policy such as abstinence only curriculum in schools and no addition of fluoride to the public water supply. Utahns pride themselves on family values and support many efforts to improve maternal and child health, especially post-conceptual care.

Education - Utahns, on average complete more years of education than persons in the U.S. as a whole. For teenagers in grades 7 – 12, dropout rates have fluctuated over the last several years between 2.5 and 4.1, and in 1998-1999 it was 3.6.[9] Although Utah is spending more money per pupil each year (5.3% increase in 1998), Utah ranks last in the nation for per pupil expenditure, $3,787 compared to the national average of $6,131.[10] Although Utah's dropout

rates are low compared to the national average, those who do drop out of Utah schools have higher percentages of low birth weight babies. The percent of low birth weight babies is nearly twice that of infants born to mothers who are college graduates (less than high school: 9.44%, high school: 7.28%, college grad: 5.15% LBW).[11]

Health Issues for Utah Mothers and Infants

Each year in Utah there are approximately 45,000 births, the majority of which result in healthy mothers and infants. However, complications may arise for the mother and/or her infant.[11]

Low birth weight - The percent of babies born at low birth weight continues to rise from 5.7% in 1990 to 6.8% in 1998. Health professionals are concerned about this rise since LBW will result in increased costs due to longer newborn hospital stay, health problems, and possible lifelong disabilities requiring special assistance. The percentage of LBW babies is much higher among African Americans in Utah (14.6%) compared to other racial and ethnic groups.[11]

Tobacco use in pregnancy – A major risk factor for low birth weight babies is smoking during pregnancy. Smoking rates among women in Utah are lower than national rates. In 1995, only 11% of Utah women smoked, while nationally, 21% of women smoked.[12] Although smoking rates for this population are low, over 30,000 Utah women smoked during pregnancy during the years 1989 through 1996. More than 6,000 of these were teens.[13]

Prenatal Care - The percentage of women receiving prenatal care in the first trimester continues to fall from 85.2% in 1994 to 79.7% in 1998. The percentage is even lower among Medicaid mothers (73%).[14]

Health Service Gaps

Unintended pregnancy - Although statewide data on unintended pregnancies is not currently available, 55% of WIC (Women Infants and Children) mothers reported their pregnancies as unintended. Nationwide, 60% of pregnancies are reported as unintended.[15] More family planning services are needed in the state to provide affordable access for those individuals desiring to plan when they become pregnant and space their pregnancies. Low cost services at the local health level would assure that low-income women throughout the state could afford to plan their families. Utah's Pregnancy Risk Assessment Monitoring System (PRAMS) is currently

collecting data on unintended pregnancy which will be available fall of 2000 and be used in planning strategies to address this issue.

Geographic Access to Prenatal Care – Access to prenatal health care varies depending on the geographic area of the state. There are areas in Utah with high ratios of women of childbearing age to providers, resulting in limited access to a prenatal provider in their area. Four rural counties (Daggett, Piute, Rich and Wayne) have no prenatal health care provider of any kind. Women in rural communities may have to travel many miles to a provider and/or hospital. The majority of counties (25 of 29) in the state have some kind of prenatal care provider, such as a general practitioner, family practitioner, obstetrician, nurse practitioner or certified nurse midwife. However, more than half of the counties (16 of 29) are without any obstetrician-gynecologist. There is a need to promote collaboration to assure better access to consultation services for rural providers. (Division of Community and Family Health Services.[15]

System constraints

Uninsured pregnant women **-** The 1996 Utah Health Status Survey found that almost 55,000 women between 18 and 49 years of age carried no health insurance. A higher percentage of women under age 35 were uninsured compared with older women. Among Utah women 18-34 years of age, 19% had no health insurance during 1996 while 10% of women 35-49 years were without health insurance.[16]

Preconceptional planning – Preparing for pregnancy can result in better birth outcomes and healthier mothers and infants. A woman and her provider can identify potential risks for poor pregnancy outcomes prior to conception and work to reduce these risks. Risks may include pre-existing medical conditions, medication, lifestyle practices such as diet or use of tobacco or alcohol, or inadequate intake of folic acid before conception. The health care system needs to encourage providers, and women of reproductive age to utilize health care visits prior to pregnancy. In addition, third party payers need to reimburse these visits to promote healthy pregnancy outcomes.[15]

Needs of Minority Racial and Ethnic populations – Health outcomes for some racial minority and ethnic populations are poorer than those for the population as a whole, such as higher low birth weight and infant mortality rates. For example, the percentage of Black low birth weight infants born in Utah during 1998 was 14.60% compared to 6.67% of White infants. The

infant mortality rate for infants born to White non Hispanic Utah women during 1998 was 5.7/1000 live births compared to 6.9/1000 for infants born to Hispanic Utah women.[11] Strategies that address the special needs of minority racial and ethnic populations need to be developed to improve access to services to achieve healthy outcomes. Improved access to translation services, more ethnic health care providers and sensitivity to the unique needs of culturally diverse population will facilitate better health care.[15]

Strengths and weaknesses of the system

Utah has a strong tertiary care system for neonatal and perinatal healthcare. Referrals are received from the entire intermountain west region. These tertiary care centers are all situated in a relatively central geographic location around Salt Lake City. However, as previously mentioned, collaborative relationships need to be fostered to encourage consultation and referral of high-risk patients as appropriate to these centers of excellence. Medical records data (1995-1998) from the Perinatal Mortality Review Program indicate that prenatal care providers need to be encouraged to refer their high-risk pregnant patients to specialist care as well as support services (e.g. dieticians, tobacco cessation programs and substance abuse treatment) to promote optimal outcomes. Data also illustrate the need for promotion of adequate prenatal risk assessment (e.g. screening for tobacco, alcohol and substance use, HIV status, history of previous low birth weight and/or fetal-infant deaths and psychosocial issues).

Major Health Status Indicators for the Titile V Population as a Whole and for Sub-Populations (MatCHIIM 1998 Data)

Health Indicator	Total Population	Hispanic	African American	Native American	Asian and Pacific Islanders	Teens (age 15 – 19 years)
Number of Births (n)	45,128	4767	274	662	1145	4385
Birth Rate	21.7 / 1,000					
Percent Low Birth Weight	6.7 n=3013	7.1 n=347	13.9 n=38	7.6 n=50	8.6 n=86	8.7 n=382
Percent Very Low Birth Weight	.93 n=421	.86 n=41		1.5 n=10	1.3 n=15	1.5 n=51
Maternal Death Rate*	10.7 / 100,000					

* Pregnancy-associated death ratio

Health Issues of Utah Children

In 1998, 27% of Utah's estimated 2.1 million people were age 14 and under, compared with 22% in the U.S.[1] The recent Utah Child Health Survey (1999 – 2000) illustrates demographic characteristics and health status of Utah's children aged 0 – 17. The preliminary results show that 36.7% of Utah children live at or below 200% of the federal poverty level.

Violence and Injury - In Utah, injury is the leading cause of death for children 1- 19 years of age. During 1995-1997, there were 624 injury deaths among Utah children age 1-19 years (29 per 100,000), accounting for 69% of all deaths in this age group. The leading causes of deaths for adolescents have changed from natural causes to injury and violence according to a national study. In 1933, 75% of deaths among teenagers aged 15-19 were due to natural causes, but today (1993), 80% of deaths in this age group were from unintentional injury and violence.[17] In addition, there were 7,398 injury-related hospitalizations in Utah, resulting in over $69 million dollars in inpatient charges.

Motor Vehicle Crashes - Motor vehicle crashes are the leading cause of unintentional injury death for Utah children age 1-19 years (including deaths to occupants, pedestrians and bicyclists). Children are at particular risk for death and injury from motor vehicle-occupant crashes. From 1994-1998, 365 children were killed as a result of motor vehicle-occupant crashes.[18]

Safety Restraints – The greatest risk for children being killed or injured from a motor vehicle occupant crash is riding unrestrained. In an observational survey conducted in 1999 by the Utah Highway Safety Office, restraint usage for children 0 – 10 years was 76.4%. More Utah teens report using their seatbelts than the national average. According to the 1999 Youth Risk Behavior Survey, 12.3% of Utah teens rarely or never wear seatbelts compared to 16.4% nationally.[19]

Suicide - Suicide is the second leading cause of death among Utah teens age 15-19 years. During 1995-1997 there were 113 suicide deaths among Utah teens age 15-19 (19.2 per 100,000) accounting for 23% of all deaths in this age group. However, males account for 95 of these teen suicide deaths (32.5 per 100,000) making suicide the leading cause of death for males age 15-19

years. In 1999, 20% of Utah students in grades 9 – 12 had seriously considered attempting suicide during the 12 months prior to the survey. Although teen suicide deaths are significantly higher for males, female students were more likely to consider suicide than males (25.5% compared to 13.7%).[19]

Mental Health – In 2000, 24.2% of children were reported to have one or more days of poor mental health in the previous 30 days.[20]

Childhood asthma - Between 1991 and 1996, the prevalence of asthma appeared to have increased slightly, but this was not statistically significant. Males in the youngest age group (0-9 years) had higher prevalence of asthma than their female counterparts (4.3% vs. 2.9%).[21]

Nutrition and Exercise – Healthy eating habits and regular exercise play an important role in the health of children, and will have life-long effects as they carry these habits into adulthood. In 1999, 25.8% of Utah students reported they ate 5 or more servings of fruit or vegetables during the 7 days preceding the survey.[19] According to 1999 YRBS data, Utah students rank among the most physically active. Seventy seven percent of the students (9 – 12 grades) reported to participate in activities that made them sweat and breathe hard for > 20 minutes on more or equal to 3 of the 7 days (vigorous physical activity). Overall, male students (81.3%) were more likely than female students (72.7%) to report vigorous physical activity. However, the recent Utah Child Health survey found that 12.3% of children (0-17 years) spend more than 3 hours per day on TV / computer games.[19] Ten percent (10.2%) of Utah students (9 – 12 grades) were at risk for becoming overweight compared to 16.0% nationally (1999 YRBS). Almost 5% of Utah students were considered overweight (BMI >or = 95th percentile by age and sex).[19]

Teen birth/pregnancy - Since 1991, Utah's teen pregnancy rate has been gradually declining. However, in 1998, the rate increased from 24.8 to 27.2 pregnancies per 1,000 15-17 year old females and from 72.4 to 79.0 pregnancies per 1,000 18-19 year old females. Teen pregnancy rates for 15 – 19 year-olds are lower in Utah than the nation (44.2/1,000 Utah females age 15-19 compared to 52.9 in the U.S. as a whole).[11]

Sexually transmitted infections - The chlamydia infections among teens (15 – 19) have increased significantly since 1996 from 315.8 per 100,000 to 444.9 in 1998.

Tobacco -Tobacco use is the number one preventable cause of death. Over 30,000 Utah youth age 12-17 years old report being regular users of tobacco, with 61% of these reporting they

have tried to quit. According to the Youth Behavioral Risk Factor Survey conducted in 1997, 14.9% percent of students reported use of cigarettes during past month. According to 1999 YRBS data, 13% of Utah students (9 – 12 grades) initiated cigarette smoking before age 13. This compares to 24.7% nationally. Males are significantly more likely to begin smoking before age 13.

Substance Abuse – Almost 19% of students in Utah in grades 7-12 reported drinking alcohol during past month. Marijuana use is increasing. Fourteen percent of Utah seniors used marijuana in the past month. The 1997 Treatment Needs Assessment school survey found that 4.9% of Utah students were classified as dependent (DSM-III-R) on marijuana and in need of treatment.

Immunization - In Utah, as in other states, there is a need for statewide coordination of childhood immunization efforts. The levels of immunization for 2 year-olds have been increasing every year since 1996. Percentages have increased from 64% in 1996 to 77% in 1998. However, Utah still falls below the national average of 81%. Data for adolescent immunization coverage levels are not routinely available. However, in 1999, school data for adolescents in Utah indicate a coverage level of 96.7% for the second dose measles vaccination. In 1999, no measles cases occurred. Hepatitis B prevalence is shifting toward the adolescent population. In 1996, 3% of all Utah Hepatitis B cases were among 11- 19 years olds and in 1999, this increased to 21%.

Fluoridation - Utah is the least fluoridated state in the country, with 97% of Utahns having inadequate fluoride in their water to prevent tooth decay. This factor contributes significantly to high rates of dental caries in children.

Health Service Gaps

Access to Health Care - Preliminary results of the 2000 Utah Child Health Survey indicate that 15% of children had problems accessing health care, including medical, dental, or mental health.

Lack of Health Insurance – In Utah, 45,700 children (6.5%) ages 0 – 17 are not covered by health insurance (Child Health Survey 2000). When asked for the reasons for lack of health insurance, 58% said that they could not afford premium and 34% mentioned that their employer offers no insurance. Although CHIP (Children's Health Insurance Plan) is available to many working families, many eligible families are not enrolled in CHIP.

Oral Health Access- Preliminary results of the Utah 2000 Child Health Survey indicate that 15% of children have never seen a dentist. Sixty-five percent of 6-8 year-old children in Utah have experienced caries, compared to 52% of 6-8 year-old children nationally. Utah's children aged 6 through 8 have a 20% higher rate of tooth decay than those in the nation. The percentage of untreated dental caries, an important measure of access to dental care, was 29% among 6-8 year-olds nationally in 1988, compared to 30% among Utah children in this age group as recently as 1996. In 1999 only 28% of the CHEC population (Utah's EPSDT) have utilized dental services.

Strengths and Weaknesses of the System

With Utah's large family size and low per capital income, economic constraints in accessing and paying for health care is inevitable.

CHIP provides greater access to affordable health insurance for many working families, primarily the working poor (at or under 200% poverty level).

Children with Special Health Care Needs

According to initial Children with Special Health Care Needs (CSHCN) survey results, the prevalence rate of CSHCN is estimated to be about 13% or approximately 100,000 children. Utah is a large and vastly rural state with variation in the distribution of pediatric primary and specialty providers. Although there has been a significant improvement in the number CSHCN covered with private insurance, Medicaid or CHIP, access to adequate health and related services, primarily in rural and frontier Utah is still problematic.

Issues for Children with Special Health Care Needs

In order to evaluate the adequacy of direct and enabling services for Utah families, a CSHCN Family Survey was developed, which subsequently became part of the larger Utah Child Health Survey. CSHCN in partnership with state MCH staff submitted the State Systems Development Initiative (SSDI) grant to establish, administer and evaluate the Utah Child Health Survey. Survey data are currently being analyzed, which when completed, will be shared with public and private stakeholders. Ultimately the results should help establish partnerships to develop solutions to improve the statewide service system. Existing collaborative forums such as

the Subcommittee C-of the MCH Advisory Committee and the Baby Watch Early Intervention Advisory board, will be utilized to develop and implement solutions.

At the end of calendar year 1999 and the first months of year 2000, the statewide Utah 2000 Child Health Survey was completed. During this telephone survey, the adult respondent was asked to respond to a short survey instrument with respect to every child in the household. The results of this information were used to identify those children in the household who have special health care needs. Each of these identified CSHCN were asked health status questions, plus additional questions regarding the needs of families with CSHCN. The specific questions to identify CSHCN in the household were based on questions from the Foundation for Accountability (FACCT) Living with Illness Module. The development of these questions and the specific questions regarding the needs of families with CSHCN were developed in collaboration with the Early Intervention Research Institute at Utah State University and the Utah Chapter of Family Voices.

A total of 760 children were identified by the survey as having chronic special health care needs, which suggests a 12.7% statewide prevalence of CSHCN. This Utah prevalence rate appears to be notably lower than rates suggested by other survey methods and may be due to various factors that are presently being investigated. These factors include differences in interviewing techniques, question wording/structure, sampling frames (e.g., all children in the general population vs. children with health insurance), and age distributions.

Demographics: The data suggest an expected higher ratio of CSHCN in males (55.2%) than in females (44.8%) and a slightly higher prevalence of CSHCN in the urban area of the state than in the general population. Although there is a higher percentage of insured CSHCN (96.0%) than in the general population, there appears to be more CSHCN families living under both the 100% and 200% Federal Poverty Levels. This is particularly concerning since this group would appear to meet the eligibility requirements for either Medicaid or CHIP programs. Nearly half (46.5%) of those families with uninsured CSHCN stated the reason for not having coverage was that they could not afford premiums.

Medical Home: Almost all families of CSHCN reported having a usual place of care for routine (96.7%) and acute (96.8%) health care needs. A physician's office was the most common place reported for this care (routine - 69.8% / acute - 69.4%). Respondents felt their doctors and

other health care providers "always" or "frequently" respected their family's beliefs, customs, and language (98.8%). They felt they and their child were "always" or "usually" treated with courtesy and respect by medical and other staff (97.6%). The respondents usually felt "satisfied" (93.5%) with getting the information they needed to make decisions about meeting their child's healthcare needs. They reported that 90.4% of the time, their providers had access to all the medical records, including specialist reports, to provide their child's care. Nine times out of ten (90.0%) these families reported the provider "always" or "frequently" had a thorough understanding of all the services their child is getting. However, almost one out of three (29.8%) reported that after going to a specialist or specialty clinic, their provider usually spoke with them about what happened at the specialist visit in a way that they did not understand.

Insurance Coverage: One of out every five (20.9%) families with CSHCN reported they could not afford medical, dental, eye care, or other health services. More than one out of every six (17.8%) families with CSHCN reported delays or problems accessing medical care in the last twelve months. The primary reason given was that services were not covered by their insurance. More than one out of every seven (15.1%) families with CSHCN reported delays or problems accessing dental care in the last twelve months. The primary reasons given were that they could not afford dental services or the services were not covered by their insurance. Difficulty in obtaining mental health services was reported by 7.2% of CSHCN families. CSHCN children ages 0 – 17 were more likely to experience more days of poor mental health. According to the Utah 2000 Child Health Status Survey, the CSHCN population experienced 4.2 days of poor mental health per month compared to 0.9 days for the non-CSHCN population.

Organization of Services: Very few (3.1%) families with CSHCN reported dissatisfaction with the health care received by their child. Service coordination among providers and services was rated high by the large majority of Utah families with CSHCN with 59.7% reporting "excellent/very good" and 25.6% reporting "good" service coordination. However, half (49.6%) of the families with CSHCN reported that they had no opportunity to talk with other CSHCN families and less than one in five (18.3%) reported receiving information or support from Family Voices or organizations for parents.

Transition to Adulthood: More than two out of five (41.2%) reported that their health care providers had not communicated with them about plans for their child's future adult life.

More information about the CSHCN population obtained from the Utah Child Health survey will be analyzed and reported in the near future.

Health Service Gaps

Outside of the urban population belt there are few pediatric specialty providers and related services. Many CSHCN are still uninsured or underinsured (see below), especially those who are undocumented citizens. Although many providers are improving their delivery of culturally sensitive services, there is still a lag in the availability of services that are culturally sensitive. There is also a shortage of pediatric and specialty dental services, especially in rural Utah. In addition, as seen nationally, there is often a shortage of quality mental health services and mental health insurance coverage. Comprehensive services for CSHCN continue to be difficult for families to access and coordinate, even with the assistance of case managers. This difficulty is in part due to the complex health care and health insurance systems, multiple funding and regulatory systems for supporting services.

Strengths

Utah continues to have very generous and broad Medicaid coverage for children, and they generally receive a more comprehensive service package through their Medicaid benefits than children covered by private insurance or CHIP.

Utah offers excellent pediatric services provided through tertiary care centers: Primary Children's Medical Center, the University of Utah Medical Center (UUMC) and Shriners Hospitals for Children. We are also fortunate to have several Managed Care Organizations which contract with Medicaid to provide high quality services for CSHCN along the Wasatch Front and in some rural areas of the state.

3.1.2.2 Direct Health Care Services

3.1.2.3 Enabling Services

Needs assessment for these two levels of the pyramid of services were combined into one section as outlined in the guidance.

<u>Priority state concerns regarding access to health care and health-related services</u>

Direct and enabling health care services in Utah are available through both public and private sector providers. Local health departments and community health centers are critical resources for the provision of services for the maternal and child health populations. In Utah,

there are twelve health departments (see maps in Section 5.3) and 10 community health centers, as well as 4 migrant centers. Local health departments provide direct and enabling services, but no longer provide primary care. The community health centers provide primary and preventive care for low income Utahns. Services for children with special health care needs are provided by the State through its various programs in the Bureau of Children with Special Health Care Needs and rural clinic sites in collaboration with the State and through private providers.

Community and Family Health Services staff provides technical assistance, consultation (administrative and clinical), training and/or mentoring as needed to local health departments and community health centers involved in conducting MCH activities, such as prenatal, family planning, immunizations, and prenatal to 5 nurse home visitation program. Program monitoring and data collection are conducted at the state level to assist in program planning and evaluation.

Financial barriers

The 1996 Utah Health Status Survey found that almost 55,000 women between 18 and 49 years of age carried no health insurance. A higher percentage of women under age 35 were uninsured compared with older women. Among Utah women 18-34 years of age, 19% had no health insurance while 10% of women 35-49 years were without insurance.

Eligibility for Utah's Prenatal Medicaid program has not been increased from the 133% of the federal poverty level (FPL) as determined in 1990. As a result, 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 0-5 years of age is 133% FPL and 100% FPL for children 6-18 years of age. The Utah CHIP eligibility level is 200% FPL for children between the ages of 0-18 years.

Access to low cost prenatal care and family planning through community health centers and local health departments has been problematic in many areas of the state, especially in the rural areas without community health centers. Although sliding fee schedules are available, the demand for low cost health care often exceeds capacity, especially for women of undocumented citizenship status. Even with release and distribution of the 1999 Department of Justice document clarifying the definition of public charge, many families who are either legal or illegal residents are

reluctant to apply for any government assistance for fear of a negative impact on their residency applications or being reported to Immigration and Naturalization Services.

Financial barriers to family planning services are significant. The state does not allocate any state dollars to family planning services with exception of the state match for Medicaid services. The Alan Guttmacher Institute has estimated that there are 123,869 women ages 13-44 years in Utah in need of low-cost family planning services in Utah. Approximately 7,000 women each year lose their Prenatal Medicaid eligibility approximately sixty days after delivery, leaving them without a third party payer for family planning. Without access to long-term family planning, adequately spacing of pregnancies for optimal maternal and child health outcomes is very difficult for many of these women. Although local health departments, community health centers and clinics operated by Planned Parenthood Association of Utah, the state's Title X agency, offer family planning services on a sliding fee scale, they all are limited in their ability to provide services to low-income women to meet the high demand for these services.

The state family planning program in the Division of Community and Family Health Services attempts to meet some family planning needs by providing oral contraceptives and condoms at no cost to four local health districts unable to obtain public health discounts due to small client numbers. However, the state has been limited in its capacity to provide the contraceptives due to funding cuts, further limiting availability for women without insurance.

Many low-income families are not able to afford medical nutrition therapy due to lack of insurance coverage or funds to pay for these services out of pocket. The Utah WIC Program provides comprehensive nutritional services, along with needed food supplements to eligible women and infants and children. However, with Utah's rising birth rate and static funding levels, WIC has been challenged to maintain services to enrollees, forcing caseload management for category 7 clients. Because the current WIC funding formula is not adequate to meet the demand and need for WIC services for all eligible women and children in the state, the Program is not able to reach out to all eligible for services due to funding shortfalls.

Results from the Utah 2000 Child Health Survey indicate that 29.6% of children had no regular medical checkup. Approximately 75 of those surveyed indicated that they had no regular provider or place for acute care for their children. More than 12% of families surveyed were unable to access a health care provider for a variety of reasons, including financial barriers.

Almost 14% of those families surveyed indicated that they had problems accessing a dentist during the previous twelve months.

Access to immunizations may be difficult for children who are underinsured, for example, children whose family income is between 100 and 200 percent of the federal poverty level who would qualify for CHIP except for the fact that they have some medical insurance. Local health departments charge an administration fee for immunizations between $5.00-$15.00 which can be waived for families unable to pay. The State Immunization Program's Vaccine for Children (VFC) Program is available for children who are on Medicaid, uninsured, underinsured, or of American Indian/Alaska Native heritage. VFC provides free publicly funded vaccine to enrolled providers, however, not all Medicaid providers are enrolled in the VFC program. There are currently 451 VFC providers in 217 provider sites. However, some areas may have low numbers of VFC providers, which may pose a barrier to eligible children accessing needed immunizations. The Immunization Program has been working to expand its VFC provider network to most Medicaid providers, as well as with other providers in the state. All local health departments, community health centers and migrant health centers are VFC providers, making low cost immunizations available in most communities.

Most children whose family income is between 100 and 200 percent of the federal poverty level who would be eligible for CHIP except that they have some medical insurance have no dental coverage because their medical insurance does not cover dental care (estimated to be about 19,000 by the Utah Child Health Survey). As a result, they are not able to easily access dental health services unless their parents are able to pay out of pocket. In addition, the scope of CHIP dental benefits is not as broad as the benefits offered to children enrolled in CHEC (Utah's EPSDT Program). Of particular concern is the lack of coverage for stainless steel crowns and general anesthesia, both benefits primarily for young children with very critical needs.

People with disabilities find it especially difficult to access oral health care for several reasons including: most clients with disabilities are Medicaid recipients; many dentists are reluctant and/or not trained to treat people with disabilities in the traditional office setting; many dentists are not willing and/or do not have the appropriate anesthesia permit to see patients with severe disabilities in a hospital or surgical care center; and, few tertiary care facilities in rural Utah where dental treatment can be conducted for people with severe disabilities.

Financial barriers continue to exist for families and children whose condition and/or services are not covered by third party payers or managed care organizations (e.g., pre-existing conditions, therapy, orthodontia, dental and surgical exclusions). Limited provider panels offered through managed health care plans reduce the accessibility to qualified specialty care available for children. The Child Health Insurance Program (CHIP) has improved basic medical coverage for uninsured families but specialty services are not covered. Though Utah's CHIP provides access to routine healthcare, it was not designed to provide adequate coverage for the special needs populations, putting them at risk of being underinsured. Family advocate groups are generating support for the Family Opportunity Act, which would allow broader financial eligibility to Medicaid for children with disabilities.

Cultural acceptability

The health care system in Utah is developing more cultural awareness, especially as the population of Utah changes in racial and ethnic composition. In 1997, the Utah Department of Health conducted a qualitative study of health status of ethnic populations of African American, American Indian, Asian American, Latino/Hispanic/Chicano, Pacific Islander American, Southeast Asian Americans and seasonal farm workers. The results 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's Office of Ethnic Health produced a directory of medical translators that is available to providers throughout the state in order to facilitate translation for non-English speaking individuals seeking health care.

More health care systems in the local health departments and community health centers have worked to hire bilingual health professionals in order to better meet the needs of their changing client population. Since the major ethnic group in Utah is Hispanic, clinics have attempted to address the needs of the Hispanic population through bilingual staff. However, there

are other groups in the state that are growing in numbers that are hard to reach due to language barriers, cultural barriers, and provider acceptability.

However, much remains to be done in this arena. Staff needs more training on cultural awareness and it needs to be recognized that cultural sensitivity incorporates more than language and skin color.

Impact of the shift in Medicaid coverage over the last five years has made on financial barriers to care and services

Over the past five years, there has been little change in Medicaid eligibility criteria that would impact mothers or children

In Utah, out-stationed Medicaid eligibility workers, a shortened enrollment form and other outreach efforts have helped increase accessibility to enrollment and coverage for families. These efforts have also increased cooperation and collaboration among health care providers and state programs.

The number of children with special needs covered by Medicaid has vastly increased over the past decade, because of restructured financial eligibility guidelines and an increase in Medicaid outreach. Medicaid does not, however, extend to children with special health care needs or their families who are of undocumented citizenship status unless they have a life-threatening condition. Children who are eligible for SSI disability benefits are also eligible to apply for Medicaid coverage, although they must complete a separate application. Although more children are able to access care through Medicaid outreach and the availability of CHIP, there are still some children that remain uninsured, either due to financial factors or inability of the parents to follow through with the application process.

Medicaid reimbursement for outreach and administrative activities has benefited a number of the MCH programs, including health services provided by school health and FACT nurses.

CSHCN Bureau clinical and case management programs are now receiving reimbursement for specific activities through a Medicaid Administrative Case Management contract. With the addition of the Medicaid reimbursement, CSHCN Bureau has been able to maintain and in some cases expand services to special needs children in Utah.

The Baby Watch/Early Intervention Program (BWEIP) has negotiated increased Medicaid reimbursement rates over the past 5 years for services for children between the ages of birth to three years. Approximately 1300-1500 children in BWEIP are Medicaid eligible. Covered services include: case management, individual physical, occupational and speech therapy, nursing and referral to other resources in the community. Medicaid also reimburses for "child find" activities and general administration of the program for Medicaid eligible children.

The Community Based Services Program administers the Travis C. Waiver for Technology Dependent Children, a Medicaid home and community-based waiver program. Through this waiver, CSHCN Bureau nurses provide intensive case management for children and families with multiple and complex needs as they care for a medically fragile child in their home. The waiver also provides eligibility for Medicaid for these children by waiving the family financial eligibility requirement. Services beyond the regular Medicaid program that are available for those on the waiver program include: case management, skilled nursing respite, family counseling visits, respiratory therapy, feeding therapy and nutritional services.

Another high-risk population of children with special health care needs is the children in Utah's foster care system. These children have in place a funding source for health care (Medicaid), but because of the complexity of the human services system, they often have poor access and therefore receive inadequate health care. Multiple foster home placements, difficulty in transferring health records and a lack of foster parents who are trained to work with children with special needs are but a few of the problems these children face. To improve the health care of these children, the CSHCN Bureau, Medicaid and Division of Child and Family Services (DCFS) in the Department of Human Services worked together to develop the Fostering Healthy Children Program. This program ensures the provision of medical, dental and mental health services for children in Utah's foster care system. State funding is maximized with federal Medicaid match funds to administer this program. Program staff assists DCFS staff in meeting the health needs of 2,400 children by co-locating nurses with DCFS case workers and providing health care case management.

Impact of shift to managed care delivery systems on service delivery and availability

Medicaid has contracts with 5 different managed care organizations (MCO) along Utah's Wasatch Front where MCO enrollment is mandatory, including children with special health care needs. During this past year, MCOs have expanded into the rural areas of the state providing an option for rural Medicaid recipients.

The Division of Health Financing/Medicaid in the Department of Health believes that the move to mandatory managed care in the urban areas of the state beginning in 1996 has improved access for Medicaid clients. The five MCO plans contracting with Health Care Financing all are vested in providing preventive health care and encourage enrollees to use preventive services. One health plan reported contracting with an additional 300 providers who otherwise would not open their practices to Medicaid clients. Managed care is beginning to move into the rural areas, with one MCO enrolling clients in Washington and Iron Counties, and soon to be enrolling clients in Cache County. Managed care experience in the rural areas of the state is too new to make a determination of its impact on services for the maternal and child health populations.

With the shift to Medicaid managed care, the public health care system in the state changed significantly. Local health departments, which previously had provided a variety of services now available only through MCOs, have been limited in their ability to deliver MCH services. Reasons for these limitations include difficulties in contracting with the MCOs and misunderstanding regulations, for example, clients being able to seek family planning services outside their MCO. Local health departments that have contracted with the Medicaid MCOs have found that their contracts have been severely cut back eroding into the integrity of locally developed programs. In addition, they have reported difficulties in obtaining reimbursement for contracted services from the MCOs and also from Medicaid for services they have provided in a fee-for-service system prior to a client's enrollment in the managed care system.

To facilitate Medicaid enrollment, the majority of Presumptive Eligibility (PE) sites (generally local health departments and community health centers) along the Wasatch Front house on-site Medicaid Bureau of Eligibility Services Outreach Workers. This system permits a woman to apply for PE and, if eligible, at the same location and during the same visit, to begin her Medicaid application. PE eligible women at sites lacking outreach workers are referred to Department of Workforce Services to apply for Medicaid. Medicaid recipients along the Wasatch Front must enroll in a Medicaid managed care organization (MCO), which must provide MCH

services, such as prenatal, family planning, well child, and specialty child health services. Additionally, a case management system must be available to screen and refer high-risk pregnant women and children to appropriate services. Numerous private family practitioners, obstetricians, pediatricians, mid-level providers are enrolled with the various MCOs giving clients a wide selection of health care providers and sites for care.

Review of the Medicaid managed care service system has indicated that access to prenatal enhanced services has probably been reduced since the move to managed care. While a managed care health system should actually increase access to these kinds of services since clients are enrolled in a health care system rather than in a fee-for-service system, the managed care organizations currently do not have an established system to ensure that at-risk pregnant women, for example, receive preventive enhanced services, such as care coordination. Rather, enrollment in case management usually only occurs when a pregnant woman or child develops a high-risk condition identified through billing for costly services.

Since Medicaid mental health services are a carve-out under the managed care system and capitated mental health centers are oriented to chronic mental illness, access to care is problematic for the MCH populations. Providers for Medicaid clients enrolled in managed care systems do not accept presumptive eligibility (PE) cards making it difficult for a pregnant woman on PE to access needed mental health services. Specialty mental health services for children are difficult to access due to a shortage of available providers.

Additionally, the move to managed care has made tracking of services for maternal and child health populations very difficult, if not, impossible. For example, tracking prenatal, family planning, EPSDT services, or immunizations is almost impossible because of the shift in data ownership from Medicaid to the Managed Care Organizations (MCO). Medicaid is able to track encounter data, but the MCOs are not able to provide encounter data for their clients due to problems with tracking these in their computer systems. Since clients are able to change health plans as often as monthly, it is difficult for MCOs to track client services, outcomes, etc. Health Care Financing/Medicaid is working with the MCOs to improve access to needed data to track outcomes, costs, services provided, etc. This year, Medicaid has mandated that the MCOs submit encounter data for CHEC/EPSDT services for the HCFA 416 form, which should provide better

data on the child population served through Medicaid MCOs. Long-range studies will be needed to assess the full impact that managed care has had on the Medicaid population in the state.

Data collection for specific services provided for the MCH populations is being developed. For example the Immunization Program is currently involved with a Government Performance Records Act Project to collect and track immunization data for Medicaid-enrolled children. The Utah Statewide Immunization Information System (USIIS) Program, an immunization registry, is being developed to collect and track immunization data for children in Utah, including Medicaid enrollees. The CSHCN Bureau continues to expand its capability of extracting data from its Megawest Clinic Billing program, which will give data on the children seen through statewide CSHCN Bureau clinics. As CSHCN Bureau provides more services through contracts with specialty providers, however, it is becoming more difficult to track the services, which are paid for but not provided directly by the Bureau.

Impact of welfare reform on the Title V populations

The impact of three-year lifetime benefit for TANF eligibility in Utah on the MCH populations won't be known for a period of time since the first group of recipients reached their lifetime limit in January 2000. However, welfare reform has resulted in some pregnant women, mothers and children being dropped unnecessarily from Medicaid eligibility, as other states have also experienced.

The Department's Health Care Financing Division/Medicaid has conducted a review of Medicaid case closures and found some problems that need to be addressed, such as cases that were incorrectly closed, not considered for other program types, or not referred for CHIP eligibility. When a financial case is closed, it should be reviewed to determine if the family, especially children, would qualify for another type of Medicaid. While the numbers of families enrolled in Medicaid through the welfare system has dropped, there has been a concurrent increase in the numbers enrolled through Medicaid eligibility workers, resulting in a stable number of enrollees.

A little more than 60% of families whose TANF eligibility was terminated due to time limits regained Medicaid status within 12 months of their TANF case closure, indicating a high need for health care coverage among this population. For the 40% who do not re-enroll in the

system, there currently is no means to track how they are doing, i.e., do they have insurance, do they know they can reapply, have they have moved out of state, etc. The Division of Health Care Financing is currently developing strategies to re-enroll individuals who were improperly denied eligibility in Medicaid when their TANF eligibility ended. More in-depth review is necessary to identify the true impact that welfare reform has had on the Utah population before the state really knows the impact of time limits, etc.

The Social Research Institute at the University of Utah was commissioned to examine the impact of welfare reform on families by the state's welfare agency, Department of Workforce Services (DWS). In the study, the SRI was to a) describe families who face severe, persistent and multiple barriers to self-sufficiency, including incidence and prevalence of mental illness, substance abuse, and physical disabilities and the extent to which families face one or more of these characteristics; b) discuss the extent to which traditional interventions are effective in reducing barriers to self-sufficiency; and, c) address the probable effects of time limits on case assistance to families who face barriers to self-sufficiency. The report "Understanding Families with Multiple Barriers to Self Sufficiency" outlines key issues relating to participants' dependence on public assistance, Family Employment Program (FEP), Utah's welfare program. For example, factors that families reported as precluding their working included: almost 35% had a physical disability or health problem; more than 20% had a learning disability; 44% had a mental health problem; and almost 23% indicated a condition with their children's health. These figures represent significant barriers to self-sufficiency that will impact the MCH populations if welfare reform mandates termination of their eligibility for FEP.

Those particularly at risk include individuals residing in rural areas or on Indian reservations which may be specifically at-risk, especially where there are few employment opportunities. Young teen mothers (12 – 15 years of age), one of the most vulnerable populations, will be unable to complete their high school education prior to loss of TANF eligibility, severely limiting their ability to earn a stable, livable income. Under-funded public agencies, including local Title V grantees, do not have the capacity to become the safety net for women or children no longer eligible for TANF benefits. Long-range studies will be needed to determine the consequences of these changes.

In Utah, TANF and Medicaid have not yet been delinked, so there is not a great loss of Medicaid recipients through the process as had happened in other states. Utah has continued to provide Medicaid enrollment to those individuals whose case is open under TANF without a separate application. However there is some loss of individuals from Medicaid who are no longer receiving financial assistance under TANF. At this point, it is not clear whether these individuals have moved on to health insurance provided by their employment, or whether they simply do not have insurance.

Of particular concern is the individual who may have been improperly denied eligibility for SSI. In 1997, with the changes in SSI eligibility for children, it was predicted that over 700 Utah children would not only lose their SSI eligibility, but their Medicaid coverage as well. In order to support Utah families through this federal eligibility change, state staff from CSHCN Bureau, Medicaid and SSI/DDS worked with the Disability Law Center to provide outreach to affected families. The Disability Law Center offered pro bono services to families who needed assistance in the SSI appeals process for their children. CSHCN Bureau and Medicaid staff helped identify families and to provide information about continuation of Medicaid eligibility, even though families might lose their child's SSI. This year, it was finally found that only 60-70 Utah children lost Medicaid and SSI because many children either qualified under a different Medicaid category or they were able to become re-qualified for SSI.

Impact of other changes in financial access (private insurance, risk pools, State insurance programs, child health initiatives) on Title V populations

The Utah Children's Health Insurance Program (CHIP), implemented in August 1998, is a state-developed health coverage assistance program for children who do not have other health insurance and who meet the program's eligibility criteria. It was estimated that 63,000 children in the State of Utah do not have health insurance. Of these uninsured children, 30,000 are not eligible for Medicaid but cannot afford health insurance premiums. As of September 30, 1999, more than 11,000 children had been enrolled in Utah's CHIP program.

CHIP is a public and private partnership that provides coverage through several private managed care health plans. CHIP benefits include a standard coverage package that allows coverage for all eligible children, designed around the Public Employee's Health Program (PEHP),

which covers public employees of the State of Utah. The focus of CHIP is on cost-effective preventive care which includes routine physicals, immunizations, vision and hearing screening, and basic dental services. Other benefits include hospital services, physician services, laboratory services, prescription drugs, mental health services, and preventive care. Families are offered a choice of several private managed care plans from which to receive services.

To be eligible for Utah's CHIP Program, a child must be age 18 or younger, not covered by an insurance plan and not eligible for Medicaid. The family's income must be below 200% of the federal poverty level (FPL) and above the Medicaid's income standard of 133% of the FPL for children ages 0 through 5 and 100% of the FPL for children ages 6 through 18.

Covering Kids Utah, a Robert Wood Johnson Foundation Partnership, is a three-year grant project managed under the guidance of a statewide coalition and state-level coordinator. It has been implemented with the support of Covering Kids, a national access health initiative for low income, uninsured children. The project's focus is on increasing access to CHIP and Medicaid for children ages 1 – 19 through strategies that include outreach, enrollment simplification and coordination at the community level. Best practices of pilot projects will be implemented on a statewide basis through local partnerships.

Three focused outreach projects in high-need areas have been mobilized through this project:

- Salt Lake City School District concentrates on zip codes 84104, 84111 and 84116 using family advocates and home visiting to canvass neighborhoods
- Murray/Midvale uses neighborhood canvassing and will work closely with both city governments and Family Support Center. It is coordinated by the Boys and Girls Club of Murray and Midvale
- Central Utah, coordinated by Central Utah Public Health Department, works closely with schools, churches and health organizations to cover six impacted/frontier counties – Wayne, Sevier, Juab, Millard, Sanpete and Piute

It is hoped that the child health initiatives (CHIP and Medicaid) will help ease the financial burden of health care for low-income families and increase access to care. It is also hoped that families, once enrolled, will utilize the system in a way that emphasizes preventive health care and

decreases the use of emergency rooms and insta-care facilities as stopgap measures to access the health care system.

Although it is too early to determine the impact of this program on the MCH populations, several problems have been noted with the child health care initiatives in the state. Enrolled families tend to drift in and out of the programs often depending on changes in income levels or in health status. Enrollment may lapse during periods of health with reapplication in time of medical need. Parents who are legal residents or of undocumented citizenship status may not enroll their children in Medicaid or CHIP for fear of a negative impact on their citizenship application, being reported to Immigration and Naturalization Services, or possible deportment.

Other child health initiatives included: an increase in funds allocated through the 2000 Utah Legislative session for the Travis C Waiver Program that created more slots to children on waiting list. The Early Intervention Program received an additional $300,000 in funding during the 2000 Legislative session which assisted in providing services to children on the waiting list. The Utah 2000 Legislature passed a mental health parity bill that mandates all insurance companies include catastrophic mental health services effective July 1, 2000. While this bill allows for coverage of some needed mental health services, it doesn't address the ongoing mental health needs of Utah's population, nor does it address preventive services for mothers, children and children with special health care needs. This bill is a start to bringing coverage of mental health services on par with physical health services.

Provider shortages and underserved geographic areas

Provider shortages exist throughout the state, except along the Wasatch Front. The maps in Section 5.3 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 the Medicaid populations and for those living in rural areas of the state.

For the maternal population, there are areas in Utah with high ratios of women of childbearing age to providers, resulting in limited access to a prenatal provider in their geographic area (see map in Section 5.3) Many rural counties lack obstetricians (see map in Section 5.3). More than half of the counties (16 out of 29) are without any obstetrician-gynecologist for the management of high-risk pregnancies (see map in Section 5.3). Four rural counties have no

prenatal health care provider of any kind, requiring pregnant women in rural communities to travel many miles to a provider and/or hospital, some living more than 30 miles from a prenatal provider (see map in Section 5.3). Obstetricians are limited in rural areas of the state as illustrated by the map in Section 5.3. In several counties of Utah there are no pediatricians or sub-specialists, necessitating families to drive long distances to access care for their children.

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.

Utah is currently experiencing a nursing shortage, making it very difficult for the public health system to offer competitive salaries to nurses who are drawn to more lucrative hospital nursing positions. The number of nurses available to provide public health nursing services limits MCH services through local health departments, including home visitation.

The Utah WIC Program is continually challenged in hiring Registered Dietitians in rural area clinics, with several Registered Dieticians covering up to eight clinic sites. Some sites have had positions for Registered Dieticians open for long periods of time, unable to fill these for some time, if at all.

Although all local health departments and community health centers are Vaccine for Children (VFC) providers, there are areas in the state with a shortage of VFC providers. The Immunization program is working diligently to increase the number of VFC provider sites by changing Medicaid provider enrollment to include automatic VFC provider enrollment unless a provider opts out of this program. The Program is also launching a statewide effort to increase the number of private providers enrolling in the VFC Program.

A continuing challenge in the delivery of community-based services to infants and toddlers with special needs is the availability of professionals statewide. There is a notable shortage in physical, occupational and speech therapists in remote or rural areas of the state. To solve this Baby Watch/Early Intervention Program (BWEIP) oversees a statewide credentialing program for personnel in the early intervention field for professionals working with children 0 – 3 years. BWEIP has agreements with the University of Utah and Utah State University for pre-approved programs of study that will allow graduates in early childhood education to receive the state early intervention credentials. Additionally, the BWEIP and the State Office of Education collaborate

on the Signal Project, which is a state improvement grant through the Federal Office of Special Education Programs that addresses the recruitment and retention of specialized personnel in early intervention and special education. The grant develops and targets strategies at the pre-service and in-service levels for personnel working in the special education field.

Access to maternal and child health care varies depending on the geographic area of the state. Even where prenatal care providers are more numerous, under- and uninsured women may be confronted with caps on the number of clients an agency is able to accommodate including Presumptive Eligibility determination. However, gaps exist in certain areas of the state, such as Wendover, in the unique situation of being located in two states with different rules and regulations governing federal and state programs.

Presumptive eligibility for prenatal Medicaid has been problematic in some areas of the state, especially in the urban areas with limited Presumptive Eligibility (PE) sites. Co-location of PE workers and Medicaid eligibility workers has assisted women in accessing Medicaid eligibility faster. For those sites where the waiting times for appointments are too long, clients are referred directly to the department of Workforce Services workers to make a direct Medicaid application. In some rural areas, PE is problematic, such as in Summit County Health Department which does not participate in the program or offer perinatal services. Pregnant clients unable to afford private care in this health department are referred to adjacent local health departments. Opportunities for outreach and education may be lost without public perinatal services available in that county.

Populations of Spanish-only speaking families are growing throughout the state, mainly concentrated along the Wasatch Front, Wendover at the western border, and in northern, southern and central Utah. These families are more difficult to reach due to language barriers; cultural beliefs surrounding health care; transportation constraints; and ineligibility for many government programs if they are of undocumented citizenship status.

In the Southeastern corner of the state on the Navajo Indian Reservation, name recognition of the Baby Your Baby (BYB) Program is poor as the signal from the local CBS affiliate broadcasting the BYB public service announcements is often not available in that area. Because of the lack of broadcast of BYB public service announcements, families in this area of the state are not exposed to the resources they might access if they were aware of them.

Obviously other methods to reach these populations are necessary so that they have the ability to access needed resources.

Access to low-cost maternal and child health care services via community health centers is problematic in several areas of the state. Many rural areas of the state do not have access to a community health center that provides low-cost health care services. The underserved areas of the state include the rapidly growing cities of St. George and Cedar City in the Southwest Utah Health Department. The Association for Utah Community Health, Inc., the state's primary care association, works to promote development of community health centers in the state and has encouraged submission of grants for areas needing improved access to health care, especially in the Southwest Utah Health Department area. Unfortunately, the community is not united in its support for a community health center in this area of the state at this time.

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 Department; Tricounty Health Department; and portions of Central and Southeastern Utah Health Departments. 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.

Through the Immunization 7-month-old survey which identifies those children who reach seven months who should have completed the majority of their first year immunizations at the 6-month well child visit, pockets of need, or children with a potential of not being fully immunized are identified. Each local health department follows up on identified children in their areas and links them to services as necessary. The largest areas of need are in the urban areas including in Salt Lake County, Ogden, Weber, and Utah Counties, representing unmet need of inner city urban areas.

A 1993 study conducted by the National Institutes of Health found 20% of Medicaid children received preventive dental services compared to 16% of Utah Medicaid children. Over the past several years, Utah Medicaid utilization of preventive dental services has gradually increased to 26%. Access to a dentist willing to provide services for Medicaid enrollees is difficult for many in the state due to low reimbursement rates and provider unwillingness to serve this

population. Medicaid operates several dental clinics in various sites in the state. While the CHIP Program covers dental health services, some needed dental services are not covered by CHIP, such as composite fillings and stainless crowns. Access to oral health services is problematic for those families with health care coverage that doesn't include dental health services.

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 Hospitals 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. The only licensed audiologist in the eastern half of the state is employed by the CSHCN Bureau. In most cases, there is only limited additional itinerant coverage from the private sector for this large geographic area. Several of the rural early intervention programs must contract for physical and occupational therapists outside their catchment area because these services are not locally available. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers.

Availability of care

Services for the three populations served through Title V are offered in a variety of settings: private provider offices; public providers in local health departments, community health centers, a clinic for the homeless, and migrant health clinics; itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty settings, such as the University of Utah Health Sciences Center, Primary Children's Medical Center, and Shriners Hospital for Children.

The majority of maternal and child health services are provided through the private sector and managed care organizations. The 10 community health centers and the Wasatch Homeless Clinic provide primary care to underinsured and uninsured MCH populations. Four of these community health centers are located in rural areas of the state. Three migrant farm worker clinics are co-located with Wasatch Front community health centers and a fourth clinic is located

in Brigham City. 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.

Most local health districts no longer provide primary care services for MCH populations. Services available through local health departments (LHD) vary depending on priorities as established by the health district. See listing of local health department service availability in Section 5.3. For example, prenatal services are no longer available through LHDs, although two districts provide clinic space and support staff for prenatal clients served by University of Utah Health Sciences Center providers. Family planning services are available only through mid-level practitioners in several health district clinics. The shift away from direct services provided by local health departments reflects the changing public health system to focus more on health promotion and prevention services.

Following a SIDS death, local health department nurses provide home visit for families who have experienced SIDS by providing support and collecting important information that assists the State in completing a data base on various factors known to impact SIDS, such as the baby's position at the time of death. Although the greatest number of SIDS deaths occurs in Salt Lake County, only one nurse is available through the Salt Lake Valley Health Department (formerly known as Salt Lake City-County Health Department) to serve these families. The SIDS Program works with hospitals, day care providers, and other organizations throughout the state. Despite efforts to reach all areas of the state, data from the 1996 Health Status Survey suggest that urban/rural disparities may exist, with a greater percentage of infants reported as placed on their stomachs to sleep in the rural counties. Hospitals, private provider offices, and community health centers provide brochures and educational information about reducing the risk of SIDS. The SIDS Program develops and distributes pamphlets, and offers inservices to these organizations to help them stay up-to-date about reducing the risk of SIDS.

Ten of the twelve local health departments offer well child clinic services to children, wherein well child assessments, developmental screenings, and immunizations are performed by registered nurses, nurse practitioners, and/or physicians. Whenever necessary, referrals are made to providers and/or clinics within the community for follow-up of identified health concerns, and the local health departments strive to assist families in identifying primary health care providers for their children.

Dental health services are inadequate for children with special health care needs, who have CHIP, Medicaid, or who live in rural areas. Limited availability of providers and limited coverage of specific aspects of dental care are identified barriers. Private insurance, CHIP and Medicaid often refuse to cover anesthesia for special needs children's dental care, which increases the financial burden on families. Specialty dental services, such as orthodontia for children with cleft lip/palate are only available from a few providers, and only along the Wasatch Front. These factors make the frequent and complex interdisciplinary care for children with special dental needs very difficult.

Availability and distribution of services for children with special needs varies considerably in Utah. Most of the population in Utah is located along the Wasatch Front from Ogden to Provo, where most specialty and sub-specialty pediatric providers are located. In addition, the state's tertiary pediatric care centers, Primary Children's Medical Center and Shriners Hospitals for Children are also located here. Although this allows for better coordination of care because there are fewer providers, it also presents a problem of service delivery to special needs children in rural Utah.

Mental health services are available privately and through Medicaid Prepaid Mental Health Plans throughout Utah. However, services are not adequate for children, especially those who are under five years old, living in rural Utah, dually diagnosed with mental health and chronic illness, or served by numerous agencies. A collaborative effort involving multiple agencies, including the CSHCN Bureau, is underway to improve the mental health services for children in the state. Utah Children, Utah's child advocacy organization, hosted a Children's Mental Health Summit to begin developing strategies for improving mental health services throughout Utah. A second effort to improve services to children which the CSHCN Bureau is participating with is the Department of Human Services, Division of Mental Health "Frontiers Mental Health" project, which is initially working to improve the quality of clinical therapy for children in frontier Utah. Thirdly, the CSHCN Bureau is also working with the Division of Mental Health and Medicaid to provide onsite consultation to Medicaid Prepaid Mental Health plans and provide training about the special health care needs of children to staff in public mental health agencies.

Quality and quantity of health related and enabling services such as respite care, pediatric home health nursing, vocational counseling, therapeutic recreation, translation and interpretive

services for children with special needs and their families vary considerably across the state. As technology continues to advance and more children are integrated into the community, pediatric specialty services and providers seem harder and harder to find, especially in the rural areas.

The public health system in Utah is hampered in providing services to all in need due to funding shortages, staffing shortages, etc. Utah is faced with a growing population of families without insurance, especially those of undocumented citizenship status, placing a stress on a health care system with limited resources. Local health districts and community health centers in the state have been forced to place limits on the number of clients due to limited resources. Limited resources also prevent hiring additional public health nurses to provide more in-depth services to the maternal and child populations of the state, such as care coordination, home visiting services, and grief support to families that experience SIDS.

Assess and describe existing resources for providing community-based care, specialty care and multidisciplinary centers

Local health departments (LHD) offer a variety of direct and enabling services for the maternal and child populations, including prenatal, family planning, SIDS counseling and support, well child checks, immunizations, tobacco control and prevention, etc. Many of the local health departments would like to expand the scope of their direct and enabling services but lack of personnel, poor Medicaid reimbursement rates, limited Title V funding, and restrictions due to managed care enrollment prevent them from doing so. A growing non-English speaking client population in the state is presenting a challenge to local health departments and community health centers with limited capacities to provide appropriate interpreters and culturally acceptable services.

Local health departments in Utah are required to annually report the number of unduplicated clients, the race/ethnicity and insurance status. Usually the clinic visit is for presumptive eligibility screening not direct care. Of the clients' insurance status collected over the past three years 1997-1999, data indicate that between 50% to 52% of prenatal clients had Medicaid coverage. The insurance coverage for family planning seeking family planning services was very different than the prenatal population, with 86%-87% of the clients reporting no insurance coverage for family planning services.

Because of the high percentage of clients seen in LHD clinics with no insurance, one of the challenges for local health departments (LHD) is maximizing their resources through adequate billing systems. This practice would enable local health departments to recuperate their costs and provide services to more individuals without third party payers. A role that the State has played during the past couple of years is promotion of billing third party payers by local health departments for covered services. However, some local health departments still do not bill Medicaid or private insurance companies for services they provide to mothers and children, limiting their ability to recuperate their expenses. Maximizing resources needs to be a priority so that LHDs can work to increase the number of mothers and children they could serve.

Perinatal services, of varying degrees, are available in eleven of twelve local health districts throughout the state. Services are available in two Wasatch Front local health departments, Salt Lake Valley and Weber-Morgan Health Departments, through a contract with the University of Utah Health Sciences Center, to utilize these agencies' facilities and support staff assist in providing low-cost prenatal care. Presumptive eligibility screening and enhanced prenatal services are available at both sites. Both programs serve numerous Hispanic women, many of who are of undocumented citizenship. Although both clinics employ bilingual personnel, many providers must utilize interpreters to communicate with clients.

Nine other health departments provide perinatal care coordination. Perinatal care coordinators assess prenatal clients for risk factors that might negatively impact their pregnancies, develop action plans based on these risk factors, and assist clients in obtaining needed services throughout their pregnancy and postpartum periods. Of these nine health departments, eight also provide pre and postnatal home visiting for Medicaid women. One local health department does not provide any prenatal services, but has arranged to refer for these services to an adjacent local health department.

Community health centers (CHCs) provide low cost services for maternal and child populations throughout the Wasatch Front and at four rural sites. CHCs along the Wasatch Front must often place caps on the number of clients they are able to serve due to limited resources and providers. Many of the staff at the urban sites is Spanish speaking. Four migrant health centers provide services to eligible women and children.

The University of Utah operates numerous community-based clinics in Salt Lake, Summit and Tooele Counties. These sites provide discounted services, but those unable to meet the system's minimum payment plan are referred to the public health sector for care. The Teen Mother and Child Program, a multidisciplinary team program available at the University of Utah Medical Center in Salt Lake City, provides teen mothers prenatal, intrapartum, and postpartum care, and also follows the family, including the children, for two years after delivery. A major focus of this program is prevention of subsequent pregnancies during the adolescent years.

Screening for presumptive eligibility is available at all local health department and community health center sites and those along the Wasatch Front also have out stationed Medicaid eligibility workers to assist clients applying for Medicaid and CHIP Programs.

Individual nutritional counseling for women at high nutritional risk is available through WIC or private registered dieticians. Psychosocial counseling is also available, usually via county mental health programs, to the same group of women. Medicaid reimbursable group childbirth education is offered through most hospitals.

The Utah WIC Program has approximately 60 clinic sites and is currently serving about 58,000 women, infants, and children. Clinics are located throughout the state in urban and rural areas, including a mobile van program in Salt Lake County, a Ute Indian reservation clinic, homeless shelter clinic and at the University of Utah Teen Mother and Child Program. Rural areas often have several satellite clinics they cover throughout each month. Because several counties are incorporated into rural health departments, clinic hours are more limited than those in urban sites, which are generally open more days and offer a larger range of clinic hours to meet client needs. Rural agencies tend to have more personalized and efficient services, while Wasatch Front clinics are staffed with a greater number of Registered Dietitians and bilingual staff.

The program currently has sufficient funds to serve this number of clients; however, if the current caseload increases, some participants may have to be removed from the program. Rising food costs, level funding, and increased participation in WIC have raised concerns about the potential need for caseload management in Utah.

Prenatal - 5 nurse home visitation is available in eleven of the twelve local health departments. Home visitation is a strategy to assist families in gaining access to information and services that support and strengthen family capacity to meet their own needs and those of their

children. The Utah program, targeted toward at-risk pregnant women and children from birth to 5 years of age and their families, is directly managed at the local health department (LHD) level and staffed by their nurses. Home visits are conducted to assess child and family strengths and needs related to overall health and well-being, and to provide anticipatory guidance, information, assistance, and/or referral to assist families in meeting identified needs. Local health department participation in this MCH Block grant-supported program component, through contract, is voluntary. In FY99, the Division reallocated MCH Block Grant funds previously earmarked for local health department Infant Development Programs to the Prenatal to 5 Nurse Home Visitation Program. Contract funding to support the program is limited and is clearly not sufficient to fully support the level of staffing needed for local programs. Several local health departments supplement MCH Block grant dollars for the program with additional local and private dollars which they've been successful in garnering through other funding sources. For those local health departments relying solely on MCH Block grant funding, their nurse home visitation programs are generally limited by funding and staffing constraints. In such areas, client participation is usually reserved for those at-risk pregnant women and young children determined by the public health nurse to have the greatest need for home visitation services. Because this is a new program and partially funded through MCH Block Grant dollars, technical assistance, consultation, development of guidelines and standards, contract and program development and monitoring, data collection and analysis, and program evaluation need to be coordinated at the state level.

Community-based dental clinics include: three community health center dental clinics in Salt Lake County; five Family Plan Dental Clinics (Medicaid only) in Salt Lake City, Ogden, Provo, and St. George; one local health department dental clinic (Medicaid only) in Vernal; three donated dental services clinics in Salt Lake City, Ogden, and Logan; and three school and community-based clinics (preventive services only) in Salt Lake City and Ogden. Funding has been requested to establish dental clinics in CHCs in Price and in Ogden. Except for Medicaid-only dental clinics in St. George and Vernal, community-based care is not available. None of the community-based centers provide specialty care such as treatment under general anesthesia or orthodontic treatment.

Services offered through the Tobacco Prevention and Control Program (TPCP) are available statewide, through a variety of mechanisms, including local health department contracts

with designated staff that serve as local TPCP coordinators. The program's primary focus areas impact children, and there is an emphasis on youth-related programming because of the potential to increase the quality of life and reduce health care costs and disease. Mini-grants to community organizations throughout the state are disseminated on the basis of their potential ability to promote positive health practices that prevent underage tobacco use or that provide information and programs to enable target audiences to quit their tobacco use. In addition, the TPCP program was granted funds from CDC to address prenatal tobacco use. The Division's Reproductive Health Program collaborated with the Utah Perinatal Association to develop a promotional campaign for prenatal care providers throughout the state to encourage them to screen and refer smoking women to cessation programs.

The Utah Department of Health received a $3 million appropriation for FY01 from the National Tobacco Master Settlement Agreement for alcohol, tobacco, and other drug prevention, reduction, cessation and control programs. During FY01 these funds will be used exclusively for tobacco prevention and control programs. An advisory committee was convened and made recommendations for use of the funds. The Tobacco Prevention and Control Program will allocate funds through a request for proposal process in the following areas: media and marketing campaign; integrated family, school, and neighborhood prevention; health care and neighborhood cessation and evaluation. Prevention and cessation efforts will focus on pregnant women as well as youth.

The Utah Abstinence-only Education Program is the state's federally funded program that resulted from the 1996 federal welfare reform legislation. The Utah Program focuses on community-based abstinence-only projects for youth (both boys and girls) between the ages of 9 and 14 years. Projects may include, but are not limited to, programs that promote self-esteem, self-confidence and healthy decision making, resisting pressure to become involved in sexual activity, prevention of sexual abuse including date rape, communication between parents and youth, parent training on abstinence, and programs that target high risk youth. Projects are required to develop a parent component and an evaluation plan. Projects are required to follow the federal definition of abstinence education.

The Abstinence-only Education Program projects are located in various communities in the state through local health departments, school districts and private not-for-profit

organizations. The communities which have projects include: Bear River Health Department (includes Cache, Rich and Box Elder Counties); Carbon County; Garfield County; Salt Lake County; Tooele County (includes Wendover), and Wasatch County. Some of the Salt Lake City based projects offer project activities in counties outside of Salt Lake City, including Weber County.

Primary Children's Medical Center in conjunction with University of Utah Health Sciences Center and Shriners Hospitals for Children provide most of the specialty/subspecialty services for children in the intermountain area, especially those with special health care needs. These centers of excellence are able to provide centralized specialty and subspecialty services to children with numerous disabling conditions, such as asthma, hemophilia, cystic fibrosis, diabetes, Down syndrome, cancer and orthopedic disorders.

Hearing, Speech and Vision Screening Program (HSVS) provides direct services to newborns, infants and preschoolers, children at risk, children in areas lacking alternative care and children whose parents request financial assistance. The following 22 rural clinic sites are routinely visited by HSVS audiologists for clinical services at least two times per year, often more: Washington County (Hurricane, LaVerkin, Hildale/Colorado City); Kane County (Kanab); Garfield County (Panguitch, Escalante); Iron County (Parowan, Enoch, Beryl Junction); Beaver County (Milford, Beaver); Millard County (Fillmore, Delta); Grand County (Castledale, Green River); San Juan County (Navajo Mountain, Bluff, Monticello); Uintah County (Ft. Duchesne); Box Elder County (Brigham City, Tremonton); and Tooele County. See map in Section 5.3. These services are provided out of 4 regional offices and 31 rural clinic sites. Hearing, speech, and vision screenings and /or diagnostic and referral services are provided. Screening services for children under three are provided at no charge to parents. For others, the CSHCN Bureau sliding fee scale is utilized. Specific efforts are made to provide culturally sensitive services and a significant number of encounters are provided to Native American and other racial or ethnic groups.

Hearing Speech and Vision Screening Program (HSVS) helps provide hearing-impaired children of families in need of financial assistance with refurbished hearing aids through the Hearing Aid Recycling Program (HARP). Children who do not qualify for insurance or Medicaid purchase of hearing aids may apply for this program. Audiology services may be provided

through HSVS, but may also be provided through school resources, or through private audiologists who agree to fit reconditioned aids through HARP for their patients.

In Utah, the BabyWatch Early Intervention Program (BWEIP) is a significant provider of therapy services, especially in rural areas. BWEIP serves 4,300 children per year and anticipates a growth rate of 20% per year because of identification of eligible children, eligibility changes to include very low birth weight (<1000 grams), the program's excellent reputation, and increased collaboration with physicians.

The Neonatal Follow-up Program (NFP) provides statewide multidisciplinary services through three satellite offices to the very low birth weight graduates of Utah newborn intensive care units. There are approximately 400-500 critically ill children born in Utah each year who have an increased risk of health and growth problems, neurological disorders, learning difficulties, mental retardation, hearing and vision deficits, behavioral disorders, language delays, delayed social skills and school failure. NFP provides periodic assessments in multidisciplinary clinics and works with the child's pediatrician and family to coordinate follow-up for these children until 6 years of age.

The Child Development Clinic (CDC) provides direct clinical services to children birth through five years of age. Services include multidisciplinary specialty assessments, case management, educational consultation, and translation services. Financial support for diagnostic services and limited treatment services are provided to those families meeting income eligibility. A major goal of the program is to promote linkage of services between the private and public sector for specialized health care for infant and toddlers.

Community Based Services Program contracts with the Utah Chapter of Family Voices to provide assistance and help with referrals for families with special needs children. The Family Voices coordinator is very involved with CSHCN Bureau activities and also legislative activities that impact children and families. Currently, CSHCN Bureau staff, Medicaid and Family Voices are working on implementing a project to locate a parent advocate in an elementary school to assist with family advocacy.

The Adaptive Behavior and Learning Evaluation Program serves complex school-aged children and their families where the child suffers problems of learning, memory, attention, sensory processing, language or cognition as well as those with chronic physically disabling

conditions. The team works with families, schools and agencies and provides multidisciplinary diagnostic evaluations and school-based care coordination of services for children.

CSHCN Bureau Systems Development Program addresses issues of transition, cultural sensitivity, quality improvement and access to specialty services for children with special health care needs. Through collaborative and contractual agreements, children are seen at Primary Children's Medical Center in neurology, cardiology, genetics, orthopedics, spina bifida, oro/facial, hemophilia and cystic fibrosis clinics. Children also receive collaborative specialty services through Shriners Hospitals for Children for orthopedic conditions, including imperfecta osteogenesis.

Additionally, the Systems Development Program (SDP) provides training, consultation, and support to CSHCN Bureau staff and community partners in the area of adolescent and young adult transition services. SDP collaborates with other private organizations (i.e., Shriners Hospitals for Children) in presenting "transition fairs", where service providers can offer information on health care for youth becoming adults, Medicaid and SSI eligibility, managed care, independent living, vocational rehabilitation, advocacy, rehabilitation, education and employment. SDP staff works with the community-based programs to identify possible participants from their communities. CSHCN Bureau staff in clinical and community-based /rural programs receive assistance and education in the process of supporting families throughout the SSI application. Training is provided in identifying potential candidates for SSI participation and increasing successful referrals of children. SDP maintains a statewide database of potential SSI eligible children age 16 and under.

Linkages

In Utah there are five tertiary centers for perinatal health care and two tertiary centers for children's health care. Each of these centers has University of Utah Health Sciences faculty assigned and is well recognized throughout the state and the Intermountain West as a consultation and referral center for obstetrical and pediatric providers. These 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.

Staff from CFHS interfaces with faculty from these centers through various MCH efforts, including Perinatal Mortality Review, Child Fatality Review, 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. For example, if through infant death review it is discovered that appropriate consultation and referral were not sought, the coordinator will contact the appropriate referral center to increase their awareness of the need for outreach to community providers and hospitals in their referral area.

The largest managed care organization and third party payer in Utah, Intermountain Health Care, recently developed protocols for obstetrical providers in their Utah plan, which encourage provision of care at all levels by providers most qualified to do so by training and experience. The protocols outline which conditions of pregnancy may be managed by a certified nurse midwife or other mid-level provider, a family practice physician, an obstetrician or a perinatologist. These specific guidelines promote provision of services and referrals among the various levels of care providers in this network.

Public health systems also play a vital role in linking services among different service levels. Perinatal care coordinators in local health departments and in managed care organizations assist clients in obtaining needed MCH services. WIC serves as a referral source to many preventive and primary care programs. Women who have not received prenatal care at the time of enrollment into WIC are assigned the risk factor “Inadequate Prenatal Care”, referred to prenatal care, and tracked until care has been established. WIC staff also refers clients to Medicaid and CHIP if not already enrolled. Most WIC clinics are housed in local health departments, which helps facilitate referrals and coordination of many needed services. Some WIC Clinics coordinate with other services such as well child exams, immunizations, Baby Your Baby appointments, and family planning. Since WIC staff sees clients at regular intervals over an extended period of time, they are a vital link in providing access to other services.

The Utah WIC Program has reinstituted the WIC Advisory Council which represents local WIC clinic administration, advocacy groups as well as WIC participants. The Council provides needed input to the state program regarding issues of funding, caseload management, access to services, policy recommendations, etc.

For child populations, the Immunization Program has established linkages between the private primary care and public health sectors for immunizations. The Immunization Hotline, promoted by KTVX, an ABC national affiliate, is utilized by the public to identify sources of care. WIC linkages provide another source of referral and link to services for immunizations. The Immunization Program has established a Scientific Vaccine Advisory Committee, which involves representatives from local health departments, pediatrics and family practice private provider community, a state epidemiologist, and a communicable disease specialist to provide policy recommendations for the Utah Immunization Program.

The Division of Community and Family Health Services is currently involved in a number of inter-agency collaborative activities pertaining to home visitation. CFHS Child and Adolescent Health Program staff serves as consultants and resources on home visitation service delivery models and the availability of public health services. One committee was formed in response to an initiative undertaken by Prevent Child Abuse Utah to assess the current status of home visiting programs in Utah. Another collaborative effort relates to improving statewide coordination of home visitation program activities, and combining resources to assist in community development and training related to home visitation programs. This effort involves multiple partners, and includes representation from Primary Children's Medical Center Child Abuse Prevention Team, Prevent Child Abuse Utah, Utah State University Early Intervention Research Institute, and the Governor's Initiative for Families Today.

Staff from the Bureaus of Maternal and Child Health and Children with Special Health Care Needs provides consultation and joins the Medicaid quality assurance staff in site-visits to each of the managed care organizations. Using a set of specific standards, documentation is reviewed and interviews conducted to determine if each standard is met. The areas of focus for the Division of Community and Family Health Services are maternal and infant health, child health, diabetes and children with special health care needs.

The primary goal of the Tobacco Prevention and Control Program (TPCP) is to provide the leadership and guidance in the development of strategies and techniques designed to boost the capacity of community-based programs at the local level. By means of collecting and summarizing tobacco-related data, the TPCP is able to identify the extent of youth-specific, tobacco-related issues and problems. This information, in turn, is used by state/local health

departments and other partnering agencies to develop strategies and programs to meet indicated needs and track outcomes. The TPCP is comprised of program specialists who primarily focus on: prevention; youth access; teen tobacco reduction (cessation) programs; environmental tobacco smoke/Utah Indoor Clean Air Act; counter-marketing; tobacco policy; and surveillance and evaluation. Besides acquiring or developing specific program materials, specialists promote adoption of strategies, programs, and activities to the public and partnering agencies.

Partnering agencies are expected to actively provide services and activities to prevent Utah's youth from becoming dependent/addicted to tobacco. The Tobacco Prevention and Control Program's collaborating partners include: local health departments; State Office of Education and local school districts; the Utah Juvenile Court Administration, including the Substance Abuse Committee and district judiciary/probation offices; American Cancer Society and American Lung Association, Utah Medical Association, Utah Dental Hygienists Association, Utah Dental Assistants Association; Chief's of Police Association and Utah Sheriff's Association; Utah Substance Abuse and Violence Prevention Council; the Utah Department of Human Services Division of Substance Abuse; the Coalition for a Tobacco Free Utah; and many others. While it sometimes takes extra time and effort to activate collaborations with "sister" agencies, the payoff in terms of the resultant extent, quality, and effectiveness of youth-related tobacco programs is very apparent.

The Tobacco Prevention and Control Program (TPCP) works with Medicaid in the coordination of media campaign efforts. The TPCP works with school health programs in curriculum development activities; statewide youth ambassador programs; asset and character building workshops for elementary students; and, alternative recreation programs. TPCP collaborates with WIC in the development of local health department contracts regarding pregnancy and smoking, and environmental tobacco smoke exposure.

The Tobacco Prevention and Control Program has also initiated activities to reduce the use of tobacco during pregnancy and after to reduce the risk of SIDS and childhood illness. The program was the recipient of CDC funding to address this important area, especially since the association of tobacco use and low birth weight is well known. Although tobacco use among Utah mother's is low, there is need to promote decreased tobacco use during pregnancy and continued cessation after pregnancy.

Hearing, Speech and Vision Services (HSVS) has developed many links with primary care providers, hospital newborn hearing screening programs, public schools, Utah Schools for the Deaf and Blind, early intervention programs, audiologists, local and community health clinics, and multidisciplinary CSHCN Bureau teams. Additionally, HSVS staff assist local agencies and programs with public and professional education; standards and guideline development; photorefraction vision screening coordination; Medicaid coordination; and technical assistance and training to local health departments and early intervention providers.

The BabyWatch Early Intervention Program (BWEIP) has fostered the facilitation of services and client referrals between the programs, the provision of joint training and the coordination on contract development. BWEIP staff collaborates with other programs outside the Department, such as working with the Department of Workforce Services (Utah's welfare agency) to design a system of subsidized childcare payment for children with disabilities. For these children, the reimbursement rate to childcare providers is enhanced, dependent on the family income. Through the Map to Inclusive Child Care project, funds were raised to provide training to child care providers to enable them to serve children with disabilities. A state curriculum was developed for childcare providers to improve their delivery of services to children with special needs.

BabyWatch Early Intervention Program (BWEIP) is also developing formal agreements between local Early Head Start and local Early Intervention programs for improved service delivery maximizing the resources of both agencies. Due to these agreements, BWEI programs may provide early intervention services to a qualified child in the Early Head Start setting. Another example of linking is the Inreach Project in which Utah State University, BWEIP and the University of Utah Medical Center are collaborating to allow families to be contacted by early intervention professionals before their child leaves the newborn intensive care unit. When the family and the BWEIP staff make contact, services are offered and an Individualized Family Service Plan (IFSP) is developed in anticipation of the infant's arrival home.

The CSHCN Bureau is working with Medicaid staff and the Children's Mental Health (CMH) Coordinator from the Department of Human Services Division of Mental Health to improve access and services through Utah's Prepaid Mental Health Plans. As part of this effort,

the CMH coordinators will be developing a standardized and improved referral system and release of information form to facilitate the exchange of information.

CSHCN Bureau clinical and case management staff, especially in the Fostering Healthy Children Program, has developed a close working relationship with the case managers in the Medicaid managed care organizations (MCO). This relationship has improved the quality and continuity of care for children served by multiple agencies and providers. CSHCN Bureau staff has been involved with Medicaid and the MCOs in developing and implementing their assessment tool to identify children with special health care needs as they enter the Medicaid managed care system. A standardized tool to be used by all the MCOs to identify and prioritize the needs of children with special needs is being worked on.

3.1.2.4 Population-Based Services

The Division of Community and Family Health Services (CFHS) directly manages a number of programs which provide population-based services for Utah's mothers, infants, children, adolescents, and children with special health care needs, which include SIDS prevention; Pregnancy RiskLine; Baby Your Baby and the other health hotlines operated by the Department; hearing, speech and vision screening, newborn metabolic screening; violence and injury prevention; immunizations; early intervention; and oral health. See Section 5.3 for the pyramid of Utah MCH services by population group. All of these programs and services have been developed in response to identified health needs, risks, and/or health problems among Utah's maternal and child populations and have been designed to address needs through broad-based preventive approaches that include outreach, education, early identification and referral, and improved access to preventive and treatment health care services.

Need for Population-Based Services

The award winning Baby Your Baby Program has promoted early prenatal care since 1988. During the initial seven years of the program, the percentage of women starting early prenatal care steadily increased. However, this trend has reversed in recent years with only 79.7% of women entering early prenatal care in 1998. These decreases may be due to several factors including: an increased number of women entering prenatal care after the first trimester, or not at

all; and, a higher percentage of births with incomplete data for this item on the birth certificate. The most significant factor contributing to the increase in late prenatal care is most likely due to incomplete data on birth certificates. In 1998, there was more than a three-fold increase in the numbers of births without prenatal care entry information recorded on the birth certificates compared to the previous year. The missing information on 1998 accounts for more than 3% of all births that year.

To promote early prenatal care, the Baby Your Baby Program (BYB) has utilized various outreach strategies, such as billboards, coupon books, public service announcements, videos, brochures, and newsletters. The BYB Program has had high visibility in the state through its ongoing television coverage. The Program continues to provide hotline services which allow the public to call for information about financial and resources for pregnancy-related and child health care. The BYB staff provide hotline services for numerous maternal and child health areas, such as immunizations, breastfeeding, or questions about specific conditions related to pregnancy or childhood.

As data have become available about women who don't receive early prenatal care, the BYB Program has developed new strategies, such as targeting public service announcements to women less likely to enter prenatal care (i.e., mothers who have had several previous children). It is clear that current public outreach and education must be continued along with messages targeted to hard-to-reach populations, based on specific data that identify barriers to early prenatal care. In late 2000, the Utah PRAMS project will have data available to enable the Division to identify and address additional barriers to prenatal care.

The Pregnancy RiskLine, with its statewide toll-free phone service, was established in 1984 as a joint effort by the Utah Department of Health and the University of Utah Health Sciences Center to address the growing need for accurate information about teratogens in pregnancy and lactation. This information is often not easily accessible to health care practitioners or consumers. Since it is common for pregnant and lactating women to be exposed to medications/drugs, chemicals, infectious agents and other potentially harmful situations, misinformation is frequently transmitted. Although there is an increased sensitivity during pregnancy to the possibility of having a child with a birth defect, women often feel their risk of having an affected child is higher than the actual risk posed by the exposure because of the poor

quality of available information about fetal effects. These perceptions of heightened risk have too often led to termination of otherwise wanted pregnancies, increased anxiety, requests for unnecessary and costly prenatal diagnostic procedures as well as repeated screening and testing of the in utero exposed infant. The Pregnancy RiskLine provides up-to-date, accurate information to consumers and health care providers regarding potential risk to a fetus or an infant due to various exposures whether they are medications, illicit drugs, chemicals, viruses, etc. Since its inception, demand for RiskLine services has steadily increased from just over 2,000 calls in its first year to more than 9,000 calls in 1999.

Although the Utah SIDS rate has decreased substantially along with the national rate decline, counseling and education about SIDS risk reduction needs to continue, especially those targeted for specific populations, such as low socio-economic status or non-White parents; grandparents and parents who have had children before 1994 who may be less familiar with the strategies known to reduce risk for SIDS; and, daycare providers. Continued public education is critical to reach these groups and further reduce SIDS deaths.

Utah's immunization rates have been one of the lowest in the nation for the past ten years. In 1999, Utah ranked 25th in the nation, up from 44th in 1998, and 51st in 1997. The coverage levels for two year-old children increased from 64% in 1996 to 82% in 1999. The Utah Immunization Program provides statewide coordination for childhood, adolescent, and adult immunization efforts, as well as other needed technical assistance and support through a variety of mechanisms.

Sixty-five percent of Utah children six through eight years of age have experienced tooth decay compared with 52% nationally. Untreated tooth decay, an important measure of access to dental care, ranges from 10% to 42% in this age group in Utah's twelve local health department areas. In five of these areas, six through eight year-old children have a higher rate of untreated decay than the national average of 29%. (National figures are derived from a 1988 survey. Utah figures are from a 1996 DMF (decayed-missing-filled) survey.) Statewide DMF surveys are typically done every five years; the next statewide survey is planned for the fall of 2000.

According to the recent Surgeon General's Report on Oral Health, fewer than one in five Medicaid-covered children (20%) nationwide receive preventive dental services. In FFY 1999, 28% of Utah Medicaid-covered children, birth through 20 years of age, received at least one

dental service. Although the utilization of dental services by Medicaid-enrolled children in Utah has gradually increased over the past several years, there is substantial room for improvement. Obtaining access to a dentist is still difficult for many Medicaid enrollees due to low reimbursement rates and provider unwillingness to serve this population.

Utah CHIP began enrollment in August 1998, and provides coverage for dental services through PEHP (Public Employees Health Program). Data collected from August 1998 through May 2000 indicate that forty-three percent of children enrolled in Utah CHIP have received dental services. Although Utah CHIP has proven a valuable resource to enrolled children, the scope of CHIP dental benefits is not as broad as that for children enrolled in CHEC/EPSDT. Of particular concern is the lack of coverage for stainless steel crowns and general anesthesia, both benefits primarily for young children with very critical needs.

Substantial numbers of low-income children still remain without dental insurance, and do not qualify CHIP because they have some medical insurance. An estimated 13,000 to 19,000 of Utah children between 100-200% of the Federal poverty level poverty have health insurance which does not include dental coverage. In order to address this concern, CFHS is currently working with the Blue Cross/Blue Shield (BC/BS) Caring Foundation to establish a program whereby these children could receive services from a BC/BS dentist. The scope of services provided through the Caring Foundation would be identical to those provided by PEHP dentists to children enrolled in CHIP.

In Utah, injury is the leading cause of death for children 1- 19 years. During 1995-1997, there were 624 injury deaths among Utah children ages 1-19 years (29 per 100,000), accounting for 69% of all deaths in this age group, of which 299 or 48% of all injury deaths were attributable to motor vehicle crashes. In addition, 7,398 injury-related hospitalizations cost over $69 million in inpatient charges, of which 1909 hospitalizations due to motor vehicle crashes resulted in over $25 million in charges. In addition to the personal and societal cost of injury deaths, the impact of non-fatal injuries is significant in terms of personal suffering, disability, and financial burden. Suicide is the second leading cause of death among Utah teens 15-19 years. For the past several years Utah has ranked among the ten highest states in the nation for teen suicide rates. During 1995-1997 there were 113 suicide deaths in Utah among teens 15-19 years (19.2 per 100,000) accounting for 23% of all deaths in this age group. However, males account for 95 of these teen

suicide deaths (32.5 per 100,000) making suicide the leading cause of death for males age 15-19 years.

Over 90% of all adult tobacco users started before age 19 and over 60% by age 14. More than 3,000 youth nationally start using tobacco every day and over 1/3 of them will die from tobacco-related causes. Tobacco use is the number one preventable cause of death. Over 30,000 Utah youth age 12-17 years old report being regular users of tobacco, with 61% of these reporting they have tried to quit. Youth tobacco users show a low level of confidence in quitting without help. In the past 30 years, focus has been on adult smokers leaving a significant gap in understanding adolescent nicotine addiction.

Successful illegal buy attempts by underage youth have ranged from 60 to 70% in areas of Utah where there has been no active compliance testing, retailer education, positive recognition or other related interventions. In areas of Utah where there have been interventions, the illegal sales rate has dropped below 20%. The problem of youth access is considered so significant that recent federal regulations require all states to take active steps to monitor and reduce youth access to tobacco. These regulations, the Synar amendments, mandate that states develop and maintain an active program for reducing illegal sales rates to 20% or less.

Newborn metabolic disorders, such as phenylketonuria (PKU) and others, have been considered the most preventable cause of mental retardation. The 1965 Utah Legislature passed a statute requiring that every newborn in Utah be tested for phenylketonuria, galactosemia and congenital hypothyroidism. These conditions are seen infrequently, and newborns appear normal at birth. Occurrence rates for the disorders are 1/10-12,000 births for phenylketonuria, 1/40-50,000 births for classical galactosemia, and 1/4,000 births for congenital hypothyroidism. If left untreated, symptoms are often seen too late to prevent permanent impairment. Untreated phenylketonuria can result in mental retardation, seizures, and emotional disorders; untreated galactosemia can result in mental retardation, growth retardation, cataracts, liver dysfunction, and death; and untreated congenital hypothyroidism can result in mental retardation and growth retardation. All three of these conditions are pan-ethnic. PKU is found with highest frequency in Caucasians of European ancestry (approximately 1:10,000 births) and rarely in the Afro-American population. No difference is found in galactosemia among the various racial or ethnic groups.

Congenital hypothyroidism tends to have a sexual bias with prevalence higher in females (2:1), with the highest risk being Hispanic females.

Four to six in every 1000 infants are born with sensorineural hearing loss and 2% of children under 18 years have permanent hearing impairment. Disorders of hearing, speech and language constitute a major public health problem and, according to the National Center of Health Statistics, are the most frequently reported cause of morbidity in the U.S. In Utah, 1 in 10 children suffers a significant communication problem, which, if undetected and untreated early, may adversely affect their social, educational and vocational development. To assure early identification, Utah legislature passed mandated newborn hearing screening effective July 1998. The screening is recommended by the Joint Commission on Infant Hearing, the American Academy of Pediatrics, the National Institutes of Health, and the Centers for Disease Control and Prevention. The Hearing Speech and Vision Screening Program oversees newborn hearing screening and works to ensure that all newborns are screened before they are discharged from the hospital.

Need for State's involvement in these direct services and programs

Development of effective interventions and strategies to decrease the number of Utah mothers who receive inadequate prenatal care is needed to address this increasing problem in Utah. It will involve identification of characteristics of women receiving late or no prenatal care and barriers to care and then strategies to address barriers specific to individual at-risk groups of women. One valuable source of data will be the Utah PRAMS (Pregnancy Risk Assessment Monitoring System) Project, which includes questions on entry into care and barriers to care. Since data from PRAMS will not be available until late 2000, it will be a while until the Division has access to this data to develop strategies.

Another source will be qualitative data from private and public providers and community leaders representing disadvantaged and minority groups. Collaboration with these entities will be needed to develop effective outreach and educational strategies for hard-to-reach populations. The state capacity for data analysis and interpretation will be required to disseminate findings. An extensive evaluation of the Baby Your Baby Program will be completed later in 2000, which will provide valuable information about the program's impact on targeting and serving populations in greatest need.

In order to coordinate counseling and education to reduce risk, the state SIDS Program works with local health departments to serve families. SIDS efforts need to be coordinated at a state level because of infrastructure building, ready access to confidential information by the state agency, and opportunities for collaboration, accurate and complete data collection and analysis, and education. The SIDS Program maintains a database of information, which includes important information that is not obtainable otherwise because it is collected by public health nurses who visit families affected by SIDS. The state assumes the responsibility for maintaining and analyzing the data related to SIDS to be used for developing new strategies or identification of new target populations based on the analysis of the data.

Since medical, nursing, pharmacy and other health-related schools do not usually provide courses in human or clinical teratology, most practitioners are not prepared to assist their pregnant or lactating patients with questions and concerns related to teratology. Prenatal and pediatric care providers throughout Utah advocate the statewide RiskLine services to their patients, as well as to the managed care groups to which they belong. More than 85% of public callers to the RiskLine were referred by health care providers. The service is provided to callers after extensive research into the research literature and other scientific sources to ensure that accurate information is provided to all callers.

In 1979 the Department of Health established a statewide Newborn Screening Program to oversee and coordinate metabolic testing of all infants born in the state for Phenylketonuria (PKU), with the addition of galactosemia and congenital hypothyroidism. The cost effectiveness of screening has been well established, with screening for Phenylketonuria (PKU) and congenital hypothyroidism saving $3.2 million for every 100,000 infants screened and $93,000 for each identified and treated case. It is anticipated in the future that Utah's newborn screening will be broadened to include other metabolic diseases, such as hemoglobinopathies. This expanded screening plan will require statewide coordination of efforts to ensure successful implementation.

By legislation, the Utah Department of Health is the central data repository for universal Newborn Hearing Screening (NHS). The Hearing, Speech and Vision Program (HSVS) administers the Utah Newborn Hearing Screening Committee, required by the legislation, which involves representatives from pediatrics, family practice, neonatology, early intervention, private insurance, other agencies and parents. CFHS staff developed the Administrative Rules for the

NHS Act, compiled a list of statewide screening and diagnostic resources, and issued recommended audiologic diagnostic protocols. All hospital screening programs are required to submit their screening equipment and protocols to HSVS for approval. Monthly data reporting from birthing institutions is required by HSVS and quarterly screening program coordinators' meetings are held at four regional sites. HSVS has ongoing coordination with the National Center for Hearing Assessment and Management (NCHAM) at Utah State University for software development, technical support, training, and equipment management. HSVS coordinates with other CSHCN Bureau programs, local public health offices, and other public and private agencies and providers.

The Utah Immunization Program has undergone significant changes in administration, program priorities and policies, program staffing and staff assignments that should work to accomplish improved immunization rates among Utah's children. The Utah Immunization Program provides statewide coordination for childhood, adolescent and adult immunization efforts through a variety of mechanisms, including oversight, data collection, identification of high-risk populations, clinical assessment of immunization levels, disease surveillance, coalition development, and vaccine management. The Program supports a statewide delivery system through contracts with local health departments, community and migrant health centers to fund activities to promote immunization services and education at the community level. The Program provides needed technical support, clinical and programmatic consultation, funding assistance, educational materials and access to training through satellite CDC courses to ensure that immunization services are available to all children and adolescents throughout the State. The Immunization Program administers the Vaccine For Children Program (VFC), which provides free vaccines to public and private providers to increase access for qualified children birth through 18 years of age. The Immunization Program will continue its emphasis on immunizations for the 0-2 population, but also has established a goal of increased focus on adolescent and adult immunizations for the next five years.

In conjunction with Immunization Program efforts to accomplish improved immunization rates among children, the Utah Department of Health has developed the Utah Statewide Immunization Information System (USIIS), a statewide immunization electronic information system. USIIS has been developed through partnerships with professional organizations,

insurance companies, managed care organizations, and public health agencies. When fully operational, USIIS will serve as a central registry to maintain current immunization information for children in Utah, making this information available to authorized public and private providers. Currently, USIIS is up and running in 22 local health department clinics. As part of data integration efforts, USIIS has linked to two major childhood databases in the Utah Department of Health. Vital Records and WIC exchange immunization information with USIIS to make immunization records more complete. It is expected that by 2001 USIIS will be accessible by schools. USIIS simplifies immunization record keeping, provides quick access to immunization records and track individual immunization status. USIIS will allow the Immunization Program and health care providers to track immunization rates in a much more efficient manner than in the past. The Registry will prevent repeat immunization administration due to poor recording keeping, and will enable providers to easily track the immunization status of their patients.

In May 1999, the Utah Oral Health Initiative was established with the goal of building a high quality integrated system of oral health care for underserved children in Salt Lake County and other selected communities in Utah. In July 1999, the CFHS Oral Health Program facilitated the development of the Salt Lake Valley Health Department Oral Health Task Force and the development of six subgroups which include: Data/Needs Assessment; Clinics; Patients; Special Needs; Volunteers; and Prevention. Oral Health Program staff actively participates in each of these subgroups and provides technical assistance and consultation as needed in the collection and interpretation of data for needs assessment and reporting.

The state has provided seed monies for a dental health clinic in a rural health department, Tricounty Health Department. The Oral Health Program strongly supports fluoridation of community water systems. The Utah 2000 Legislature passed a bill allowing counties of the second class to present a referendum to its residents to vote on fluoridation. Davis and Salt Lake Counties will have fluoridation on the November 2000 ballot and three other counties, which include Utah and Weber Counties, are working actively toward the same. There are only two communities in the state with added fluoride in the water supply: Brigham City in Box Elder County and Helper in Carbon County.

Since none of the local health departments has a dental director to provide oversight of community needs, it is vital for the state to continue to expand its efforts to promote better dental

health care and access, especially for the disadvantaged populations. The state staff plays a key role in assisting communities, provider and advocacy groups, insurers, and other partners to improve the oral health status of Utah children by developing effective strategies to promote and implement prevention-focused activities and by seeking ways to improve access to oral health care services. The Oral Health Program is committed to promoting oral health as a priority for a broader population of Utahns, i.e. pregnant women whose poor oral health may impact their pregnancy. Additionally, the state needs to be committed to addressing the particular dental needs among MCH populations by developing strategies, which will improve oral health status.

The Division is currently recruiting for a new Dental Health Director for the state who will also serve as the Oral Health Program Manager. It is anticipated that the new Director will work to develop effective strategies to promote oral health in the state, and to seek funding for improved oral health among Utah citizens.

The mission of the Violence and Injury Prevention Program (VIPP) is to reduce the incidence of fatal and non-fatal injuries among Utah residents by collaborating with Department and community partners to improve injury data collection, epidemiology and research for use in prevention planning, implementation and evaluation; conducting education to a) increase awareness about the causes and preventability of injuries; b) promote behaviors that prevent injuries, e.g., use of seat belts, bicycle helmets, smoke detectors, etc.; and c) promote policy changes, legislation and enforcement activities that reduce injury hazards or increase safe behaviors, e.g., standard seat belt law, graduated driver licensing, school zone speed limit enforcement, etc.

Correct use of vehicle occupant restraints and bicycle helmets has been demonstrated to reduce the incidence and severity of crash injuries and deaths. Although a standard seat belt law was passed in the 2000 legislative session, Utah does not have a law requiring bicycle helmet use and it is unlikely to be enacted in the near future. In recent years coordinated community-based efforts have resulted in a modest increase in helmet use. However, Utah's bicycle helmet use rate among 5-12 year-old bicyclists in 1998 was 12.65%, still far below the national objective of 50%. There is need to continue to expand the successful methods which have been piloted in several communities throughout the State.

Education about the importance of and the correct use of occupant restraints, especially infant and child safety seats, and bicycle helmets, needs to be continued in order to reduce the preventable deaths due to their lack of use or incorrect use.

Although there have been numerous studies that identify causes and contributing factors as well as treatment and intervention for those who attempt suicide, little is known about early identification and effective prevention measures for teens who may be at risk but have not yet attempted suicide. The Violence and Injury Prevention Program has supported the Utah Youth Suicide Study and the Utah Suicide Prevention Task Force. There is a need to apply the results of the Youth Suicide Study in planning, implementing and evaluating prevention strategies for high-risk youth.

Assess and describe the State's coordination with other agencies and organizations (e.g. managed care, provider groups, Universities etc.) in the provision of direct services and programs.

Baby Your Baby coordinates with many different groups through its advisory board, consisting of representation from Intermountain Health Corporation, the state's largest health care system and managed care organization, a local affiliate of CBS and others. The Advisory Board meets regularly to provide input to the Department on priorities and mechanisms to accomplish the priorities. Baby Your Baby staff also provides coverage for other Department of Health hotlines, such as the Immunize by Two Hotline, Truth about Tobacco Hotline, Health Resource Line (which is a general health resource hotline callers can phone to obtain needed information about resources in their communities), and the CHIP Hotline. Each of these hotlines has an advisory committee or board with which the Department coordinates efforts. In addition the Department also has a BabyWatch/Early Intervention Hotline that is a separately operated hotline from the others.

The Pregnancy RiskLine has a close relationship, in fact, a partnership, with health care professionals at the University of Utah Health Sciences Center. For example, one of the leading supports for the RiskLine and its work comes from a medical geneticist at the University. In addition there is a strong collaborative relationship with a medical bioethicist, etc. It is anticipated that this relationship will be strengthened with the recently awarded Genetic Services and Data

Integration Grant from the Maternal and Child Health Genetic Services Branch grant and the reconstitution of the Genetics Advisory Board

Students in the medical, pharmacy, nursing and health education schools at the University of Utah, Salt Lake Community College and Westminster College all participate in a rotation with the Pregnancy RiskLine Program. Ongoing continuous education to community health providers is done in collaboration with medical associations, such as Utah Medical Association, Intermountain Pediatric Society (Utah's chapter of the American Academy of Pediatrics), and the Utah chapter of American College of Obstetricians and Gynecologists, and other health professional groups. During the first 15 years of operation, more than 5,000 medical residents, pharmacy and nursing students, community and academic physicians, nurse midwives, pharmacists and other health care practitioners have received education from the Pregnancy RiskLine.

The Immunization Program supports care in the primary care medical home and prevents missed opportunities by offering the Vaccines for Children (VFC) Program. The VFC Program puts free vaccine in provider offices for eligible children ages 0-18. This enables providers to more fully meet the needs of their clients without having to be referred to another provider for immunization coverage.

CFHS staff has also participated in health fairs throughout the state to promote maternal and child heath issues, such as early prenatal, dental care and SIDS risk reduction. Staff has participated in health fairs on Utah Indian reservations at the request of various tribes. These health fairs are funded through a DREAMM Grant (Developing Reservation-based Efforts Addressing Mortality and Morbidity) obtained by the Ute Indian Tribe, which has provided opportunities to present public education messages to tribal members on MCH issues. The fairs also have provided opportunities to collaborate with tribal and local agencies in improving delivery of maternal and child health services.

The Utah Immunization Program regularly coordinates and collaborates with managed care organizations, public and private providers, community health centers, and Medicaid in the provision of statewide services, outreach, and education.

The Utah Immunization Program has a strong relationship with Medicaid to provide vaccine to eligible children ages 0-18 through the VFC program. Both coordinate vaccine management issues and support for private and public providers. The Immunization Program also

coordinates with Medicaid to support the media campaign for public education on vaccine issues targeting the 0-2 year old age group. Since WIC linkage activities are mandated on a federal level, coordination with WIC allows immunization education, outreach and access activities at WIC clinics statewide. The Utah Immunization Program coordinates with major providers of health-related services such as American Academy of Pediatrics, Utah Medical Association, community health centers, managed care organizations, and Children's Health Insurance Program (Utah's CHIP Program). The program supports the Every Child By Two Taskforce chaired by the First Lady with the goal of education, increased access and rates for 0-2 year olds. The state task force supports development of local coalitions.

The State Scientific Vaccine Advisory Committee was first convened in 1999 to provide some scientific input to the priorities and policies of the Immunization Program. Members of the committee include representation from a local health department officer (who also is a pediatrician), the state epidemiologist, a family practice physician, a pediatric physician, a medical communicable disease specialist, and Medicaid. The committee meets quarterly to review recommended practices and provide recommendations to the state as to necessary actions. The most recent recommendations the Vaccine Advisory Committee made to the state was to mandate for day care and school entry vaccination with varicella and Hepatitis A. At this point, the Immunization Program is evaluating the ability to provide these vaccines for this population if the mandate were implemented. It looks unlikely that, because of cost of the vaccine and available resources, the recommendation for varicella will not be possible at present. Continued collaboration with these partners is vital to the program, as is the identification of new public/private partnerships to support the immunization registry and outreach and education efforts to improve Utah's immunization rates.

The Immunization Registry, (USIIS – Utah Statewide Immunization Information System), is coordinated with the Immunization Program, Medicaid, WIC and others outside the Department of Health. The effort has been supported through state funding, as well as federal immunization program funding. USIIS has an oversight committee consisting of Department representatives, as well as representatives from the private provider community, managed care organizations, and local health departments.

The Oral Health Program works with state and local partners to identify and address oral health needs of Utah's children to assist them in planning, developing, and implementing improved programs and/or effective systems of care and to improve access to and appropriate utilization of dental health services among Utah's children. Consultation and technical assistance services offered by Program staff in regard to needs assessment, statewide data and surveillance, promotion of oral health prevention measures, program planning and systems development, are available to all twelve local health departments as well as to public and private agencies and providers within the State.

The Oral Health Program is an integral player in the FACT Initiative, a collaborative effort among the Departments of Health, Human Services, and Workforce Services, the State Office of Education, and the Office of the Courts.

Using the Oral Health Task Force model implemented in Salt Lake County, an Oral Health Initiative needs to be expanded to include selected communities to build an integrated system of oral health care for underserved children. Collaboration among many players in these communities must be accomplished in order to coordinate growth of the system, outreach and referral, volunteer services, special needs services and public awareness. Prevention must be maximized to reduce the demand upon the system.

The previous Dental Director, who retired in spring of 2000, was a member of Utahns for Better Dental Health, a group organized to promote community water fluoridation in Salt Lake County, served as a consultant to county boards of health throughout the state which are involved in water fluoridation activities, and also as a member of the Utah Dental Association Dental Access Committee. The acting Oral Health Program Manager, a registered dental hygienist, is continuing these collaborative activities until a new Director is hired. The new Director will further strengthen those collaborations already begun, and broaden program activities beyond those directed solely for children. The issue of dental health services for pregnant women and mothers is an area that the Division hopes to expand to oversee, as well as oral health among other populations. The program, which previously had been located in the Division Support Services Bureau, was relocated in the Maternal and Child Health Bureau in July 2000.

To reduce injuries among Utah children, the Violence and Injury Prevention Program (VIPP) collaborates with many partners including other UDOH programs, state and local

agencies, local health departments, businesses as well as non-profit community organizations, health care providers and others. Activities that involve the program's partners include: efforts to pass legislation for primary enforcement of seatbelt use for children and young adults up to age 19; participation on the Motor Vehicle and Pedestrian Safety Committee created by the 1999 Legislature; pedestrian safety awareness; appropriate car seat use and bicycle helmet use; participation with the SAFE KIDS Campaign and collaborating with the Coalition to sponsor the annual Utah SAFE KIDS Week; semi-annual Injury Prevention Partnership Summits; the Utah Youth Suicide Study, a three-year research project coordinated with the University of Utah; the Suicide Prevention Plan for Utah; and the interagency Child Fatality Review Committee. VIPP staff members also collaborate with local health department (LHD) staff in evaluating local injury issues, planning interventions and evaluating progress toward injury prevention goals through use of injury data. VIPP conducts periodic local health department site visits for monitoring and training purposes. VIPP coordinates and has direct access to three injury databases, the Student Injury Report System, the Traumatic Brain Injury Registry.

The interagency Child Fatality Review Committee (CFRC) was established in 1992 by the Violence and Injury Prevention Program (VIPP), under the auspices of the Utah Department of Health. CFRC brings together the many diverse agencies and organizations that serve Utah children and families, with the goal of better understanding the causes and circumstances of child fatalities in the hope of preventing future deaths. Committee representation includes the Medical Examiner's Office, Office of Vital Record and Statistics, Emergency Medical Services, Reproductive Health Program, Department of Human Services, State Office of Education, Attorney General's Office, Administrative Office of the Courts, local law enforcement agencies, Criminal Justice, Child Protection Team from Primary Children's Medical Center and others. This multi-disciplinary committee reviews all available information on child deaths in order to identify and describe: 1) prevalence of risk factors among deceased children; 2) trends and patterns of child deaths in Utah; 3) response of service systems to high-risk children; 4) preventable deaths and strategies to reduce the number of child deaths; 5) accuracy and completeness of information on death certificates; and 6) strategies to improve the quality of care to the child and family through provision of professional and community education. The CFRC also works to assure complete and thorough investigations are performed on all child deaths, to

maximize resources through collaboration, and to make policy recommendations to improve the system response.

Geographic availability/distribution and funding of direct services and programs

Each local health department receives Title V Maternal Child Health (MCH) Block Grant monies and prioritizes its MCH services by determining the amount of funding for each service. These services may include:

- Prenatal services
- Family planning
- Child health services
- Immunizations
- Oral health
- School health
- Communicable disease control
- Hearing, speech and vision screening
- Early identification and referral of children with special health care needs
- Injury prevention and control
- Sudden infant death follow-up
- Child mortality review

The Division provides Title V, state, CDC and other sources of funding to local health departments to offer services to the maternal and child populations in their areas. Although not all local health departments are able to offer all services needed by the MCH populations, they offer the services they believe are a priority in their communities. Some local health departments coordinate efforts with adjacent departments in order to maximize resources.

Although MCH funding to local health departments has remained static for several years, the numbers of clients served has increased in many areas, decreasing the amount of funding available per client served. Most health departments supplement MCH funds with local funds and grants.

The SIDS Program, which offers services statewide, is funded primarily by federal MCH funds, although some activities for the SIDS Awareness Campaign have been funded through grants and private donations.

Public outreach and education are incorporated in all of the maternal and child health programs throughout the state. The various hotlines operated by the Department for individuals needing information are available throughout the state via 1-800-numbers.

Access to the services provided by the Pregnancy RiskLine is facilitated statewide through the program's toll-free telephone service. Consumers, as well as health care professionals, call Pregnancy RiskLine if they have questions about potential impact of an exposure on a pregnancy. These services are available to callers during regular business hours; however, the program has an answering machine that enables program staff to return calls to callers who have accessed the program during non-business hours. Pregnancy RiskLine staff also provide many educational presentations to community and health care provider groups across the state. Pregnancy RiskLine services are funded through Title V, University of Utah Health Sciences Center funding, grants from the federal government as well as from private non-profit, such as the March of Dimes Birth Defects Foundation, and other sources. Birth Defect Network, part of the Pregnancy RiskLine program, is funded through the federal MCH Block Grant, as well as from smaller grants from the local and national March of Dimes, the Centers for Disease Control and Prevention, the University of Utah Medical School, and from private foundations.

WIC services are available statewide, with all program funding coming from the United States Department of Agriculture.

FACT Nursing and Prenatal to 5 Home Visitation contract services are offered by all local health departments except Summit County.

Services supported through the Utah Immunization Program are available statewide, with funding from several sources, including a CDC grant, state general fund for vaccine, and the Maternal and Child Health Block Grant. These services are available through local health department, community health center, and migrant clinics, as well as in private provider offices. Currently, there is a need to establish a funding formula with base level funding for local programs. CDC has cut local program support, making it difficult to maintain immunization services in the local health departments. Although each health department receives some CDC

funding for immunization services, more efforts to recuperate costs from third party payers need to be implemented. Outreach and education efforts are supported through private funding from corporate and media partners and Medicaid match.

In Utah, 13% of Medicaid covered children and adults receive dental services from five Family Dental Plan Clinics, which are Medicaid-only clinics managed by the Division of Health Care Financing/Medicaid, located in Salt Lake City, Ogden, Provo, and St. George. Additionally, there is one local health department Medicaid-only dental clinic in Vernal. Four community health center dental clinics are also available to serve adults and children who are covered with Medicaid or can pay on a sliding fee scale. Three of these clinics are located in Salt Lake County, and done in Utah County.

Community-based injury prevention programs are available in each of the twelve local health departments (LHD) through contracts from the Violence and Injury Prevention Program (VIPP). These prevention programs address occupant protection and child car use, bicycle safety and helmet use, pedestrian safety, etc. throughout the State. While individual LHDs are encouraged to base their injury prevention plans on the unique needs of their local communities, all are required to include at least one major component that addresses motor vehicle crash injury prevention including occupant protection, bicycle helmet use or pedestrian safety. VIPP activities are funded primarily through the Maternal and Child Health Block Grant and the Preventive Health and Health Services Block Grant, with some additional funds being provided through the Utah Highway Safety Office and some categorical grants.

Tobacco Prevention and Control Program activities are funded through state and federal sources and are carried out in all local health departments. Federal sources are the Prevention Block Grant and Centers for Disease Control and Prevention Office of Smoking and Health National Tobacco Control Program. State sources include funding from the National Tobacco Master Settlement Agreement and a Tobacco Prevention Restricted Account from tobacco excise tax.

There are six hearing, speech and vision regional diagnostic centers and eighteen traveling clinic sites that coordinate with local community resources. The Newborn Hearing Screening systems are funded through a variety of resources, including Title V, early intervention funds,

PART H, hospitals, managed care organizations, private insurance reimbursement, Medicaid and family resources

Newborn metabolic screening is available in every hospital in the state and through provider offices. Funding for the program primarily comes from the hospital purchase of screening kits.

The Bureau of Children with Special Health Care Needs continues to provide direct and enabling services to special needs children who are unable to access services through other sources and in collaboration with the tertiary care centers. These direct services include rural multidisciplinary pediatric clinics; early intervention services in 12 rural and 7 urban centers; newborn follow-up multidisciplinary clinics for newborn ICU graduates in Salt Lake, Provo and Ogden clinics; and two behavioral and developmental clinics in Salt Lake City through the Adaptive Learning and Evaluation and the Child Development Programs. The System Development Program works with the clinical programs to improve the provision of enabling services to all children with special needs in the areas of transition, cultural sensitivity and improved access to SSI services. Case management and other enabling services are provided to children who are followed in clinics or early intervention centers, and to children served by dedicated case management programs such as the Fostering Healthy Children Program and the Technology Dependent Care Waiver.

Through a state/local partnership in nine rural areas, the CSHCN Bureau contracts with local health departments to provide on-site nursing case management and clerical support services, including scheduling of clinics, providing follow-up after specialty clinics are held, management of records and development and implementation of individual care plans. See Community Based Services map in Section 5.3. The Bureau also contracts with the private non-profit parent organization, LINCS (Liaisons for Individuals Needing Coordinated Services), to attend clinics, provide family advocacy and assist in the promotion of family-centered care for children seen in the itinerant clinics. The nurse case manager is responsible to assist the local primary care physician and family in coordination of specialty and tertiary care.

3.1.2.5 Infrastructure Building Services

Comprehensive system of service

Comprehensive service systems for Utah's mothers and children must include a broad range of preventive, primary, secondary, and tertiary health care services that are available and accessible to all mothers and their families, regardless of income. These services must also be coordinated with other health-related, educational, and social services so that a complete spectrum of services is offered in a cohesive and seamless manner, thus facilitating continuity of service delivery. Comprehensive systems of services must include both direct and enabling services, and must be built on an infrastructure with adequate resources to support ongoing financing of care, needs assessment and planning, surveillance, data collection, program monitoring and evaluation, quality improvement, provider education and training, community/systems development, and research based on complete population data.

In order to best meet the needs of Utah's children and their families, service delivery systems must be available, affordable, coordinated, effective, culturally sensitive, acceptable, family centered, community-based, and accountable. Across all health care services, quality must be maintained according to established standards.

At the state level, what is needed to promote such systems of services are:

- adequate funding to support systems development and service delivery
- continued availability of expert staff to provide technical assistance, training, and consultation in various clinical and programmatic areas related to maternal and child health
- development and/or adaptation of policies, standards and guidelines
- adequate data collection and analysis systems
- ongoing monitoring of program effectiveness
- needs assessment-based program planning
- systematic and ongoing evaluation of programs and services

The three figures in Section 5.3 outline existing services or programs in Utah for each of the three MCH populations according to level of service.

In order to fully evaluate the needs of mothers, children and families within the state, more information is needed. The Utah PRAMS (Pregnancy Risk Assessment Monitoring System) will be able to analyze its first year of data later this year. These data will provide invaluable information about the needs of pregnant women in the state. When available, the more detailed

analysis of the Utah 2000 Child Health Survey data will provide state planners with important information about the issues that are critical for children's health, including children with special health care needs, that the state has never had access to previously. This information will be available early FY01 for staff to begin working to identify key issues relevant to children in Utah and to develop strategies to address these issues.

Currently steps are being taken to develop and implement a comprehensive oral health care system for low-income, uninsured children and adults and people with disabilities. In July 1999, the Utah Oral Health Initiative was implemented in order to conduct needs assessment, strategic planning, and system development. Collaboration is taking place to coordinate growth of the system, outreach and referral, volunteer services, services for people with special needs and public awareness. In October 2000, the Utah Oral Health Summit, sponsored and facilitated by HRSA and HCFA, will take place, at which time the first annual report of the Salt Lake Valley Health Department Oral Health Task Force will be presented and the many participants from around the state will develop strategies for improving oral health status I local communities.

Additional components of a comprehensive health care system for MCH populations that need attention include adequate funding to support systems development and service delivery; there never is enough funding to provide the needed services in the state, even with influx of local funding. There is always the challenge to determine best use of limited funds and often the decision has to be made between putting the dollars into treatment or into infrastructure development and prevention. One of the challenges created by the 2000 Utah Legislative session was a budget cut to the Department of Health that was to address the legislators' perceived need to find more dollars to fund direct services for disabled individuals in the state who were currently on waiting lists. During the next fiscal year, allocation of MCH funding among local health department will be examined to determine if reformulation of the funding needs to be done.

Another need in the comprehensive health care system is continued availability of expert staff to provide technical assistance, training, and consultation in various clinical and programmatic areas related to maternal and child health. Staffing has become a problem both locally as well as on a state level due to a nursing shortage that makes it difficult for the public sector to compete with private sector salaries. Funding for identified necessary positions has been lacking. For example, to adequately address both adolescent health and school health issues in

Utah, there is need to expand the current combined position into two positions. However, since funding has been lacking, potential funding sources are continually being sought to add another nurse consultant whose time could be designated specifically to adolescent health issues.

Another staffing need at the state level is a MCH epidemiologist to perform more detailed analysis of MCH data that can be used in program planning and implementation efforts. Examples include: analysis of pregnancy-related risk factors that contribute to low birth weight among Utah mothers; and Utah has a significantly higher induction rate compared to the rest of the nation and further data analysis is needed to determine if this observation is impacting pregnancy outcomes, costs of health care, etc. Some excellent injury data are available but underutilized. If Utah had a MCH epidemiologist, data currently not being analyzed could be used for injury prevention needs assessment, planning and evaluation. Meeting these needs will require a review of funding allocations to determine if funding can be reallocated to address identified staffing needs.

Utah has developed strong data capacity in terms of data collection and analytic systems that provide public health officials and interested others with valuable data. Various databases containing information on MCH populations have been developed which include the perinatal mortality review, child fatality review, SIDS, etc. The Department has developed larger databases that are useful for public health staff, such as the Hospital Discharge database, and Action 2000 which includes birth and death data. The Office of Vital Records and Statistics works closely with the CFHS Division staff to provide data access as needed. For example, the Office provides the birth certificate files from which the PRAMS monthly sample is drawn; files of infant deaths for programs, such as newborn screening and immunizations, that require direct contact with parents, enabling these programs to delete families whose babies have died from their contact lists. The Immunization Program is able to obtain information about Hepatitis B vaccination among infants because it is recorded on the birth certificate.

Larger data systems have also been developed that provide a broader range of data for program planning. These include: 1) the Utah Pregnancy Risk Assessment Monitoring System (PRAMS) project, which is state funded but operated under a Memorandum of Understanding (MOU) with the Centers for Disease Control and Prevention. The MOU requires state compliance with PRAMS methodology in order to include Utah data with the other CDC PRAMS state data. Utah PRAMS was started in 1999 with first year's data will be available late

fall 2000. 2) The Child Health Survey, funded through SSDI grant funds, surveyed families with children as well as those with special health care needs. Preliminary analysis of data from this survey was available for both the child population as well as the children with special health care needs population for inclusion in this grant application. Further analysis will be necessary in order to fully utilize the data from the survey for identification of issues related to child health care and the development of strategies to address identified issues for both populations. 3) Immunization Registry known as USIIS (Utah Statewide Immunization Information System. This registry will enable health care providers to check on immunization status of their patients. 4) The USIIS-WIC bridge which enables local WIC staff to enter immunization data which is later downloaded into the USIIS data base; and 5) MatCHIIM, an internet-based interactive query system that addresses data analysis needs of many of the MCH Performance and Outcome measures. MatCHIIM has increased access to data in the Department, as well as for communities. Data are available on a statewide, local health department, county-level, and small area level, making the data very practical for public health officials to access and utilize for identification of problem areas at several different geographic levels. All of these data sets have increased the data capacity of the Division to address needs of all three MCH populations.

Other databases that are available but have been underutilized for program planning include the following databases: WIC Program, Medicaid, Child Fatality Review, and Injury.

The Department has embarked on the beginning development of an integrated data project, the Child Health Advanced Record Management (CHARM) initiative, which is a collaborative effort between the Department's Chief Information Systems Officer, the Office of Vital Records and Statistics, and Children with Special Health Care Needs' Newborn Screening Program and Hearing, Speech, and Vision Services Program. The short-term goal of CHARM is to link hearing screening records, newborn metabolic screening records, and birth certificates so that a large number of health outcome indicators and risk factors will be brought together for the entire population of children born in Utah. Future plans include linking other child health data sets, such as WIC and immunizations, etc. The long-term goal of CHARM is to integrate early childhood databases to provide Utah families, private and public health care providers with secure, confidential access to a comprehensive, integrated public health database to track the health of Utah children.

The Bureau of Children with Special Health Care Needs established the cultural diversity committee, which includes representative from Primary Children's Medical Center, Utah University Medical Center, Americorps, CSHCN Bureau and others from culturally diverse backgrounds. The two large categories of barriers to health care for culturally diverse populations in Utah that were identified by the committee are 1) education of providers and families, and 2) access to services, including primary and specialty care, as well as access in the rural areas of the state. The committee is now developing specific action plans to deal with these barriers.

The CSHCN Bureau has developed an internal plan to improve its level of cultural sensitivity, which include cultural sensitivity training, establishment of policy, which is reflective of cultural sensitivity, and establishment of a translation/interpretation for clients. Further plans for this project include infrastructure building through the training of community providers of care for children with special health care needs.

Overall system of care

The health care system for the MCH populations in the state includes public and private sector systems. The public system involves local health departments, community health centers, and managed care organizations. Private sector services are available to MCH populations through private managed care organizations, private and academic health care providers. Most local health departments do not provide primary care for any populations in the state, but do provide direct services to some, such as family planning, perinatal care coordination, immunizations, well child care, etc. Community health centers do provide primary care to its clients, including maternal and child health populations. However, there are areas in the state that do not have community health centers, making access to low cost primary care difficult in those areas. The Division of Health Care Financing has mandated that all its participants along the Wasatch Front where the majority of the state's population reside enroll in one of five managed care organizations (MCOs) that contract with Medicaid to provide covered services for eligibles.

These MCOs are responsible to provide covered services to Medicaid eligibles enrolled in their system including pregnant women, infants, children and children with special health care needs.

The following is a description of health issues/system issues among maternal, infant, child, adolescent and children with special needs populations. Although Utah's fetal, infant and maternal death rates are relatively low, these deaths are tragic occurrences and some may be preventable. The Perinatal Mortality Review Program (PMR) was developed to review fetal deaths that occur after 34 weeks' gestation; infant deaths due to perinatal conditions identified through vital records, and maternal deaths. The PMR administered at the state level, enables statewide surveillance of these events. Health and vital records data are collected, summarized, and reviewed by perinatal health care specialists from different disciplines and settings to identify opportunities for prevention.

During the past two years, maternal deaths have been identified through a matching of fetal death certificates and birth certificates with death certificates of all women of childbearing ages whose death occurs within one year of the pregnancy termination. Linking of certificates and expansion of the definition of maternal deaths to include those that occur with one year of pregnancy termination has resulted in an expected increase in maternal deaths due to improved case finding. The deaths are reviewed to determine if they are directly related, indirectly related or not related to pregnancy. Data for each case are collected and summarized by the Perinatal Mortality Review Coordinator who, with other health care professionals, reviews these deaths. During the review process, recommendations made by the review team are recorded and used to plan interventions for the prevention of future deaths. Collaboration with professional organizations has enabled the Division to promote review findings to providers in order to address provider practice issues. Better consultation and referral networks within the state health care systems would promote better pregnancy outcomes.

SIDS deaths are reviewed with the Child Fatality Review Committee to identify policy issues and preventive aspects. This review enables the SIDS Program Coordinator to maintain a database, identify factors related to SIDS deaths, and develop prevention strategies to reduce the risk of SIDS.

The Utah Birth Defect Network (BDN) collects data on the prevalence and distribution of pregnancies and births that are affected by a major birth defect. The Birth Defect Network began

surveillance activities in 1994 tracking only neural tube defects (NTD). In 1995, oral facial clefts and the common trisomies were included and in 1997, the surveillance was expanded to other birth defects, including cardiac anomalies. In January 1999, the BDN became a full surveillance system collecting all major structural malformations, excluding ventricular septal defects. All potential cases are reviewed by the Director and a pediatric geneticist for classification of isolated versus multiple defects and etiology, if known. Demographic data obtained on each case will provide the Bureau of Children with Special Health Care Needs with information about clinic access, distribution by subspecialty. In addition to needs assessment, the BDN annually evaluates the effectiveness of the folic acid prevention activities on the NTD prevalence rates for Utah. These data enable the state to plan for needed health services.

A number of existing systems currently collaborate to provide health care to uninsured children. These systems and efforts include the managed care system in the provision of services; the DOH in providing outreach to get eligible children covered and in trying to simplify systems; Utah Department of Health programs (CHIP, Medicaid, Covering Kids, Maternal and Child Health programs, etc.) working together to provide outreach and spread information; legislators in providing funding; and, administration in providing guidance. Local health departments participate in Covering Kids Utah Project, activities through active association with the Covering Kids Coalition. In addition, one of the three Covering Kids pilot projects is managed by the Central Utah Health Department which provides outreach activities in six rural counties.

Collaborative mechanisms include regularly scheduled meetings to share information and ideas; data sharing among programs and systems; informal verbal communication and electronic communication; collaboration on the production of outreach materials. The work of CHIP, Covering Kids and Medicaid is very closely tied together with regular communication and cooperation.

There are, however, some issues that need to be addressed, as outlined below:

- Outreach may not be reaching all eligible families
- At the application level there is fear/suspicion among some potential clients of using governmental programs, especially among the growing population of individuals of undocumented citizenship. This fear of using government programs

also prevents parents from enrolling their children, even though many are legal citizens because they have been born in the country

- More language appropriate eligibility workers need to be employed and placed in accessible areas
- Materials need to be available in more languages and more widely throughout the State
- It is difficult to cover some health care needs in rural areas, such as high-risk pregnancies or children with special health care needs
- Some clients have difficulty understanding and using the health care system
- Some clients have trouble with the health care available to them because it is not language or culturally appropriate to their needs
- Some services are not available to all those in need due to provider shortages or inadequate funding.

There is a growing need for available, affordable, and high quality (including healthy and safe) child care for Utah's children. According to the recent Utah KIDS COUNT report, Measures of Child Well-Being in Utah 2000, an estimated 142,100 of Utah children are in need of child care. In contrast, there are only an estimated 35,487 licensed child care slots available throughout the State. In a recent survey of Child Care Resource and Referral agency clients, conducted by Utah's Office of Child Care, 41.6% of the respondents cited “no openings ” as a barrier to finding child care and 32.4% of these survey respondents indicated that “schedule problems ” was a barrier to finding care. Many families moving from welfare to work are finding jobs with long or unusual hours where work hours fall outside of “normal ” 8:00 to 5:00 hours. Night time and weekend care is rare and very difficult to find in Utah.

Although school health programs and school nursing services are arranged and coordinated at the local level, there is a need for state level assistance that includes clinical and programmatic consultation, policy development, standards and guideline development, information dissemination, and training. State consultation and technical assistance to school nurses are provided by the CFHS School and Adolescent Nurse Consultant who serves as a state resource and representative for school and adolescent health. The consultant identifies and addresses important issues that affect school nurses statewide and serves on state committees and

task forces that address issues pertinent to school nursing. Information on various issues related to school nursing is collected, prioritized, and disseminated to school nurses, school administrators, and local health department nursing directors throughout the State through training, seminars, and newsletters.

At the present time the Division does not have enough staff to adequately address the needs of the adolescent population since one nurse serves in the capacity of School and Adolescent Nurse Consultant. However, in order to more adequately address adolescent health issues in Utah, potential funding sources are continually being sought to support the addition of another nurse consultant to the staff, whose time could be designated specifically to adolescent health issues. Funding reallocation of MCH Block Grant funds may be necessary in order to fund a position dedicated to adolescent health needs.

Local delivery systems

Local delivery systems for maternal and child health populations are designed to meet the health care needs of mothers and children in their communities, with a particular focus on those without insurance. Local services may be delivered through the local health department, community health centers (if available in the area), managed care organizations or through the private sector. Each local health department receives MCH Block Grant funds via contracts to provide selected MCH services based on local need. In addition, through other funding sources, the Utah Department of Health contracts with local health departments to provide other services to this population, such as immunizations, WIC, violence and injury prevention, etc. Not all local health departments provide all MCH services. For example, Summit County Health Department does not provide any Presumptive Eligibility, but instead has an arrangement with an adjacent local health department for these services for their community members. Because local health departments are autonomous and funding is limited, each local agency determines what services they are able to provide given their resources. In addition, due to different levels of local government support in each local health district, there is great variation in the ability of the districts to provide services. See Section 5.3 for Utah map of local health districts.

Despite a high number of physicians and mid-level providers working through a variety of private and public agencies, obtaining early, continuous prenatal care remains elusive for Utah women in certain categories. Unmarried teens living at home often do not qualify for Medicaid as

their parents' earnings place them over the income standards. Unfortunately, many families caught in this situation either do not have insurance or their carrier does not cover a dependent's pregnancy and they lack adequate cash to cover the teen's pregnancy expenses. Women and their families working at low paying jobs may also find themselves just over income limits, unable to afford insurance, and without sufficient cash. For both of these groups, finding prenatal care in a timely fashion becomes a difficult task.

Another growing segment of the population unable to obtain prenatal services is undocumented women. These women do not qualify for presumptive eligibility and Medicaid is available to them only under the Emergency Medicaid Program for labor and delivery services. Two Wasatch Front health departments providing on-site antenatal care enroll increasing numbers of undocumented, often non-English speaking women in their prenatal programs. Even though these women receive antenatal care, paying for needed outpatient and laboratory services is difficult. Community health centers along the Wasatch Front faced with the same growing numbers of undocumented women have been forced to place caps on the number of prenatal clients they enroll. In some rural areas of the state, community health centers are not available and providers are unwilling to see non-paying clients. As a result, some undocumented women are unable to obtain prenatal care and seek medical care only at the time of delivery via hospital emergency rooms.

Easily accessible, affordable family planning services remain problematic for many Utah women. Women on Prenatal Medicaid, whether fee-for-service or enrolled in managed care programs, are only eligible for family planning coverage for approximately 2 months following delivery. Following termination of their Medicaid eligibility, many women are unable to afford family planning services. Due to funding limitations, local health departments, community health centers and Title X clinics have not been able to meet the demands for the number of women needing family planning services. One local health department will provide family planning services only to their own postpartum clients. One of four community health centers in the Salt Lake City area has also limited family planning services to established clients only.

At the state level, reduced MCH funds has severely limited purchase of low cost oral contraceptives for distribution to local health departments unable to obtain public health discount rates. As a result, women unable to afford full retail cost for oral contraceptives may be limited to

using less effective methods of birth control increasing their risk of unintended pregnancies. Many teens, at increased risk for unintended pregnancies, do not have access to Title X clinics (offered through Planned Parenthood Association of Utah, the state's Title X agency) that do not require parental consent, sites, especially those in rural areas. The state law requiring government agencies in the state to obtain parental consent prior to discussing or providing family planning information or services to minors continues to present a barrier to teens needing these services.

Every Utah hospital with delivery services has staff that collaborates with the Birth Defect Network to provide families affected by major birth defects with information about support and medical and other services provided by the Network. These hospitals also cooperate with the Perinatal Mortality Review Program to provide access to medical records for data needed for the review.

School health is coordinated at the local level. In Utah, school nurses are either employed directly by the school district, or the school district may contract with the local health department for these services. In both arrangements, the local districts look at the priority needs of the children, along with state mandates, to decide what school health services to offer. The ratio of students to school nurses in Utah, one nurse to 6,181 students, severely limits the services school nurses directly provide. Secretaries or other school staff often have to perform direct student care on a daily basis after the school nurse has trained them on proper procedure due to the high student to school nurse ratio.

Throughout the State, a number of site-based programs under Utah's Families, Agencies, and Communities Together (FACT) Initiative are located in schools determined to be "at-risk" based on the percentage of students eligible for reduced price or free school lunch. Designated FACT nurses, usually employed by local health departments, are assigned to specific FACT school site-based programs to provide a variety of school nursing services and coordinate care for students and their families identified as the highest risk. FACT, a multi-agency initiative, is supported largely by state funding allocated to each participating agency. The Division of Community and Family Health Services contracts, using state and federal funds, with eleven of the twelve local health departments to support FACT nursing time.

Existing systems and collaborative mechanisms for preventive and primary care

Each local health department determines which MCH services it will provide based on resources, community priorities and need. Each district receives MCH block grant funds for provision of services for the MCH population, although each varies in which services it offers. Clearly demand and need for services exceeds the system's capacity to provide these services to the maternal and child populations.

Prenatal services, of some degree, including Presumptive Eligibility (PE) determination are offered by eleven of the twelve local health departments (LHDs). Two urban LHDs (Salt Lake Valley and Weber/Morgan Health Departments) serve as sites for direct prenatal services provided by the University of Utah Health Sciences Center.

In the past the system for accessing presumptive eligibility (PE) has been effective. However, currently there are problems in the Salt Lake County area. Since PE is restricted by federal regulation, such as agencies authorized to do PE and lack of reimbursement for the service, all PE screening sites but two Salt Lake Valley Health Department clinics are not able to do PE determinations for private provider clients. As a result, the PE system, originally designed to promote early access to prenatal care, actually creates a barrier to care.

Federal MCH funding has been allocated to two agencies, Salt Lake Valley Health Department and the Community Health Centers, Inc., to support prenatal services to uninsured women through public services in Salt Lake City. Depending on a client's payer, all or a portion of the enhanced prenatal services (perinatal care coordination and pre/postnatal home visiting, nutritional counseling, psychosocial counseling, and group pre/postnatal education) are available directly or by referral to other agencies.

Nine local health departments provide presumptive eligibility determination, and obtain a prenatal history, including obstetrical, nutritional, and brief socioeconomic and psychosocial review. Risk factors are identified and a plan of action developed. The client is assisted in finding a provider and referrals to other resources are made based on client need. Availability of enhanced prenatal services varies among the health districts and even among an individual health district's sites.

Since one rural local health department does not offer perinatal services or PE screening, women in this district have to access these services in an adjacent local health department. Unfortunately the PE system is only a band-aid approach to assisting pregnant women without

insurance to gain early access to prenatal care. In fact, because of the federal regulations that limit how PE is administered, PE poses a barrier to early entry. A more effective system would be for Medicaid eligibility workers to provide PE to those pregnant women whose Medicaid application cannot be completed upon their initial application.

Complete family planning services are only available in six local health districts, while three provide partial services for family planning clients by obtaining medical histories, providing education on contraceptive options, referring women to providers offering discounted services, and providing no or low cost contraception. Three health districts do not offer any family planning services.

There are few programs for pregnant teenagers. However, the University of Utah Health Sciences Center has a comprehensive program for pregnant teens in the Salt Lake City area, partially funded by MCH Block Grant monies. This program includes Presumptive Eligibility (PE) screening, prenatal care for the teen and a prolonged period of intensive follow-up for the mothers to prevent rapid repeat pregnancies and for her infant via well child care. Three University of Utah Health Centers in Salt Lake City also provide presumptive eligibility for women enrolling in their prenatal programs. Another program specifically directed towards teenagers is the Teens N Tots Program through Salt Lake Valley Health Department. This program's specific goal is reduction in second pregnancies among already pregnant teenagers.

Low cost perinatal and family planning services, utilizing a sliding fee scale, are available via community health centers along the Wasatch Front and at four other sites in rural areas of Utah. Family planning services based on a sliding fee scale are also available through Planned Parenthood Association of Utah (PPAU), the state Title X agency. One PPAU clinic in the Salt Lake City area contracts with certified nurse midwives to provide on-site prenatal care services and provides Presumptive Eligibility determination. MCH has developed a strong relationship with PPAU over the past six years with much collaboration between the two agencies on a number of common issues.

A clinic for comprehensive health care for homeless individuals is located in Salt Lake City. Presumptive eligibility is available as well as family planning through this agency's contract with Planned Parenthood Association of Utah. A migrant health center in northern Utah, Centros de Buena Salud, in Brigham City, provides presumptive eligibility (PE) screening and antenatal

care to eligible women. Additionally, the Utah Department of Health at the Cannon Health Building in Salt Lake City also screens pregnant women for PE.

Prenatal care and family planning services are available to Native American women at Ft. Duchesne in northwestern Utah, and at Montezuma Creek and Monument Valley Medical Clinics on the Navajo Indian Reservation in southeastern Utah. Both sites on the Navajo Indian Reservation provide presumptive eligibility screening.

The Department of Health toll-free Baby Your Baby Hotline continues to provide information and referrals to callers seeking providers and/or financial assistance for prenatal care, family planning, well childcare, nutrition services, or other MCH-related services. The hotline staff collaborates well with community resources in order to promote these and ensure that information that is given to callers is current. The hotline is viewed as a valuable resource for both callers, as well as community resources. The Department sponsors numerous other hotlines that serve the MCH populations. These are outlined in Section 4.2.

The SIDS Program provides information on risk reduction for SIDS through various different mechanisms, such as pamphlets, website, educational in-services, media messages, and the SIDS Awareness Campaign, a yearly intervention that targets a specific high-risk group. The SIDS Program collaborates with the Utah SIDS Alliance, a parent support group for SIDS families, on a regular basis. State staff had a significant role in the planning and presenting at the National SIDS Conference in Salt Lake City this spring. Because of the local health department support for data collection via the home visitation program, the SIDS program has a close working relationship with local health department public nurses. These nurses were able to attend the National SIDS Conference because the SIDS Program Coordinator applied for a grant through an advocacy organization to fund their registration fees.

The Birth Defect Network, along with WIC, Baby Your Baby, the local March of Dimes Chapter, and the University of Utah Schools of Medicine and Health Education conducts a statewide Folic Acid Awareness Campaign to make sure all women of childbearing age know about the vitamin's ability to protect against some neural tube birth defects.

The School and Adolescent Nurse Consultant regularly collaborates with staff from other programs and Divisions to ensure that the needs of Utah's school-age and adolescent populations are addressed. During the past two years, the nurse consultant chaired a statewide Task Force for

Adolescent Health, which was originally part of Utah's previous State Systems Development Initiative (SSDI) grant-supported project. Members of this Task Force included representation from Medicaid, State Office of Education, Mental Health, Substance Abuse, University of Utah Teen Mother and Child Program, State Parent Teacher Association (PTA), school nurses, local health departments, and the juvenile justice system.

School Nurse Incentive Program funds, which are awarded by the state legislature for school nurses, must be applied for each year, and are awarded through the Utah State Office of Education to local school districts. As part of the application process the school districts and partnering local health departments must provide matching funds and provide proof that certain policies or tasks are completed before monies are awarded. The School and Adolescent Nurse Consultant provides input to the Utah State Office of Education into the development of the annual application requirements for these funds, and participates in the review of completed applications.

Utah's Families, Agencies, and Communities Together (FACT) Initiative is a multi-agency effort, involving, at the state level five agencies: the Departments of Health, Human Services, and Workforce Services; the State Office of Education; and the Office of the Courts. FACT is supported largely by state funding allocated to each of the participating agencies. These agencies, in turn, use FACT funding to support a number of community and site-based initiatives and projects. Local FACT site-based teams have representation from the local health department where the nurse is employed, the education system, the local workforce services agency, the local mental health; and, families and family advocates. All of these team members assist in coordination of care and services to help high-risk families.

Another example is found in the CSHCN Bureau itinerant clinic staffing, held with local providers, such as pediatricians, public health or mental health workers, human service workers and families/ family advocates, after the child has been evaluated in the multidisciplinary CSHCN Bureau clinics, during which a multi-agency care plan is developed for each child.

Activities undertaken by the Salt Lake Valley Health Department Oral Health Task Force have resulted in increased access to preventive and treatment care among children residing in Salt Lake County. Collaboration among community health center dental clinics, Medicaid dental clinics and school nurses has resulted in a referral system which guarantees children identified with

emergency dental needs timely access to care. A similar collaboration among public dental clinics, volunteers examining Head Start children, and Smile Factory has resulted in more children being identified in need of dental treatment and accessing care. Children are referred to the appropriate facility based upon the type of treatment required as well as the child's economic/insurance status. Sealant Saturday projects provide occlusal sealants for many uninsured/under insured children. Collaboration among the Oral Health Task Force Prevention subgroup, Utahns for Better Dental Health, and the local sections of the Utah Dental Association and the Utah Dental Hygienists Association has made it possible for Salt Lake County residents to vote on community water fluoridation in the November 2000 general election.

CSHCN Bureau clinical staff participates in Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee. This committee meets every week to determine coverage of non-covered services for Medicaid recipients. Of note in the year 2000, the CSHCN Bureau pediatric neurologist and pediatric physical therapist were given voting status on the committee, thus participating in decisions made about expanded care for children.

This year, the Division of Health Care Financing/Medicaid with input from staff from the CSHCN Bureau added language to the state Medicaid Plan to include participation of CSHCN Bureau staff in the process of consultation and quality assurance with the Medicaid Prepaid Mental Health plans. CSHCN Bureau staff assisted in adding language to the Medicaid contracts, which requires them to provide outreach to children with special needs as well as to exchange information with CSHCN Bureau programs for children served by both agencies. CSHCN Bureau and Medicaid Mental Health staff collaborates in training children's mental coordinators and staff from Medicaid mental health plans.

Maternal and Child Health staff participate with Utah's Department of Health, Division of Health Care Financing, Bureau of Managed Care staff in quality monitoring activities for Medicaid contracted managed care organizations (MCOs). The monitoring activities include periodic site visits to each 5 MCO. To access services for pregnant and postpartum women, children with special health care needs and the provision of EPSDT services.

The relationship between the local health departments and the MCH programs have been strong, although in recent times, it has been somewhat strained due to numerous factors, including funding issues, reporting and contract issues, and issues among the local health department staff.

The relationship between the Department of Health and local health departments has been strained in recent months, creating tension between state and local staff. Program staff works hard to encourage a strong relationship with the local health department staff in spite of the tension that exists between the agencies on a higher administrative level. This is an area in which MCH needs to work hard to develop a stronger and more cohesive relationship.

Additionally, while the relationship with community health centers in the state is cordial, the state needs to develop this relationship better and to recognize community health centers as a critical health care system in the state.

Coordination efforts that address Medicaid, SSI, Ryan White, social services, special education, early intervention, vocational rehabilitation, mental health, transition, developmental disabilities, SSDI, school health, and WIC

State maternal and child health staff coordinates efforts with many different agencies in order to accomplish its goals.

Over the past two years, the Utah Department of Health has been integrally involved in a state level coalition building effort targeted toward systems improvement related to early childhood services. An Early Childhood Integrated Services Committee (ECISC), chaired by the Department's Deputy Director, has been established involving multi-agency and community representation. Agency and provider representation on the ECISC includes state and local health department programs (including Early Intervention, Maternal and Child Health, and Children with Special Health Care Needs, Child Care Licensing); the State Office of Education (including Preschool and Students at Risk programs); FACT (Families, Agencies and Communities Together); the Department of Workforce Services Office of Child Care; Department of Human Services; Utah Head Start-State Collaboration Project and local Head Start programs; migrant health; mental health; family support centers; child advocacy groups; local child care providers; and the private provider/pediatric community.

The Early Childhood Integrated Services Committee (ECISC) has been involved in discussions centered on the need for and the development of more integrated systems of multi-

agency early childhood services. The ECISC has recently focused its effort on the conceptualization of a Community-Based Early Childhood Services Systems Initiative. An initial set of guiding principles for this initiative has been developed which will be used to guide local and state systems development. The ECISC is working to identify funding sources for support of state and local community level systems development activities modeled around these guidelines, and to assist local communities to gain skills and knowledge in developing effective strategies to improve their early childhood services delivery systems.

The Division of Community and Family Health Services has been collaborating on a new project with Health Care Financing/Medicaid which is focused on building capacity of Medicaid programs to support effective child health and development services for their clients. Utah's Medicaid agency received grant funds under a new Commonwealth Fund/National Academy of State Health Policy initiative entitled ”Building State Medicaid Capacity to Provide Child Development Services”. This project began activities in March 2000 aimed at the development of a nurse home visiting program for Medicaid children. Project activities will involve the review and development of risk assessment tools; protocols and guidelines; parent and provider educational materials; and, administrative infrastructure/payment methodologies. Several MCH staff representing several content areas will be working closely with Utah Medicaid staff over the next three years in implementation of this project by providing technical assistance and consultation related to setting up home visiting services and activities, and establishing protocols, guidelines, and training.

Community-wide collaboration efforts for the Robert Wood Johnson grant project for CHIP outreach, Covering Kids Utah, include training staff and disseminating information through groups such as: non-profit social service or advocacy organizations; health settings, including hospitals, provider offices, pharmacies, health fairs; ethnic leaders; school systems, including school lunch programs, FACT, and PTA; Head Start and child care settings; businesses, media, churches, food pantries, conferences, family advocates, lawyers, and UDOH programs. Many of these groups either serve directly or have the opportunity to interact with individuals and families who may be uninsured. Once they are supplied with the information on the programs they can assist with the CHIP and/or Medicaid application and referral process. Local health departments participate in Covering Kids activities through active association with the Covering Kids Coalition.

In addition, one of the three Covering Kids pilot projects is managed by the Central Utah Health Department. The project provides outreach activities in six rural counties.

The CSHCN Bureau has participated in the development of Utah's CHIP program to insure that the program includes services needed by children with special needs. However, Utah's CHIP program has limited coverage of certain services such as physical, occupational and speech therapies, mental health, and dental services, so that many of the more severely disabled children the Bureau of Children with Special Health Care Needs refers find better coverage through SSI and Medicaid. CSHCN Bureau continues to work with the CHIP staff to expand services and outreach to children with disabilities or those who are at risk. Additionally, as part of all the CSHCN Bureau clinics, resource specialists and/or a Medicaid/CHIP outreach worker provide parents with on-site consultation on accessing resources for coverage of care.

The State Systems Development Initiative (SSDI) grant for fiscal year 2000 was developed to assist in the improvement of the data collection and reporting requirements for the MCH Block Grant. The grant activities have focused on identification and collection of information about the child and CSHCN populations not readily available previously. The Utah 2000 Child Health Survey was developed and implemented to collect this information. The initial data analysis, just recently completed, and future analysis will aid in the identification of child health issues to develop systems of care or resources to meet these needs. Future plans include the prioritization of child health issues and coordination of resources through the planned Child Health Summit set for spring of 2001which has a goal of developing a state child health action plan.

The SSDI grant has also worked with the CHARM pilot project mentioned earlier in this section to link three infant data sets. The data sets are from the newborn (metabolic) screening data, newborn hearing screening data, and the birth certificate data set. The pilot project will be implemented July 1, 2000. This project is part of the initial phase to link and track child interactions with the health care system to identify issues and services for improved child health. SSDI grant funds have assisted in the development of some of the activities of this pilot project.

Department of Health programs work together to promote a comprehensive school health model. A Community and Family Health Services Comprehensive School Health Committee meets on a regular basis with membership from various Department programs, including chronic

disease, health education and school health. This committee also invites the State Office of Education health curriculum specialist to attend these meetings. All of these programs must work together to ensure the local school health programs are comprehensive.

The School and Adolescent Nurse Consultant regularly collaborates with staff from other UDOH divisions and programs, especially Medicaid, to ensure that the needs of Utah's school age and adolescent populations are addressed. The Consultant in provides technical assistance to Medicaid regarding appropriate nursing delegation procedures and contracts between school districts and Medicaid. These contracts allow school districts to be reimbursed by Medicaid for selected health services performed in the school setting.

The Child and Adolescent Health Program Manager and the FACT Site-Based Program coordinator (currently located in the Oral Health Program) collaborate in providing oversight for the FACT nursing contracts with local health departments and serve as consultants to local FACT nurses in carrying out these contract requirements. They also collaborate regularly with the School and Adolescent Health Nurse Consultant and Utah's CHEC/EPSDT Coordinator in assessing the need for and planning services for Utah's school-age population.

Local school nurses work collaboratively with their school district special education departments in a variety of activities, such as writing health care plans for children with special health care needs. School nurses also provide the training and education to staff regarding special needs children, and may designate responsibility for providing certain health services, as appropriate under the current Nurse Practice Act and accompanying rules.

The Division has collaborated with other agencies and programs in and outside the Department of Health to improve access of child care providers to important health and safety training through a federal Health Systems Development in Child Care Healthy Child Care America Grant. CFHS has developed partnerships among a wide range of agencies and programs involved in Utah's child care system including the State Office of Education, Utah's Head Start State Collaboration Project and local Head Start programs, the Department of Health's Bureau of Licensing, Department of Workforce Services Office of Child Care, and the BabyWatch/Early Intervention Program to develop the Utah Health and Safety (H/S) Training Curriculum for Early Childhood Providers. Public health nurses from each local health department (LHD) and Head Start/Early Head Start program were trained on use of the five-module, ten-hour curriculum and

local level implementation of the training. The training is currently offered by eleven of twelve LHDs to child care providers in their areas by public health nurses who also provide health consultation for child care providers. Local area Child Care Resource and Referral agencies collaborate with LHDs by assisting with course notification and registration.

Oral Health Program staff has well-established working relationships with Utah's Medicaid staff, and regularly combines efforts with Medicaid staff to improve availability and accessibility of Medicaid dental providers throughout the State. Program staff participated in defining and establishing a basic scope of dental benefits for Utah's newly implemented Children's Health Insurance Program (CHIP), and continues to serve in a consultative capacity to the Utah CHIP administrator on issues relative to accessing needed dental care for children on CHIP.

The Oral Health Program coordinates with the Utah Dental Association Dental Access Committee and the Utah Dental Hygienists Association in securing and training volunteers for various activities including Sealant Saturdays and Head Start dental examinations. The Oral Health Program Manager serves as a consultant to and coordinates activities with the director of the dental clinics in two community health centers in Salt Lake County. The Oral Health Program collaborates with the Utah Department of Health Indian Health Liaison by providing oral screenings and oral health education at DREAMM (Developing Reservation-based Efforts Addressing Mortality and Morbidity) Grant Health Fairs throughout the State.

The CSHCN Bureau Director and Therapy Service Coordinator participate in the Medicaid Utilization Review/CHEC (Utah’s EPSDT) Expanded Services Committee. Through their participation, they have expanded the knowledge base of the Medicaid prior authorization committee to improve the coverage of services to children who receive Medicaid, resulting in improved coverage of specialty services for children. The CSHCN Bureau Director has also participated with the University of Utah Department of Pediatrics to work with the Medicaid Drug Utilization Board, which has helped to improve Medicaid coverage of medications for children.

A CSHCN Bureau staff member, identified as the SSI Specialist, works with the Office of Disability Determination Services (DDS) that evaluates children and adult disability claims for SSI eligibility. The specialist reviews the referrals and provides outreach and referral for appropriate families to Medicaid that, in Utah, requires a separate application. The specialist also provides

information, referral and enabling services to families having difficulty accessing or utilizing Medicaid/ SSI services. The families may be referred to resources such as Utah Legal Services, Disability Law Center or consultant staff in DDS.

In addition, a CHSCN Bureau staff member participates on the Disability Determination Services Advisory (DDS) committee that has fostered cross training of CSHCN Bureau and Disability Determination Services (DDS) staff. It also provides the development of professional relationships between SSI, DDS and CSHCN Bureau staff so that conflicts over individual applicants can be resolved.

The HIV/AIDS Program in the Department of Health, Division of Epidemiology and Laboratory Services administers the state's Ryan White program. Utah does not have a Title IV grant due to its inability to compete for these funds because of its low rates of women, infants and children infected with HIV. Utah's Ryan White Program is required to spend approximately 10% of its funds, or $303,000, on direct and support services to women, infants and children. This funding supports services such as health insurance continuation payment, purchase of High Risk Insurance Pool (HIP) coverage, drug assistance, day care, transportation and case management services. The Division of Community and Family Health Services has recently begun to participate in a committee with staff from the Division of Epidemiology and Lab Services to coordinate state level services to women, infants and children with HIV/AIDS. Membership of this collaboration committee includes staff from the Department's Reproductive Health Program, Medicaid, Baby Your Baby and WIC. CSHCN Bureau has had few referrals of children to the Technology Dependent Waiver program, although most of these children receive medical coverage through Medicaid and Ryan White funds.

CSHCN Bureau staff participates on the Health Care Advisory Council for the Division of Child and Family Services (DCFS), Utah's child welfare agency, which meets monthly and advises the DCFS Board on the health status issues for children in their system. The council identifies barriers and works toward the development of solutions to improve access to and continuity of health care. Another related collaborative effort between the two agencies is the Fostering Healthy Children Program (FHCP). Through this program, CSHCN Bureau nursing staff co-locates with DCFS caseworkers and assists them in coordinating the children's health care. Since

all foster children in Utah are covered through Medicaid, the FHCP staff collaborates closely with Medicaid to ensure that services are accessible for this population of children with special needs.

CSHCN Bureau and the Office of Students At Risk (SARS), Utah's state level special education program, enjoy a strong working relationship and have collaborated on a number of projects. For instance, CSHCN Bureau participated in the Office of Special Education's 5-year strategic planning process. A SARS/CSHCN Bureau committee is reviewing an existing Memorandum of Agreement between the two agencies and will work on implementation of the agreement throughout the state. This year a staff member from SARS office has been added to the MCH Advisory Committee for the subcommittee for children with special needs. CSHCN Bureau and SARS are working together to begin a needs assessment process for children with autism. In addition, CSHCN Bureau works with special education, human services, vocational rehabilitation at all levels of the FACT (Families, Agencies, and Communities Together Initiative) process, an interagency collaboration to provide wrap-around services to children at risk or with special needs.

In Utah children from birth to 3 years of age are served by local providers through contract with the BabyWatch/Early Intervention Program (BWEIP) located in the Bureau of CSHCN. Children 3-5 years of age receive early intervention services through the local school districts. Because of the strategic positioning of the 0-3 BWEIP, CSHCN Bureau staff has a close working relationship with the state level staff and the contracted local service providers. The CSHCN Bureau Director hosts the Interagency Coordinating Council for the BabyWatch Early Intervention Program. The membership of this council ensures a forum of collaboration among all the organizations and agencies and families of all preschool children in early intervention programs including MCH staff; State Office of Education; Services for Persons with Disabilities; School for the Deaf and Blind; Mental Health; Utah State University; private providers of child care, early childhood services and services for children with special needs; parents; and legislative representatives.

In Utah, the Office of Vocational Rehabilitation (VR) is located in the State Office of Education. CSHCN Bureau staff participates on a number of working and advisory committees to the vocational rehabilitation programs and the two programs have recently developed an interagency agreement. CSHCN Bureau also participates with the Utah Center for Assistive

Technology (UCAT), part of the Office of VR, through advisory boards, contractual assistive technology services and support of the UCAT assistive technology helpline and website, "Access Utah."

In the early 1990s, the Division of Mental Health (DMH) in the Department of Human Services began to work on developing leadership in regional mental health centers throughout the state. The Child and Adolescent Services System Program (CASSP) through a National Institute of Health's SAMHSA grant was awarded to all states to support planning and development of children's services. Through this grant, each of Utah's ten mental health centers worked with the state DMH and the Utah State Hospital to develop a network of children's mental health service in a system that had previously only been focused on adult mental health. A children's mental health coordinator was identified in each of the mental health centers and at the state Division of Mental Health; and, two programs for children, the Children's Program and the Youth Program, were established at the Utah State Hospital.

Concurrent with the Child and Adolescent Services Systems Program (CASSP) efforts, state mental health funding was earmarked for children's mental health service development. In 1992, the FACT (Families, Agencies and Communities Together) Initiative was begun through state legislation and funding. The FACT program established interagency service teams throughout Utah to work with children with special health care needs and children at risk. Mental health coordinators, as well as CSHCN Bureau and local health department staff, are included as members of these interagency service teams.

The state Division of Mental Health was awarded additional SAMHSA funding for the Frontiers Mental Health Grant in 1998 to further support the system by building on previous efforts to expand and coordinate children's mental health services. The Frontiers Mental Health Grant will support the expansion and strengthening of frontier community capacity to provide services to meet the mental health and related service needs of the children and youth with serious emotional disorders.

The Director of CSHCN Bureau participated in the 1999 Children's Mental Health conference, sponsored by Utah Children, Utah's child advocacy organization. Over 110 participants representing urban and rural populations worked within structured small groups to discuss advances and barriers within the system and to develop action plans to combat the

barriers. Forum participants were drawn from stakeholder groups such as mental health advocates, mental health providers, special educators, juvenile justice system pediatricians, child psychiatrists and parents. The forum workgroups identified strengths, barriers and made recommendations for change in the Utah system. The Division of Mental Health will use the information from this forum to develop and implement state plan for children's mental health.

CSHCN Bureau has established a Systems Development Program, which houses transition efforts. In addition to establishing the full time SSI Specialist/Program Manager, CSHCN Bureau has contracted with a specialist to provide transition services, such as vocational/career, health and financial planning, to young adults (14 years of age and above). This specialist provides transition training and consultation to CSHCN Bureau staff, other agencies and health professionals and assists individuals and their families in developing and implementing individual transition plans.

CSHCN Bureau works closely with the Division of Services for People with Disabilities (DSPD) in a number of ways. Representatives from DSPD are on the BabyWatch/Early Intervention Program (BWEIP) Interagency Coordinating Council. CSHCN Bureau is involved with the Coordinating Council for People with Disabilities, which includes participants from Medicaid, Vocational Rehabilitation, Special Education, and Mental Health to review difficult issues, coordinates interagency treatment funding for individuals, and develop the Interagency Memorandum of Agreement (MOA) for Assistive Technology. See Section 5.3.5 for MOAs. CSHCN Bureau staff will participate in training efforts with DSPD staff.

In collaboration with the Utah State University, Center for People with Disabilities, the Disability Law Center and University of Utah's Social Research Institute, CSHCN Bureau has submitted a grant application to the Interagency Outreach Training Initiative to fund an interagency training project on assistive technology for children. If funded, this project would provide training for professionals in vocational rehabilitation, Medicaid, education, CSHCN Bureau, and Division of Services for People with Disabilities on how to support families in the successful acquisition of assistive technology.

Formal agreements have been established between CSCHN and other divisions outside the Department such as the Division of Vocational Rehabilitation and the Division of Students at Risk (Special Education) in the Utah Department of Education; the Division of Mental Health and the

Division of Child and Family Services in the Department of Human Services. Additionally, CSHCN Bureau has established Memoranda of Agreement or contracts with programs within the Department, such as Division of Health Care Financing. See Section 5.3 for MOA.

CSHCN Bureau collaborates with other Department programs by participation on committees and advisory boards such as the Emergency Medical Services for Children Advisory Board, the Children's Fatality Review Committee, and the Early Childhood Integrated Services Committee. CSHCN Bureau provides consultation in the development of health care standards for programs that work with children with special health needs, such as the Violence and Injury Prevention Program (Traumatic Brain Injury), the Health Care Financing CHEC/EPSDT Utilization Review Committee, and the Health Care Advisory Committee for the Division of Child and Family Services.

CSHCN Bureau participates in Senator Orrin Hatch's Advisory Committee on Disability Issues, a forum for national and state political issues affecting people with disabilities, provides direct input to Senator Hatch's office through conferences with his congressional aides. Through this committee the scope of involvement with other public and private and private agencies is significantly broadened to include the Disability Law Center, Association of Retarded Citizens, School for the Deaf and Blind, State Office of Rehabilitation, Governor's Council on People with Disabilities, University of Utah Medical Center Rehabilitation Services, Utah State University Disability Resource Center, and families of people with disabilities.

WIC is located in the MCH Bureau in the Division of Community and Family Health Services. Collaboration between WIC and MCH programs has been strongly encouraged within the Bureau and Division, and even at the Executive Director Office level in the Department of Health. WIC staff are invited to participate on various committees related to maternal and child health, including the 0-5 FACT (Families, Agencies and Communities Together Initiative) programs; and data integration efforts, such as the WIC-Immunization Bridge which enables local WIC staff to enter immunization data on their clients which is downloaded into the immunization registry system. The need for collaboration is clearly recognized by the MCH staff; however, there is much that needs to be done to promote the need for collaboration with the WIC program staff. This is a critical area that needs to be fostered and developed much further than it currently exists.

Coordination efforts with major providers of health and health related services, such as children's hospitals and tertiary medical centers, AAP, ACOG, family and parent organizations

MCH staff works closely with the Departments of Family and Preventive Medicine, Pediatrics, Obstetrics, and College of Nursing of the University of Utah to review fetal, infant and maternal deaths. Faculty members from each of these areas participate on the review committee and actively participate in the review process including review of records, determination of preventability and recommendations to prevent future deaths. Data and recommendations from the review process have been presented by University faculty at various meetings, such as the American Academy of Pediatrics, and have been published in a peer review journal. Coordination of the review process with University faculty has ensured the success of the perinatal review program's work.

The SIDS Program collaborates through the SIDS Advisory Council, comprised of a local public health nurse, SIDS parents, police, EMT, funeral director, medical examiner, pediatrician, bereavement experts, and Holy Cross Ministries (a religious organization that is committed to serving disadvantaged populations in the state). In addition, the Program works with hospitals, medical centers, and family and parent advocate groups to educate health professionals in hospitals and provide educational materials. The SIDS Program is actively involved with the Utah SIDS Alliance, referring families who experience infant deaths to the support group, and involving SIDS parents in education efforts. The SIDS Program works with other bereavement organizations, such as SHARE Parents of Utah and Compassionate Friends.

The Birth Defect Network has a close relationship, in fact, a partnership, with health care professionals at the University of Utah Health Sciences Center. For example, one of the leading supports for the program comes from the medical geneticists at the University. In addition, they have as strong working relationship with a bioethicist, etc. It is anticipated that this relationship will be strengthened even further with the reconstitution of the Genetics Advisory Council through activities of the Genetics grant recently awarded to the Department by the federal Maternal and Child Health Bureau Genetic Services Branch. The activities to be pursued with funds from the grant are: 1) assessment of needs for statewide genetic services; 2) development of a state genetics services plan based on that assessment; 3) assessment of needs for child health data integration; and, 4) development of a plan for implementing coordination and integration of

the data. Initial emphasis will be placed on planning for the integration of vital records, birth defects and immunization registries and newborn hearing and metabolic screening data.

Utah is fortunate to have Primary Children's Medical Center (PCMC), which is one of the Regional Centers of Excellence of Care for Children from several states, including Utah, Idaho, Nevada, Wyoming, and Montana. This Center, combined with the Shriners Hospital for Children, provides state-of the-art acute, chronic and tertiary care for children with special health care needs and their families. CSHCN Bureau has an excellent working relationship with these centers, and works closely with their staff through a number of ongoing advisory committees, such as the American Professional Society on the Abuse of Children, the American Academy of Pediatrics/Intermountain Pediatric Society Pediatric Continuing Education Committee, and the MCH/Medicaid sponsored Managed Care Task Force which was developed to improve the quality of care provided for Utah children with special needs.

CSHCN Bureau has partnered with Shriners Hospital for Children in the Intermountain Collaborative Transition Center project, initiated by an MCH/SPRANS grant, "CHOICES." Through this project, CSHCN Bureau staff participates in an interagency advisory committee and collaborates in large and small group training workshops.

The CSHCN Bureau director co-chairs the Utah Chapter of the American Professional Society on the Abuse of Children (APSAC) Medical Standards Subcommittee, an affiliate of the national APSAC organization, which establishes medical guidelines and protocols for referrals of children who have been abused. Projects the committee has recently dealt with include the treatment of STDs in children and the establishment of a statewide Ethics Committee on the treatment of children who are sexually abused.

The CSHCN Bureau participates in the Utah Chapter of the American Academy of Pediatrics Children with Special Health Care Needs Committee, which includes CSHCN Bureau staff, academic pediatricians from the University of Utah Medical Center and private pediatricians from one urban and one rural area. This committee has developed, published and distributed a booklet entitled, "Providing a Medical Home for Children with Special Health Needs" which is a CSHCN resource guide for primary care providers along the Wasatch Front. In collaboration with members of this committee, CSHCN Bureau staff has developed a number of lectures on issues for CSHCN and their families on topics such as medical necessity, medical home, collaboration

and resources for “medically challenged” children, and discharge planning from an acute care facility.

CSHCN Bureau collaborates with several family practice physicians in developing transitional medical homes for young adults with special health care needs. A representative of the American Academy of family Practitioners is on the steering committee for the state “Every Child Deserves a Medical Home Facilitator Training.”

The CSHCN Bureau includes parent advocate representatives on the MCH Subcommittee to support bureau strategic planning and to review and develop policies. The Bureau also contracts with staff from each of the following parent advocacy organizations: Utah Parent Center; Family Voices; Liaisons for Individuals Needing Coordinated Service; and Allies for Children to consult in the development of care plans for children with special needs.

Development and implementation of standards of care, guidelines, monitoring of program effectiveness, and approaches to the evaluation of care

The Perinatal Mortality Review Program helped to implement the Centers for Disease Control and Prevention guidelines for the prevention of perinatal Group B Streptococcal Disease in Newborns in Utah through the distribution of guidelines and posters explaining the algorithm to all deliveries hospitals. This information was also disseminated through poster presentation, newsletter article and website.

With the recently published American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin on Induction of Labor, Department of Health, Reproductive Health Program has conducted analysis of birth certificate data to determine induction practices in Utah hospitals. Preliminary data indicate an increasing trend in the percentage of electively induced labors with wide variation among hospitals and hospital type. Additional analysis will be required to determine the reason for the trend and variation. These data were presented by MCH staff at the Fifth Annual Maternal and Child Health Epidemiology Conference sponsored by the Centers for Disease Control and Prevention.

Late last year, the Division produced a report, “Low Birth Weight In Utah” which outlined risk factors associated with low birth weight among Utah mothers. The recommendations in the report included issues such as: appropriate consultation and referral and the need for risk assessment and provider referral for high-risk pregnancies, especially those

complicated by an accompanying medical condition. The report was widely disseminated to private and public health care providers and also was added to the Reproductive Health website for easy access.

The report also addressed concern with increasing numbers of multiple births in Utah that are probably resulting from artificial reproductive technology (ART) procedures. The Department is closely following this trend and has moved to develop requirements that any ART clinic must operate under the recommendations of the American Society for Assisted Reproductive Medicine. There are three ART clinics in the state, with only one being certified by the American Society for Assisted Reproductive Medicine. The Division of Licensing in the department is developing a white paper to propose that all ART centers must comply with American Society for Assisted Reproductive Medicine requirements in order to ensure that all clients are receiving quality, optimal services. This move may play a role in reducing the numbers of multiple births that often are low birth weight, thus impacting quality care for both mothers and infants.

The Birth Defect Network (BDN) developed and distributed a brochure to all Utah hospitals in 1999 to provide phone numbers for families to contact when a child has been diagnosed with a birth defect. A Resource and Referral Guide has been developed by BDN staff to meet the needs of families for information regarding medical, social or financial inquiries. As questions arise regarding birth defects, information is gathered from an existing anticipatory guidance as well as other medical literature and compiled for families. Newborn nursery staff distributes the brochure to the family. A logbook is maintained for all calls with requests fro information.

The WIC Program has compiled national and state policies into a very clear concise manual. The Policy and Procedure Manual is distributed to local agencies once each year with changes highlighted. There are many quality improvement type committees that are jointly attended by state and local WIC staff including, nutrition education, breastfeeding, computer issues, and risk factors.

The Immunization Program follows the guidelines developed by the National Advisory Committee on Immunization Practices (ACIP) and as a result has mandated second dose MMR

for children. The Program works closely with the Scientific Vaccine Advisory Committee to develop new recommendations as needed for immunizations for children and adults in the state.

The Utah Immunization Program has developed and implemented standards of care through the School Rule under the auspices of State Statute and Immunization Policies and Procedures. Monitoring of program effectiveness is carried out by annual program review in local health departments, contract reports, and in the State program through annual federal reports on various program components and site visits. Approaches to evaluation of care and to monitor continuous quality improvement, currently include local program review and assessment of immunization coverage levels in public clinics, with plans to eventually expand into the private provider offices. The Government Performance Records Assessment (GPRA) Project, in collaboration with Medicaid, provides quality review of immunization levels of two year-olds enrolled in Medicaid.

Child and Adolescent Health Program nursing staff is involved in ongoing literature reviews and identification and/or development of training resources related to nurse home visiting programs; review and identification of effective service delivery models; and review and development of program standards and guidelines. Program staff have reviewed the home visitation literature and compiled a Home Visitation Summary. The program plans to develop standards for home visitation and to identify effective models.

With the current school nurse to student ratio being so poor, it is very difficult for school nurses to accomplish what is needed for the school population in the state with the extremely limited amount of direct time with students. School nurses are forced to delegate clinical tasks to school personnel, often clerical staff; these tasks in other settings are only provided by licensed health care providers. State nursing licensure standards allow for the practice of delegation to such personnel; however, it is of great concern that there are children in the normal school setting with extreme nursing care needs that have to be provided by non-nursing, non-licensed school personnel due to school nurse shortages. In order to provide guidelines to local school nurses and the Office of Education regarding school nursing and school health, a revised Utah School Nurse Manual is being compiled and will be published in September 2000. This manual will contain state legislation regarding what school health services are required to be provided in school settings as mandated by law. Where appropriate, guidelines in implementing these laws will also

be incorporated into the manual. Also provided will be guidelines regarding care plans, delegation, and special needs children.

One of the challenges Utah faces is that there have never been state standards on many issues regarding school nursing care, in part due to the autonomy of local health departments and school districts. However, to try and ensure that best practice is followed, the School and Adolescent Nurse Consultant, in collaboration with university nursing faculty (University of Utah, Westminster College, Brigham Young University, and Weber State University), local school nurses and administrators organized a task force to develop a Continuing Education (CE) program for school nurses. The CE program modules are based on the National School Nurse Certification Exam. It is anticipated that participation of school nurses throughout the State in this program will enhance quality of care.

In 1996, the Utah Legislature passed legislation to establish the School Nursing Services Incentive Program. As a result of this legislation, funding was appropriated to the State Office of Education for the specific purpose of supporting the delivery of school nursing services. As of 1999, the established annual funding level for this state program was $499,000. All forty school districts in Utah participate in the Program and receive enhanced funding through the program to help support needed local school nursing services.

The School and Adolescent Health Nurse Consultant provides consultation to the State Office of Education on the program. The funds are contracted by the SOE to local school districts submitting annual applications which meet program requirements including demonstration of local inter-agency collaboration and contribution of local matching funds. The Program has been influential in improving Utah's school nurse to student ratio from 1 nurse to over 8,000 students in 1996 to the current ratio of 1 nurse to 6,181 students, a ratio still well below that recommended by the American Nurses' Association of 1 nurse to 750 regular education students. There are approximately 115 full and part-time nurses in Utah serving 475,974 Utah students. Utah clearly does not have sufficient numbers of school nurses to ensure that the health needs of Utah's children are being adequately addressed in the school setting.

Whenever possible the Tobacco Prevention and Control Program acquires and disseminates recognized information regarding standards of care that contain a tobacco-related element. Agency for Health Care Policy Research guidelines for provider interaction with

tobacco-using patients are an example. The standards were developed at the national level but are promoted through state and local health care provider programs. Development of guidelines and protocols for various youth-related tobacco prevention activities also occurs at the state level. Examples include the development of Senate Bill 39 (civil penalties and tobacco license revocation statute) and HB 31 (tobacco self-service restriction statute) protocols/training for local health departments. State-level data collection, e.g., compilation of data and reporting system for teen tobacco reduction programs, allows trainers to monitor effectiveness and make changes when warranted. Finally, collection and reporting of underage tobacco compliance checks, accessing Juvenile Court reports on youth tobacco-related offenses act to allow measurement of extent and nature of underage tobacco use in local as well as state levels.

The state monitors its program effectiveness through a variety of mechanisms, such as data, including small area analysis, contract monitoring, and site visits to local programs funded by the state. Site visits to local health departments provide opportunities to monitor programs, and for state staff to provide needed consultation and technical assistance for its various programs.

Staff from MCH Programs provide technical assistance, consultation (administrative and clinical), training and/or mentoring as needed to local health department nurses involved in conducting activities related to maternal and child health services, including prenatal, family planning, 0-5 home visitation, school nursing, etc. Program monitoring and data collection is also conducted at the state level to assist in program planning and evaluation.

The local health departments provide information to the state on services to women and children via the semiannual Maternal and Child Health Periodic Report Form. Through these reports, data on the number of clients and services provided along with demographic information on the racial/ethnic mix, number of undocumented women served, and payment sources are obtained.

The Perinatal Mortality Review (PMR), SIDS and Utah PRAMS (Pregnancy Risk Assessment Monitoring System) programs are continuous efforts to monitor and improve the quality of care for women, mothers and infants in Utah. Both the PMR and SIDS programs utilize vital records and medical records data to track trends in infant deaths. PRAMS data are collected by surveying Utah mothers to determine trends and problems related to their pregnancy

and birth experiences. All of these data will be utilized for planning interventions that are evidenced based and therefore more effective public health strategies.

Mass mailings to private providers, public agencies, and hospitals with perinatal services have been utilized to inform health care providers of the importance of preconceptional care and available family planning resources within the state. In addition, the Reproductive Health Program issues a quarterly newsletter covering a wide range of topics including smoking cessation, updates on oral and emergency contraception, pregnancy and AIDS, and postpartum depression. Newsletters and information on various topics related to pregnancy and family planning are available on the Reproductive Health Program's website. Many of the topics that are included in the program's materials are developed because of a need identified through the perinatal mortality review process, or through development of reports on reproductive health topics, such as the Low Birth Weight report published late last year.

The SIDS Program engages in education of health professionals to reduce the risk of SIDS, as well as groups, like law enforcement professionals, who have contact with families after a death. A parent evaluation, solicited 6 months after a death, asks questions about the quality of care families received, as well as what else could be done to help them. Since so many families are lost to follow-up the quality of the data is poor, and this evaluation may not be continued in 2001. The SIDS Program also evaluates presentations regularly and does an annual evaluation of the SIDS Awareness Campaign activities in order to improve future educational efforts.

Included in the Medicaid contract with each managed care organization (MCO) is the requirement of a satisfaction survey for special needs populations. CSHCN Bureau staff has been involved with the planning process of the two surveys that have been completed in the past three years. The first Consumer Assessment of Health Plans Survey (CAHPS) survey sample was taken from Medicaid disabled category children. Results were favorable. Parents were generally satisfied with the availability of care and quality of services received through the MCOs, including specialty services (i.e., 87% satisfaction with "getting into a doctor" and 86% satisfaction with "getting special services"). The initial CAHPS survey has been revised with the addition of other questions developed by the survey team. Analysis on the 2nd survey is not yet available. CSHCN Bureau collaborated with Utah Family Voices to identify families to participate in the Brandeis

University survey on quality of care for CSHCN in MCOs. Results from the Utah portion of this survey showed overall satisfaction with medical services received for children with special needs.

CSHCN Bureau established a cultural diversity committee, which included representative from Primary Care Medical Center, University of Utah Medical Center, Americorps, CSHCN Bureau and others from culturally diverse backgrounds. The two large categories of barriers to health care for culturally diverse populations in Utah that were identified by the committee are 1) education of providers and families and 2) access to services, including primary and specialty care, as well as access in the rural areas of the state. The committee is now developing specific action plans to deal with these barriers.

The CSHCN Bureau has developed an internal plan to improve Bureau's level of cultural sensitivity, which include cultural sensitivity training, establishment of policy, which is reflective of cultural sensitivity, and establishment of a translation/interpretation for clients. Further plans for this project include infrastructure building through the training of community for children with special health care needs.

Maternal and child health staff, representing the three populations served through Title V funding, participate with Health Care Financing (HCF) staff in quality monitoring activities of the five managed care organizations (MCOs) contracting with the state to provide health services to women and children enrolled in Medicaid along the Wasatch Front. Professional nursing and nurse practitioner staff from the CFHS Bureaus of Maternal and Child Health (Child and Adolescent Health Program and Reproductive Health Program) and Children with Special Health Care Needs (Community Based Services Program) collaborates with HCF staff in conducting quality reviews and on-site visits to the Medicaid MCOs. The monitoring includes periodic site visits to review prepared written documentation, such as MCO policies, manuals, and patient education materials as well as staff interviews to assess compliance with established standards for MCH populations. Standards are used to assess a variety of areas including identifying and providing services for pregnant and postpartum women, children through EPSDT/CHEC services and for children with special health care needs. A report of findings of the site visit on compliance with the standards including recommendations is developed with input and recommendations from all three MCH areas.

After the initial review, each MCO is re-evaluated every 1-2 years to follow up on previous recommendations and findings. Standards that were found unmet are reassessed and further recommendations are made, if needed. Compliance with the HCF contract is monitored yearly. The site reviews are an opportunity for Title V staff to provide information and updates on new areas to focus, such as interpregnancy spacing, immunizations, public health programs and educational offerings available for plan recipients as well as educational opportunities for MCO staff. Additionally, CSHCN Bureau staff continues to work with Medicaid and Medicaid MCOs to improve care to children with special needs through the MCH/Medicaid sponsored Managed Care Task Force, developed to improve the quality of care provided to Utah children with special health care needs.

CFHS has ongoing efforts to monitor and measure the effectiveness of its own programs through strategic planning and ongoing program outcome measurement. Covering Kids Utah will measure its effectiveness by monitoring CHIP and Medicaid enrollment increases in the zip code areas where specific pilot projects are being conducted. It will also track process measures such as numbers of clients reached, numbers of presentations made, etc. It will also eventually look at numbers of enrolled children actually using the health services. The ultimate goal is increased health service utilization and prevention among Utah's children.

The Baby Your Baby Program has recently undergone an evaluation of its outreach efforts to promote prenatal and well child care. The results will be available later this year.

The Utah WIC program conducts an annual survey of its clients to determine their satisfaction with provided services, including classes, etc. The information from the surveys is used to determine needed changes in program approaches to better serve its client populations.

Each local WIC agency is monitored once a year and evaluated for compliance to policy. In addition, each local agency writes a yearly Nutrition Education Evaluation and Plan, which is submitted to the state office for approval. The evaluation process includes a quality assurance audit of participant records, the results of a participant satisfaction survey, and a detailed needs assessment including demographic and health data. Each agency conducts a yearly needs assessment in which demographic and health data are analyzed. During this process clinic staff compare progress made toward meeting national health objectives on a national, state, and local agency basis. Each agency chooses three target areas to work on and develops appropriate goals

for the upcoming year. In addition, local agencies conduct ongoing quality assurance audits to measure performance objectives in the clinics.

The Immunization Program utilizes the Centers for Disease Control and Prevention Clinical Assessment Software Application (CASA) to determine provider immunization rates and to provide data to practices to improve their client immunization rates.

The effectiveness of the Folic Acid Educational Campaign is monitored using a random household population-based survey tool (the Behavioral Risk Factor Surveillance System) to assess awareness of women of childbearing age throughout the state. This survey has been ongoing since July 1998 and assesses multivitamin consumption, other behavioral characteristics and demographic information.

A variety of mechanisms allow for the monitoring of quality improvement in Tobacco Prevention and Control Program (TPCP). These include focus groups to gain input on youth tobacco issues; statewide youth tobacco use surveys; key informant interviews with high risk youth/parents; input from civic organizations and disparate population organizations, leaders, and youth; feedback on training and presentation evaluations; and, health care institution and provider experiences with tobacco-related issues they experience in treating children. Additional mechanisms include site reviews with local health departments and community mini-grant recipients, and on-site observations of youth-related tobacco activities. Local health department site reviews act to identify local community programming and training needs. These also act to maximize the collaboration between the TPCP and individual health departments. Finally, more traditional data sources and surveys are also utilized to monitor the quality of services.

Local program monitoring by the state includes contract monitoring, data review and review of local program activities. During sites visits by Reproductive Health Program staff to review prenatal and family planning services to local health departments any program changes are discussed and information on various perinatal issues are presented to nursing directors and public health nurses. Topics have included preconceptional care, smoking cessation, low birth weight risk assessment, and emergency contraception. Data on pregnancy outcomes for each health districts have been presented and discussed as a means of promoting needs assessment.

Consultation is provided to local health departments, community health centers, and other Qualified Providers in the Presumptive Eligibility Program and to local health districts providing

family planning services. Vital records information on entry into prenatal care and racial/ethnic disparities in pregnancy outcomes has also been provided to selected sites to assist in targeting at-risk populations. At local health departments, charts of perinatal and family planning clients are audited to assure compliance with program protocols and policies. Information updates are provided on topics such as accessing Department of Health Internet databases, preconceptional care, unintended pregnancy, emergency contraception, and screening for low birth weight risk. Other programs serving MCH populations such as the prenatal to 5 home visitation program, injury prevention, tobacco control, immunizations, etc. conduct similar monitoring site visits.

Community-based service systems monitoring of local immunization efforts is completed by annual report, CASA (Clinic Assessment Software Application) audits, and site visits.

Another mechanism to monitor how effective MCH programs are addressing these populations is through monitoring of the MCH performance measures. By annually reviewing progress with attainment of its established goals toward the performance measures, the state is able to determine which areas require more attention. At the end of FY1999, of the 18 Core Performance Measures Utah has achieved or exceeded the performance objective for 13 or 72% of the measures.

On the performance measure for newborn screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies, this objective was not attained by 1/10 of a percentage point, which probably is within standard variation, though still unmet. It is important to note that the Healthy People 2000 target was 95% of infants screened for galactosemia and Utah's performance objective was 98.5% and the performance indicator was 98.4%.

On the performance measure relating to the percent of children without health insurance, data were not specifically collected during the reporting time period and the Utah CHIP Program was not initiated until August 1998, therefore the performance indicator used to report is the same as for FY97. It was anticipated that there would be a decrease in the indicator but the data were not available to document the rate change. Based on the performance objective of 8.0%, and our data must be based on previous year's data, 8.5% children in Utah remain without health insurance, indicating lack of progress with this performance measure. Utah initiated the Utah Child Health Survey in 2000, which will provide better information in the future for this performance measure.

The performance measure for the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program was not attained due to lack of 1999 data availability. The data source for this measure was to utilize the HCFA 2082, which identifies services to Medicaid eligibles by age. HCFA has not yet approved the Federal Fiscal Year 1999 form so data are not available to report. As a result, last year's data has been used to measure this objective. It was anticipated that there would be an increase in the proportion of children receiving a service to 72.0%.

The objective for the performance measure related to the percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care was not attained because of an overestimation of the increase in the percent of CSHCN children with a source of insurance. The performance objective was 92.5%, with the indicator being 90.1%. Although the objective was not attained, the percentages are increasing, indicating a move in a positive direction from 89.2% to 90.1%.

The objective for the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children was not attained because the death rate increased partly due to a change in the definition of the population counted, but mostly due to a real increase in the death rate. It has been anticipated that the death rate would remain the same, however, a possible contributing factor to the increased death rate could be the massive reconstruction of the Salt Lake County freeway system, along with concurrent local road construction. The reconstruction effort has required closure of some areas of the freeway forcing more traffic to side streets, thus increasing local traffic congestion. It also has been noted in the news media there has been an increase in the incidence of "road rage" secondary to frustration due to the reconstruction efforts.

Development of community based service systems

The development of most of the community-based service systems has historically occurred via local health districts. Required site reviews and reports enable the State Title V agency to accurately monitor the progress of community-based service systems in a timely and efficient manner. Some community-based strategies are developed on a state level, e.g., media campaigns; protocols; standards; provider awareness campaigns; and public awareness campaigns. Monitoring by the Department occurs by collecting, compiling, and reporting results of activities.

Staff also serve on boards, steering committees, and/or provide technical assistance to agencies and projects. Beginning in 1999, there has been an increasing emphasis on disseminating community-based mini-grants at the local level for programs, such as tobacco prevention activities. It is anticipated that there will be more emphasis on community-based services in the next year. Progress monitoring of community based activities occurs at the state level through technical assistance, contract review and monitoring, and similar mechanisms. Through a series of summits, training, site visits, and required reporting Title V staff are able to determine progress and to identify additional resources to promote progress. The State contacts and collaborates with other state level agencies (e.g., the State Office of Education, the Juvenile Court, MCOs health care facilities) that offer services on a statewide and/or regional basis for maternal and child health populations.

Participation in various task forces has provided staff with the opportunity to become aware of and have input into some community based services. These have included participation in the Utah Ryan White Title II HIV Consortium, the Women and HIV Taskforce, DREAMM Fairs (Developing Reservation-based Efforts Addressing Mortality & Morbidity), and participation with other agencies at health fairs. Consultation is also provided to the Utah Spanish Perinatal Education Board regarding funding, development, and presentation of annual conferences for providers/agencies and individuals serving the Spanish speaking prenatal population in Utah.

The SIDS Program works with community organizations like local health departments, community health centers, hospitals, and police departments to educate those who work with populations at risk for SIDS, and those who work with families after a SIDS death to ensure that community-based services for these families are available and helpful. The SIDS Program works to provide them with up-to-date information, resources, and contact with parent advocacy groups to aid their development.

The State of Utah has received federal monies to fund abstinence-only education programs. The Division of Community and Family Health Services decided to commit all the federal funds to community-based programs. The Reproductive Health Program is the grant administrator of eleven community projects throughout the state. Projects are situated in local health departments, school districts and non-profit agencies. Several projects have expanded their

geographic area beyond their home base allowing access to these programs in additional areas of the state.

Four constructs of a service system for children with special health care needs

This section is only a small representation of how the state addresses the four constructs of a service system for children with special health care needs. In earlier sections of the needs assessment are many citations about the work of the state to foster a service system for these children. Please refer to these sections for a complete picture of Utah's efforts in this arena.

State collaboration with other state agencies and private organizations:

CSHCN Bureau works with Medicaid to administer a home and community based waiver, the Travis C. Waiver, for children who are technology dependent that currently serves 87 children. At this time there are no children on the waiting list and Medicaid has made a commitment to cover new qualifying children as they are identified. The CSHCN Bureau staff is also working with Medicaid to explore other waiver options, such as the Katie Beckett/TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) Medicaid option, a law that allows states to adopt an optional way for CSHCN to be eligible for medical assistance. CSHCN Bureau has collaborated with Division of Services to People with Disabilities to improve medical coordination for CSHCN included in Utah's DDMR waiver. Although $8 million was requested by DSPD to eliminate their waiver waiting list, the 2000 Utah legislature identified $1.8 million in state funding which will cover an additional 500 children and adults who were previously on the DDMR waiver waiting list. Although this will decrease the waiting list considerably, there are still many children and adults who need assistance through this type of waiver.

State support for communities

The Community-Based Early Childhood Services Systems Development Initiative has evolved from the collaborative efforts of a broad-based group of early childhood professionals

over the past two years. These professionals have identified a pervasive need for improved coordination and integration of existing services for young children and families throughout the State of Utah, into a unified and comprehensive early childhood service delivery system.

Support made available through this initiative will assist local communities to focus efforts toward the development and or improvement of their current early childhood services system. These efforts would be designed to ensure that all families with young children from birth through age 8 years are able to access the full range of care and education, health, and social services available to them within their communities. The ultimate outcome of successful early childhood systems development and improvement activities facilitated through this initiative is anticipated to be the improved well-being of Utah's young children and their families.

CSHCN Bureau staff has been active in providing technical assistance and consultation for a number of community development efforts. The BabyWatch/Early Intervention program has initiated a training program for early childhood staff through state universities and remote campuses. The state program also provides training and certification of providers throughout Utah, in an effort to increase the quality of early childhood education providers.

The Community Based Services Program continued to provide rural itinerant specialty clinics and has supported these clinics with community case management teams through the local health departments in nine rural sites. Training for these teams is provided both on-site and through telehealth. Local nursing case management is also provided through nurses who partner with local Human Services office staff in eight Utah sites, to provide health case management to children in Foster Care.

The CSHCN Bureau Systems Development Program addresses issues of transition, cultural awareness, and quality improvement. The community –based programs will receive training, consultation, and support, particularly in the area of adolescent and young adult transition services. Systems Development collaborates with other private organizations (i.e., Shriners Hospital for Children) in presenting "transition fairs", where service providers can offer information on healthcare, Medicaid, SSI, independent living, vocational rehabilitation and then coordinates with the community based programs to identify possible participants from their communities.

CSHCN Bureau has worked closely with Primary Children's Medical Center (PCMC) charitable contributions to enhance the coverage of medical care for children with special needs. Specifically, eligible children receive financial coverage for needed services through joint agreements between CSHCN Bureau and PCMC/Intermountain Health Care. The CSHCN Bureau provides financial and in-kind support to collaborative specialty clinics with University of Utah Health Sciences Center, Shriners Hospital for Children and PCMC. CSHCN Bureau staff supports the Utah Center for Assistive Technology in providing evaluations and adaptation of equipment for children.

Coordination of health components of community based systems

CSHCN Bureau staff have worked closely with Intermountain Health Care, the largest managed care organization in Utah, to set standards for that organization in providing health care to children with special health care needs. The CSHCN Bureau Director met with the committee to explain the state CSHCN Bureau programs and services and to establish an ongoing public/private collaboration.

CSHCN Bureau staff is working with the state directors of Children's Mental Health to develop partnerships in delivering services to children. Meetings with the CMH directors have allowed examination of issues for children served by both agencies and to help establish protocols of referral between the agencies, so that there will be minimal duplication of service and maximum quality of care for the children.

The CSHCN Bureau Director has been involved in the development of several grant applications by Primary Children's Medical Center to identify new ways to treat children with chronic care needs. Members of the Pediatric Ambulatory Care Committee, University of Utah, Department of Pediatrics has included CSHCN Bureau as well as other pediatric community providers, in the development of a Robert Wood Johnson Foundation Asthma Grant and a CSHCN Ambulatory Care Grant. Letters of intent to apply for both grants have been submitted.

The CSHCN Bureau Director meets quarterly with the Primary Children's Medical Center Inpatient Rehabilitation Director to collaborate about children with chronic illness. Specifically, issues are addressed about children with special health care needs, such as traumatic brain injury (TBI), cerebral palsy, and transition from acute rehabilitation settings. The CSHCN Bureau Director is the Medical Consultant for the Utah Traumatic Brain Injury Surveillance Grant

through the Violence and Injury Prevention Grant. However, there is no coordinated system of care for TBI. For example there is a TBI waiver for adults, but none for children. Although there are TBI teams in all school districts throughout the state, there is not as much collaboration as would be hoped among the different agencies and providers involved with children. Finally, there is no statewide TBI plan or advisory committee for children or adults.

The CHSCN Bureau Director also participates in Emergency Medical Services (EMS) for Children Advisory Board. Currently the advisory board has been discussing the provision of EMS to children during the 2002 Olympics, and Para-Olympics.

Coordination of health services with other services at community level

CSHCN Bureau clinical staff participates in the Family and Communities Together (FACT) Interagency Consultation Team, a state level team of professionals that facilitates problem resolutions in collaboration with families, local community agencies, local interagency councils and local administrative teams in providing appropriate supports to children and youth who have challenging needs. This team is usually involved with children with physical, emotional or behavioral conditions who are involved with multiple agencies, whose care is very expensive and for whom traditional services have been exhausted.

The CSHCN Bureau has begun a process of identifying Medicaid children served by CSHCN Bureau and the local community mental health centers (CMH). The CMH case file on the identified children will then be reviewed during a yearly site visits by the state's CMH staff and Medicaid. The review will assess access to services as well as appropriateness of services and providers. Language has been written into the state Medicaid Mental Health Plan and into the Medicaid CMH contracts requiring that the CMH plans participate in a monitoring process with Medicaid including CSHCN Bureau. As part of this process, Bureau staff will join Medicaid and the CMH staff to assist in site visits and client chart reviews. The Bureau is developing a monthly report of CSHCN Medicaid children, sorted by CMH district, which will be shared with the corresponding local CMH coordinator, which will allow better communication between local CMH and CSHCN Bureau coordinators. After each CSHCN Bureau itinerant clinic, the nurse case manager routinely invites the local Children's Mental Health staff to community staffing to discuss children being referred to the area mental health center.

3.2 Health Status Indicators

3.2.1 Priority Needs

Infrastructure building capacity is strong, with much work accomplished in the areas of data integration and data analysis. The Division has built strong collaborative relationships with many different programs within the Department as well as with outside agencies. The area that requires further attention is assisting local public health providers serve more of the low-income maternal and child health population. Strategies such as third party billing, examining cost-effectiveness of locally delivered services, etc. will enable more clients to be served. Two additional areas need to be addressed which are state staffing needs: the need for a MCH epidemiologist and an adolescent health consultant. After completion of the five-year needs assessment, the Division will review its current allocation of funds to determine how these staffing needs can be met.

Population-based service capacity has developed and flourished over the past five years. The Division has developed stronger, broader programs to address the needs of the MCH population. The Injury Prevention Program, for example, has greatly expanded its activities to include domestic violence and sexual assault in its program plan. The Division has expanded its hotline services to include immunizations, and other more general health hotlines to better serve people of Utah.

Direct and enabling services are generally available statewide for the maternal and child health populations, however, there are some pockets of greater need than can be addressed with current funding and available resources. The Division has developed strong enabling services, but there is great need to examine mechanisms to ensure that more services are available for the maternal and child populations without insurance. With completion of the five-year needs assessment, funding to local health departments will be examined to determine if there are better ways to allocate the available funding.

The Division has selected nine priority areas that need to be addressed to improve health of Utah mothers, infants, children, adolescents and children with special health care needs. These were selected after a prioritization process utilizing the Pickett-Hanlon Method previously used by the Washington State Department of Health.

The nine priority needs that the Division identified are:

Low birth weight

Unintentional pregnancy

Mental health

Unintentional injury

Vaccine preventable illness

Dental health

Intentional injury

Vision screening for amblyopia

Transition to adulthood for children with special health care needs

Low birth weight rates should be reduced, especially among minority and racial populations with rates above the state average. Unintentional pregnancy needs to be reduced among Utah women to reduce its associated consequences of poor pregnancy outcomes. Mental health services need to be more readily available to low-income maternal and child populations, especially children with special health care needs. Unintentional injuries need to be reduced, especially those that are due to motor vehicle or pedestrian accidents. Vaccine preventable illness needs to be reduced through improved immunization rates among Utah's population, especially among children. Dental health access for low-income children and adults needs to be improved in order to ensure better oral health. Intentional injury needs to be reduced, especially suicide rates of adolescents in the state. Vision screening for amblyopia needs to be universally available to reduce the high morbidity due to late detected or undetected amblyopia. Transition to adulthood services needs to be more readily available for children with special health care needs as they become adults.

In addition to the nine health priorities, the Division identified health systems issues that need to be addressed. While they are not included in the priority needs section, they will be incorporated into the activities that the Division develops to address the priority health needs.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

3.3.2 Other Requirements

The Division of Community and Family Health Services (CFHS) is organized to address specific maternal and child health needs through a partnership between State agencies and the private sector to form a coordinated statewide system of health care. CFHS'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.

The amount of state funds that will be used to support Maternal and Child Health programs in FY01 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 FY01 [sec.505(a)(4)].

It is understood that for each four federal dollars a minimum of three state dollars will be specifically designated as match. CFHS allocates a total of $15,088,700 of state general funds appropriated by the Legislature for MCH activities. A total of $8,327,400 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of $4,700,348. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and other federal funding to expand and enhance MCH programs and activities. Programs including Baby Your Baby, Pregnancy RiskLine, Tobacco Education, Fostering Healthy Children, and Immunization significantly benefit from this use of the state funds. CFHS receives private donation and grant funding which is used to enhance selected programs such as Baby Your Baby, Utah State Immunization Information System (USIIS), Pregnancy RiskLine, SIDS Program, and Covering Kids Utah. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities.

CFHS 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)].

CFHS 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 every three years 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.

CFHS 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. The allocation of funds is subject to review by the MCH Advisory Committee. In addition, there are a number of other program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as Child Fatality Review, WIC, SIDS, Newborn Screening, and Baby Watch/Early Intervention.

The budget reflects some adjustments resulting from internal reassessments conducted in an effort to keep actual expenditures in close alignment with available funding. The component 30%-30% requirement indices were used to set program priorities and maintain focus. With this year's five-year needs assessment and identification of priority health needs, the Division will examine funding allocations to ensure priority needs are addressed.

The Department negotiates a single contract 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 sudden infant and childhood death counseling. 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 annual action plans 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.

It should be noted that the Utah Department of Health was restructured during the 1995/1996 time frame. This was a result of an internal initiative to better integrate categorical public health programs into a coordinated system of services for children and pregnant women. During this process, many programs of the former Division of Community Health Services and the Division of Family Health Services were merged to form the Division of Community and Family Health Services. Budget figures for FY97 were developed prior to these changes. Reported increases in FY97 expenditures reflect the expanded CFHS organization.

Form 3

The overall budgeted subtotal (line 7) increased from $18.1 million in FY1996 to $33.4 million in FY99 and the corresponding annual expenditures increased from $20.0 to $33.4 million. These increases were due to the Division merge as noted above which increased the amount of reportable MCH activity expenditures beginning with the FY1997 expenditures. Other increases included an additional $750,000 in state funds appropriated by the Legislature in FY1998 to cover the increased caseload in the Baby Watch/Early Intervention Program. The WIC Formula Rebate funding was not reported in the FY1996 budget or expenditures, but was included beginning in FY1997; this is also the source of funding for the increase in line 5 (Other). Local health department funding of approximately $930,000 was inadvertently left off the FY1996 budget and expenditures which contributed to the expenditure increase of the federal allocation between FY1996 and FY1998.

FY1999 expenditures Line 2 (Unobligated Balance) is $622,813, reflecting the actual carryover balance, which was significantly different from the estimated FY1999 unobligated balance of $1.4 million. This difference was partly due to increased expenditures for computer upgrades. State funds (Line 3) for the FY2001 budget increased by $3 million due to new Tobacco Settlement funding received by the Division, and also an increase of $300,00 for the Baby Watch/Early Intervention Program growing caseload. Local health departments continue to contribute additional local funds for MCH activities which resulted in a reported increase on Line 4 of approximately $200,000 for FY1999 expenditures and the FY2001 budget. Other Funds (Line 5) FY1999 expenditures and FY2001 budget increased by approximately $900,000 due to

an increase in the WIC Formula Rebate funds. A new grant received by the Division from the Robert Wood Johnson Foundation for Covering Kids Utah also contributed an increase of more than $300,000 to Line 5 for the FY2001 year. Program Income (Line 6) for FY1999 expenditures and FY2001 budget increased from the FY1999 budget due to several factors: additional $1 million in Medicaid matching funds for CSHCN Administrative Case Management; increased Medicaid match of $430,000 for the Fostering Healthy Children Program; Medicaid match for the FACT contracts of $350,000; and slight increases in medical billing collections for CSHCN clinical programs.

Form 4

The subtotal spent (Line I-g) increased from $20.1 million for FY1996 to $33.2 million for FY1998. These increases were due to the Division merge as noted above which increased the amount of reportable MCH activity expenditures beginning with the FY1997 expenditures. Over half the increases in expenditures were for pregnant women and infants because of the inclusion of the WIC Formula Rebate funding which was not reported in the FY1996 budget or expenditures, but was included beginning in FY1997. More funding is being allocated in the Children 1-22 category due to the merger of the two divisions. The old Community Health Division included programs with a focus on this age group, which correspondingly increased the expenditures and budget. Also contributing to this increase were additional Tobacco funds (Medicaid match and State funds); increases in Fostering Healthy Children Program Medicaid matching funds; additional Medicaid match for the Immunization Program; and increased contribution of local funds by the local health departments. It should be noted that when the Division receives new or additional state and other funding such as referenced above we are obligated to use the funding for the purpose it was appropriated or received for, which in this case has resulted in Children 1-22 receiving more of the fiscal pie than the other categories. However, this does not mean that Title V funding is allocated disproportionately. CDC MCH related support increased from $0.3 million to $4.6 million between FY1996 and FY1998 due to the Division merger. In FY1996 the old Family Health Services had only one grant from CDC which was the Disabilities grant. After the merge with Community Health Services we included grants such as Preventive Health Block Grant, Immunization, Core Capacity Tobacco, and Breast and Cervical Cancer.

The increase in the FY2001 budget for Children 1-22 is due to approximately $2.4 million in new Tobacco Settlement funding received by the Division. Other increases include an additional $400,000 in Medicaid match for the Fostering Healthy Children Program, and an increase of approximately $200,000 in WIC Formula Rebate funds. The FY2001 budget for CSHCN reflects increases for the Baby Watch/Early Intervention Program at $400,000 which includes state funds and collections, and a slight increase in the WIC Formula Rebate funds. The Tobacco Settlement funds also increased the FY2001 budget in the Other category by $600,000.

Form 5

Between FY1996 and FY1998, expenditures increased $12.1 million from $20.1 to $33.2 million. The majority of this increase (approximately $8.6 million) was the WIC Formula Rebate funding which increased the Enabling Services category. These funds were not reported in the FY1996 budget or expenditures, but were included beginning in FY1997. Other increases in Enabling Services include an additional $550,000 for the Baby Watch/Early Intervention Program.

FY1999 expenditures show a decrease from FY1999 budget due to $45,000 for Prenatal Enhanced Services being shifted to Enhanced Services. Baby Watch/Early Intervention Program was also reassessed and the percentage for Direct Services was reduced and shifted to Enhanced Services. Local health departments also reported a decrease in Direct Services of $100,000. For the same time period, the Enabling category increased based on those items noted above; there was also an increase in the WIC Formula Rebate funding expended in FY1999. Population Based Services expenditures increased for FY1999 due to local health departments contributing additional local funds for these services.

FY2001 budget reflects a 6% increase in Direct Services which is accounted for by additional funding contributed from local health departments to MCH activities throughout the state, as well as small increases across all programs within the Division. The Enabling Services category increased by 11% for the FY2001 budget due to increased funding in Baby Watch/Early Intervention Program, WIC Formula Rebate funding, and Fostering Healthy Children Medicaid matching funds. FY2001 reflects a large increase in the Population Based Services category (49%) which is $2.4 million in new Tobacco Settlement funds, and more than $300,000 for the Covering Kids Utah private grant. A 15% increase in FY2001 for Infrastructure is the result of Tobacco Settlement funding and Baby/Watch Early Intervention additional funding.

Figure 3

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

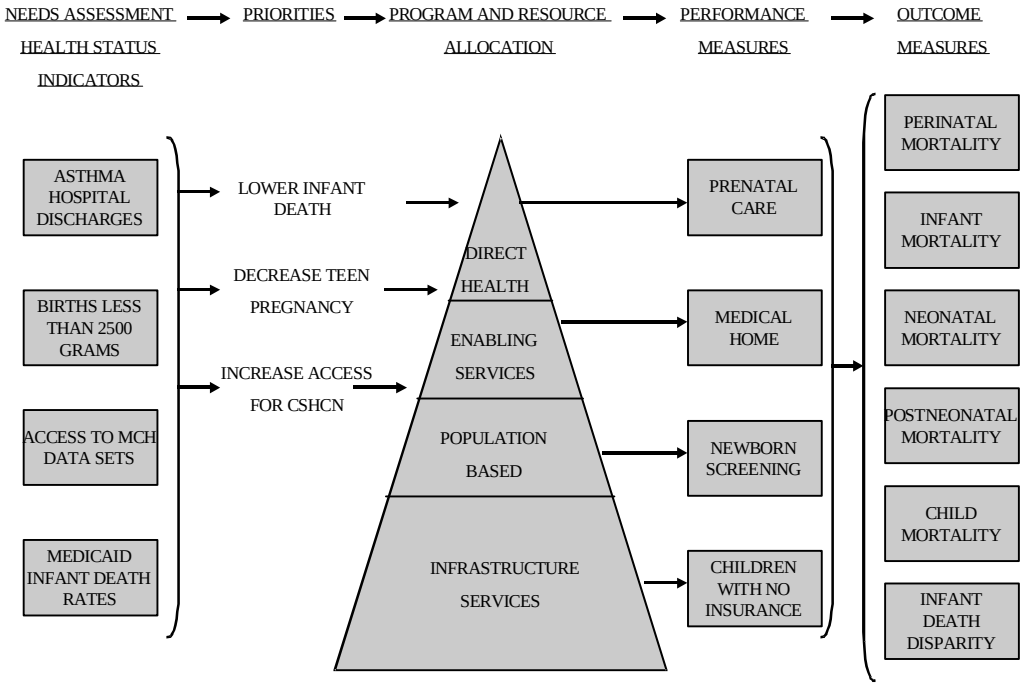


Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) 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.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickcle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP1 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.	X				X		
SP2 The percent of cigarette smoking by teenagers age 12-17 years.		X					X
SP3 The percent of bicycle helmet use among bicyclists 5-12 years of age.			X				X
SP4 The percent of use of vehicle safety restraints among child occupants under nine years of age.			X				X
SP5 The percent of kindergarten through twelfth grade students who receive two doses of Measles, Mumps, and Rubella (MMR) vaccine.			X				X
SP6 The rate (per 10,000) of neural tube birth defects.			X				X
SP9 The percent of pregnant women with adequate weight gain who deliver live born infants.				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Objectives

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

During the first year of performance measures, CFHS developed nine state performance measures. In evaluating these nine measures this year, the Division has decided to drop two for the coming year with plans to develop at least two additional replacement measures during the coming year based on the needs assessment identification of priority needs. The performance measure related to development of the internet-based query system for MCH measures, MatCHIIM, was dropped because this performance measure has been accomplished. The second performance measure that was dropped was the one relating to day care provider participation in the Utah Health and Safety Curriculum. This measure was dropped because of difficulty in measuring the objective because it depended on data sets from CFHS as well as data sets from the Division of Health Systems Improvement, Bureau of Licensing, responsible for licensing day care providers in the state. The Division will continue its efforts in this area, but will probably develop a measure that is more

reflective of Division activities. Utah's state performance measures include one for each of the four levels of the pyramid of services and at least one for each of the three population groups. Over the next year, Division staff will review the state performance measures to ensure that the priority areas identified in this year's needs assessment are reflected.

The categories were chosen for placement on the level of the pyramid of services based on the category of program activities planned to meet these measures over the next five years. We have added the state performance measures at the end of Figure 4.

3.4.2.2 Discussion of State Performance Measures

These state negotiated performance measures were chosen due to their importance to the Division's program's goals as contained in the Annual Division Plan. The Division has developed this document for internal use to guide program efforts over the upcoming year. We refine the health status indicators as we check our progress in achieving our stated mission and goals.

State performance measures were included in the priority MCH needs we outlined on Form 14 in last year's application and were placed on the level of the pyramid of services based on the category of program activities which are planned to meet these measures in the upcoming years. However, we will re-evaluate state performance measures after we have had a chance to review this year's needs assessment information.

Rationale behind the selection of some state performance measures is illustrated in the choice of state performance measure #4 (to increase the percentage of use of vehicle safety restrain to among child occupants under 9 years of age) has a clear relationship with the outcome measure to reduce the rate of preventable deaths per 100,000 children aged 1-14.

We had selected these state performance measures because they represent the best link to the Division's desired outcomes, they are representative of Title V activities which we consider to be important and we have data systems already in place to measure them thereby keeping this process practical.

3.4.2.3 Five Year Performance Objectives

3.4.2.4 Review of State Performance Measures

Will be discussed at MCH Block Grant Review in August 2000.

3.4.3 Outcome Measures

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

Direct Health Care

PM1 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.

CSHCN will work toward strengthening its support in assuring rehabilitative services to children receiving SSI benefits by working with Utah representatives of SSI and Disability Determination Services on collaborative projects. Specifically, the Assistant Bureau Director is being nominated to the Disability Determination Advisory Board for the upcoming fiscal year which will improve the communication between agencies.

CSHCN will provide training to staff (resource specialists, nurses and social workers) to improve their rate of identification of potential SSI beneficiaries within the CSHCN population served through its clinics. In addition, CSHCN will increase the rate of collection of social security numbers on children served by the CSHCN programs by making sure that all Bureau programs have the information collected, which will allow for improved data linkages with the Department of Workforce Services in tracking SSI eligibility for specific children.

In order to further our efforts in assisting disabled children to access SSI (Supplemental Security Income) we plan to develop a better relationship with the Social Security Administration. One of our goals will be to help parents understand their appeal rights for SSI. CSHCN will also develop training for staff in the use of PASS (Plan to Achieve Self Sufficiency), which is an option through SSI that allows young adults the added benefit of increased income through the use of a vocational/educational plan.

PM2 The degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to clients.

There are a number of ways in which the CSHCN Program provides or pays for various specialty and subspecialty services. Many of the CSHCN clinical activities are collaborative efforts between CSHCN staff, the University of Utah Department of Pediatrics, Primary Childrens Medical

Center and Shriners Hospitals for Children. CSHCN tries to provide services as they are not otherwise available in the community. In Salt Lake County, where the pediatric tertiary care providers are located, CSHCN augments existing services by ensuring that multidisciplinary clinics and care coordination are available for children with special health care needs. In rural Utah, CSHCN provides a larger part of the specialty and subspecialty services through travelling clinics and local health department case management.

The Neonatal Follow-up Program plans to continue the support of the statewide system of multidisciplinary follow up for a target population of very low birth weight infants (VLBW) through the preschool years. To accomplish this, CSHCN is working in partnership with all Utah newborn intensive care units, early intervention and private primary care providers to develop a network of services for these children. The Neonatal Follow-up Program ensures that VLBW babies receive routine multidisciplinary screening services and that identified problems are referred to appropriate community resources and health care providers.

The Child Development Clinic Program provides direct clinical services to children birth to five years of age with special health care needs. Goals for the upcoming year include identifying and enhancing community partnerships for improved service delivery; increasing community awareness activities through the dissemination of educational materials and program information; increasing participation in educational training activities; developing a support group for families of children with psychosocial issues; and improving clinical support for multineeds children in foster care and early intervention programs.

The Adaptive Behavior and Learning Evaluation Clinic (ABLE) plans to continue to provide comprehensive health services to school-aged special needs children who have complex health needs, including medical and physical challenges, emotional difficulties, learning disabilities, developmental delays, behavioral disorders and/or attention disorders. The staff is involved in interagency staffings to coordinate services for these children by developing core teams in schools and other agencies providing services to the family and by participating in Families, Agencies and Communities Together (FACT). The team will continue to visit certain schools on a rotating basis to staff at-risk children and outreach to more schools. Plans also include meeting with at-risk families in non-traditional settings to provide services for those who have difficulty in traveling to the clinic.

The Fostering Healthy Children Program (FHCP) will continue to partner with DCFS to provide collaborative health care case management with the Division of Child and Family Services. FHCP will finalize and distribute the Health Status Outcome Measure report. Reports will be shared

with key stakeholders in the foster care system and will be used as a tool to improve the medical, dental and mental health care of these children. The SAFE system, Utah's child welfare database, will be finalized and will include fully implemented health care screens. During FY01, FHCP staff will work working toward fully immunized children for the 0-5 year old population. Standards and procedure for the provision of health care to foster children will be finalized.

The Systems Development Program will continue to provide specialty pediatric services through our public–private partnership with University of Utah Department of Pediatrics and Primary Children's Medical Center. The Department of Health will continue to work towards "privatization" of these services, playing an active role in contracting for specialty medical services rather than being a direct service provider.

SP1 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.

Community Based Services (CBS) will continue to contract with 5 Local Health Departments during FY01 and maintain clinical sites in 9 locations around the state. Through the local health contracts, nurse case managers and clerical staff will schedule clinics, send out appointment letters, call families, provide case management services, coordinate tests and laboratories, collect reports and maintain charts. Ongoing training will be provided by CBS to local staff on case management issues, the Access software database, encounter forms, and resource information.

The CBS Newsletter will continue to be developed and distributed monthly to local sites as a method to disseminate information. Chart audits will be conducted again this year beginning in January. Follow-up from last year's recommendations will be assessed as well as any new areas for improvement. A satisfaction survey is planned for December of 2000 to assess parent satisfaction with the CSHCN clinical services received in their local area. Surveys will be sent to families whose child was seen during the past year.

Hearing, Speech and Vision Services will provide pediatric speech, hearing and photorefraction vision services throughout Utah. Once a problem is identified, children will be referred to appropriate local services for continued management. Clinical facilities are located in Salt Lake, Ogden, Cedar City, Price, Vernal, and Montezuma Creek, Utah. Services will also be made available to all other CSHCN clinical programs. Approximately 2,000 patient evaluations and 500 additional screenings

will be provided statewide. There will an effort to increase vision photoscreening in all clinical programs.

HSVS will continue to support their regional clinical offices in Price and Cedar City, which serve the rural eastern, central, and southern areas of the State. Hearing, speech and vision services will be provided at eleven itinerant CSHCN clinic sites, and twenty-two itinerant HSVS sites. Direct clinical services will be provided in local health departments, Head Start, Early Head Start, hospitals, early intervention centers, preschools, and to the public throughout the State.

During FY01 the CSHCN Bureau will continue its efforts to improve services to rural children with special health care needs through the use of telehealth technology. These activities will supplement services to rural children with special needs using videoconference technology currently in place through the Utah Telehealth Network at the University of Utah. It is hoped that services can be expanded to additional sites along with other needed services. The telehealth network will be used to provide long-distance clinical health care, patient and professional health-related education, public health and health administration.

Enabling Services

SP2 Percent of cigarette smoking by teenagers aged 12-17 years.

The recent data showed that 14.9% of teenagers, age 12-17 years, used tobacco. Since the data indicate there has not been a decrease, this state measure continues to be a priority for the Division. The activities identified target three approaches to reducing cigarette smoking among teenagers. These are youth tobacco cessation, youth tobacco access and tobacco prevention.

Youth tobacco cessation activities include continued implementation of the E.N.D. (Ending Nicotine Dependence) Program. Facilitators will be identified and trained throughout the state. Pre- and post-test results will be analyzed and results disseminated statewide.

Local health departments and law enforcement agencies will complete compliance checks on all tobacco retail outlets. Results will be compiled and analyzed.

The anti-tobacco media campaign "The Truth About Tobacco" will utilize television and radio ads targeted to youth. A survey of non-smoking youth will determine the campaign's effectiveness in preventing youth from using tobacco.

The Department of Health received additional monies for FY2001 from the National Tobacco Master Settlement Agreement for tobacco prevention and control activities. With the increase in funding tobacco control efforts will expand from the youth-only focus of the past. Cessation efforts will now include adults with increased emphasis on smoking among pregnant women. The media campaign will be expanded and will continue to utilize successful strategies from other states. Several statewide and community level projects will be funded to address various prevention and cessation strategies. Local health departments will continue to play a unique role in community level tobacco prevention and control efforts.

PM3 The percent of CSHCN in the State who have a "medical/health home."

CSHCN and the Data Resources Program (DRP) developed and administered a survey for families of children with special health care needs, which was administered in conjunction with the Child Health Survey for Utah children and families. Four questions were included which were developed to identify which survey respondents had a "medical home." Evaluation of these questions will be available in the fall of 2000. The questions were:

- "When you take "J" to Dr. Smith's office how often do the providers you see have access to ALL THE MEDICAL RECORDS, including specialist reports, to provide his care
- "When you take "J" to Dr. smith's office how often does the provider have a thorough understanding of ALL the services he is getting?
- "How often do the doctors or other health care providers at Dr. Smith's office respect your family's beliefs, customs, and language?
- "After going to the specialist or specialty clinic, does the provider at Dr. Smith's office usually talk with you or "J" about what happened at the specialist visit in a way that you understand?"

As previously mentioned, Utah is the fourth state in the nation to participate in the American Academy of Pediatrics/Shriners Hospitals for Children "Every Child Deserves a Medical Home Facilitator Training." The Director of CSHCN Bureau will work with key staff from the Utah Chapter

of AAP Primary Children's Medical Center (PCMC), Shriners Hospital and Medicaid managed care organizations to define and tailor the medical home training to the medical home for Utah children. In 2001, a two-day long facilitator-training program will be held at PCMC and Shriners Hospital for Children. In addition, after the training sessions have been completed, plans will be made for follow up training for physicians and allied health personnel on specific issues pertinent to children with special health care needs, such as transition to adulthood, and providing culturally and family sensitive care.

Population Based Services

PM6 The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Although the teen pregnancy rate has been decreasing in Utah as in the U.S. as a whole, activities related to a continuing decline in rates are a priority for the Reproductive Health Program during 2001. Activities for this year will include: continuing support of local health department efforts in adolescent pregnancy prevention; maintenance of a website related to Utah teen pregnancy statistics with links to the National Campaign to Prevent Teen Pregnancy's Website; continued support to the work of Utahns Concerned with Adolescent Pregnancy and Parenting (UCAPP); and, continued funding and support of abstinence education or motivational programs for youth between the ages of 9 and 14. Local health departments are provided with data and statistics upon their request, in order to target areas and populations within their health districts with locally developed interventions. Because of state and community mores, education and promotion of contraceptive use among sexually active teens is difficult in Utah. Therefore, the Department prefers to allow local communities to develop interventions that are suited to their communities' needs. Continued collaboration with Planned Parenthood Association of Utah will help to accomplish common goals of teen pregnancy prevention. The Reproductive Health Program website (www.utahrhp.org) contains an analysis of teen pregnancy data with links to resources for the prevention of teen pregnancy. The Program will continue to develop and add appropriate links and resources and to promote the use of the website to the public as well as to health care providers. Collaboration with UCAPP enables the Department to partner with many other organizations throughout the state that are involved in teen pregnancy issues. This coalition meets on a monthly basis to identify priority needs in the area of teen pregnancy. The

Reproductive Health Program oversees federal funds that have been allocated to eleven communities projects around the state to promote abstinence education among 9 to 14 year olds. Most of these projects have been in operation for three years now and are doing an excellent job. The Program will continue oversight of these projects and provide technical assistance to them as requested.

PM9 Percentage of mothers who breastfeed their infants at hospital discharge.

The American Academy of Pediatrics has recommended breastfeeding as the preferred feeding method for infants during their first year of life. Not only does it provide optimal infant nutrition, but it has also been proven to decrease infections through immunities provided from mother to infant and to promote maternal-infant attachment. In order to increase the percentage of mothers who breastfeed their infants at hospital discharge to 77% during 2001 from the 76.2% % of women who did so during 1998, the Maternal Child Health Bureau has identified the following activities: continuation of WIC breastfeeding classes for pregnant and postpartum mothers, promotion of the development of breastfeeding support groups/classes for postpartum women in WIC; training to increase the number of public health and other community agency staff trained in the basic breastfeeding support skills; and, collaboration between WIC clinics, community hospitals and medical clinics in breastfeeding promotion and support. In addition, the WeeCare perinatal case management program within the Reproductive Health Program plans to track its case managed clients and report on the percentage of women who breastfeed. They are developing many excellent resources to promote breastfeeding among their clients. The Reproductive Health Program will also collaborate with WIC on their "Breastfeeding Welcome Here" campaign to encourage worksites to be "breastfeeding friendly". The Reproductive Health Program will track breastfeeding rates among Medicaid clients cared for by managed care organizations along the Wasatch Front during our annual quality assurance reviews. An important comment from the Division of Health Care Financing/Medicaid encouraged us to pursue efforts to educate health care providers who can in turn educate consumers about the advantages of breastfeeding, not only obstetricians, but family practice, pediatric and nurse practitioner health care providers as well. We will collaborate with Medicaid this year to distribute information to health care providers promoting this important strategy to improve the health of Utah infants.

SP6 The rate (per 10,000) of neural tube birth defects.

There are currently very few known strategies to prevent congenital anomalies. However, in recent years, the supplementation of folic acid to the diets of preconceptional and early pregnant women has shown promise in reducing the devastating toll of neural tube defects (NTD). It is Utah's goal to reduce neural tube birth defects to 6.3 per 10,000 live births in 2001 from the current rate of 6.6 per 10,000 live births (1998). In order to accomplish this goal, we have the following activities planned: implementation of a teacher module including educational materials and state and national contacts about birth defects and prevention for all 100 high schools statewide; utilize grant funding obtained to purchase multivitamins with folic acid and distribute them to all WIC clinics statewide with face-to-face counseling to women enrolled in WIC about folic acid consumption and birth defects prevention; continue the NTD Recurrence Project, outreach to women who have a pregnancy affected by a NTD with appropriate information about folic acid and recurrence prevention; and lastly, continue to educate health care providers, through the Intermountain Pediatric Society, the Family Practice Refresher Course and others, on the topic of folic acid and prevention of NTDs.

PM7 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

During FY01 CFHS will continue to promote sealants through screenings and referrals to public and private dental offices and dental hygiene schools, and through community outreach. The Salt Lake Valley Health Department Oral Task Force (OHTF) will conduct at least three Sealant Saturdays for children in grades one through three enrolled in "high risk" elementary schools in Salt Lake County. The Oral Health Program in collaboration with the Utah Dental Association and component dental associations will promote the Sealant Saturday model developed by the OHTF in order to conduct Sealant Saturdays on a statewide basis. A public awareness campaign will be conducted by the OHTF to promote oral health preventive measures including the use of sealants. Sealants will be promoted by school nurses in classrooms throughout the state using educational materials developed by the Oral Health Program. Other strategies to promote sealants include television spots on the Baby Your Baby series, WIC clinic presentations, and outreach to dental professionals.

PM5 Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Through FY01, the immunization registry, USIIS (Utah Statewide Immunization Information System) will complete the development of the CDC-required 13 minimal functional attributes. USSIS will roll out the registry applications and connections to all public providers and some private providers, 6 or 7 health plans, and 5 school districts in the Wasatch Front area. Providers can use any of the two USIIS self-developed applications, Personal Oracle Local Database, KIDS, or Web application WebKIDS. The registry will have capacity to receive immunization data in the HL7 format. The registry will provide training and support to users at all levels. As resources permit, USIIS will develop additional functions such as vaccine ordering to support the Vaccine For Children (VFC) Program.

The VFC Program will actively recruit health care providers to increase enrollment. This increase will be accomplished through contacts to newly enrolled Medicaid providers and managed care organizations, and personal contact by program regional specialists to physicians in their assigned areas identified as not enrolled in VFC. Each provider will receive an information packet describing the program, and a baseline assessment of the immunization levels in their practice to identify strategies to complete immunizations. An annual customer survey will be completed to identify program changes or enhancements that would increase enrollment. The "Every Child by Two" Immunization Task Force Private Provider committee and pharmaceutical company representatives will participate in efforts to recruit providers into the VFC program.

The successful "Immunize by Two, It's Up to You" media campaign will be continued. Its goal remains to raise awareness through education and information to remind parents of the importance of immunizing their child by age two. First Lady, Jacalyn Leavitt, will continue as the spokesperson and chair of the statewide immunization taskforce. The campaign in partnership with private business support will continue to use the media campaign and targeted promotions with a focus on Infant Immunization Week. Mobile immunization clinic activities (Care-A-Van) will continue. The campaign will be supported by the Hallmark two-month birthday card program.

The Immunization Program will continue to develop public/private partnerships to promote the need for immunizations. These partnerships will include Office of Child Care, PTA, WIC, local health departments, and community and migrant health centers. WIC clinics will continue to screen clients for immunization status, provide education on immunizations before nutrition classes, and refer them

to their primary care providers for immunization. Special emphasis will be outreach to special ethnic populations to include a refugee health contract and Native Americans through participation in DREAMM Fairs (Developing Reservation-based Efforts Addressing Mortality & Morbidity).

The Immunization Program will work with the Utah Medical Association, pharmaceutical companies, Medicaid, and managed care organizations to train private physicians and office staff in using the Clinic Assessment Software Application (CASA) to document their immunization rates.

SP5 The percent of kindergarten through twelfth grade students who receive two doses of Measles, Mumps and Rubella (MMR) vaccine.

The Immunization Program will continue to educate parents and providers about this new requirement and work with school districts and school nurses to enforce the newly established requirement for two doses of measles vaccine. The electronic database developed to enhance reporting will be further developed. The Immunization Program will continue a collaborative relationship with the State Office of Education in collecting and analysis of school immunization data to increase rates and develop strategies to increase compliance. Educational materials including, The Utah School Law -A Parent's Guide brochure, will be distributed to schools, local health departments, and community and migrant health centers.

PM8 The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Among Utah children ages 1-14 years, motor vehicle crashes are the leading cause of injury death. To reduce these preventable deaths, the Violence and Injury Prevention Program (VIPP) will continue to collaborate with its numerous state and local partners to develop and implement effective strategies for reducing motor vehicle crash fatalities among children in Utah.

The 2000 Utah State Legislature passed legislation requiring primary enforcement of seat belt use for children and young adults up to the age of 19. Although this law is less than the universal standard seat belt law that had been advocated, it is a major step forward in promoting seat belt use among adolescents, the population at highest risk of motor vehicle crash injury and death. VIPP will continue to provide information and assistance to the Motor Vehicle and Pedestrian Safety Committee

established by the 1999 Utah Legislature. The purpose of the committee is to investigate issues, establish legislative priorities and recommend legislation. The Utah Department of Health Deputy Director will be a member of the committee and VIPP staff will report or attend committee meetings upon request.

VIPP will continue to provide funding, training and technical assistance to local health departments to conduct motor vehicle safety and injury prevention programs including promoting use of bicycle helmets, child car seats, booster seats and seat belts, and pedestrian safety education for school age children and youth. During FY2001, VIPP and local health departments will begin a coordinated statewide campaign to promote use of booster seats among children ages 4-8 years.

VIPP will continue to develop and coordinate a pedestrian safety campaign that targets adolescent drivers and pedestrians. Objectives and activities include increasing pedestrian safety awareness and instruction in high school drivers education classes, and conducting a pedestrian safety media campaign, distributing educational materials, providing articles for newspapers, and providing information on the UDOH internet site. VIPP will also continue to promote the Wary Walker Pedestrian Safety Curriculum and making it available to K-3 elementary school teachers.

SP 3 The percent of bicycle helmet use among bicyclists 5-12 years of age.

During the 1995 Utah Bicycle Helmet Use Survey, only 7.6 % of elementary school age children observed were wearing bicycle helmets. The 1999 survey showed an increase to 15.6%. While this increase is encouraging, this rate is far below the HP2000 objective of 50%. Studies have estimated that wearing a bicycle helmet reduces the risk of head injury by 85% and the risk of brain injury by 90%. Proper use of bicycle safety helmets is the single most effective measure for preventing bicycle-related brain injuries and deaths. To reduce mortality and morbidity due to bicycle-related head trauma, the Violence and Injury Prevention Program (VIPP) will continue to collaborate with many state and local partners to increase the use of bicycle helmets among elementary school-age children in Utah.

VIPP will continue to provide community education through media interviews and PSAs, distributing educational materials, providing articles for newspapers and providing information on the UDOH Internet site. VIPP will continue to seek sources for low cost helmets and make them available for distribution through local health departments and other community partners. The VIPP

will continue to conduct its annual observation survey to estimate bicycle helmet use in Utah. The results of these surveys will continue to be shared with LHDs and other interested parties.

VIPP will continue to provide training, technical support and funding for contracts with local health departments to promote bicycle helmet use. Examples of local community activities may include distribution of bike helmets during bike rodeos and other bike safety events; low cost helmet sales; distributing bike safety and helmet information for parents through PTAs and school mailings; worksite presentations; poster contests for kids; school assembly and classroom presentations and instruction; local business sponsorship of bicycle rodeos; displaying posters; providing coupons as incentives for helmet use; and, public education campaigns that use statewide and local media including newspaper articles, letters to the editor, radio or TV PSAs, local radio interviews, distribution of posters, and flyers, etc.

SP 4 The percent of use of vehicle safety restraints among child occupants under nine years of age.

Proper installation and use of safety belts, car seats and booster seats is the single most effective action for preventing motor vehicle crash fatalities. To increase use of safety restraints among children, the Violence and Injury Prevention Program (VIPP) will continue to collaborate with state and local partners. VIPP will continue to work closely with the Utah SAFE KIDS coalition and local chapters and coalitions to promote child occupant protection. Activities will include conducting car seat and booster seat inspections and training; providing free and/or low-cost car seats; conducting safety education for school age children; conducting media interviews; providing articles for newspapers; and, providing information on the UDOH Internet website.

During FY2001, VIPP and local health departments will begin a coordinated statewide campaign to promote use of booster seats among children ages 4-8 years. This will include a public awareness campaign to educate parents about the importance of booster seats for children ages 4-8 or 40-80 lbs. and conducting car seat checks that provide inspection and training about the proper use of booster seats.

VIPP will continue to collaborate with the Utah Highway Safety Office, Utah Safety Council and Utah SAFE KIDS to identify sources of low cost car seats and booster seats and facilitate their

purchase and distribution through local health departments, hospitals and clinics, and other organizations.

The Utah Highway Safety Office/Highway Patrol conducts annual observation surveys to determine car seat and seat belt use and publishes an annual report. VIPP will continue to distribute these data to LHDs and other interested parties, and use this information to track progress toward state objectives for occupant protection use.

PM4 Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies.

The Newborn Screening Program will continue its surveillance and identification of children with phenylketonuria (PKU), congenital hypothyroidism and galactosemia. During the coming year, CSHCN will be implementing its new care coordination & data tracking system for these children. CSHCN will be investigating the addition of hemoglobinopathy (sickle cell) to its screening battery. Partners in this will be the Division Epidemiology and Laboratory Services and Primary Children's Medical Center's Hematology Department.

CSHCN will continue to provide collaborative and financial support to the metabolic follow-up clinic, which follows children with phenylketonuria (PKU) and galactosemia. In the 1998 legislative session, a bill was passed mandating that the Utah Department of Insurance develop ICD-9 codes for medicinal food required for children with inborn metabolic errors. CSHCN staff will continue working with families, the Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

PM10 Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Hearing, Speech and Vision Services (HSVS) will assist in increasing the percentage of newborns screened, improve the hospital screening pass rates, and improve the outpatient screening and diagnostic audiology completion rates. Technical assistance and audiological supervision will be provided statewide by HSVS licensed audiologists. Information will be distributed regarding equipment, test protocols, follow-up procedures, and parent education materials.

HSVS will continue to work with known birth attendants to meet State hearing screening requirements of all newborns and provide parental educational and referral materials. A reporting

system for home births will be investigated. HSVS will also work with Utah Vital Records and Newborn Screening in a pilot program to evaluate the use of a unique identifier, utilizing electronic links. Finally, HSVS will continue to maintain a statewide hearing loss database to ensure appropriate diagnostic and habilitative interventions.

Infrastructure Building

PM15 Percent of very low birth weight live births.

Very low birth weight births contribute to a major proportion of the infant mortality rate in Utah and the U.S. as a whole. The greater percentage of these births is due to preterm deliveries, for which no preventive strategies have been identified at this time. However, a few promising interventions have been suggested. In order to decrease the percent of very low birth weight live births to 0.95% during 2001 from its current level of 1.0% in 1998, the Reproductive Health Program will: promote risk assessment for all pregnant women during their first prenatal care visit to identify risks for delivering very low birth weight infants including asking women about their relatives' (maternal grandmother, aunts, sisters and mother) pregnancy histories of delivering low birth weight infants, as well as careful screening for abuse of substances; continue to promote referral of women at high risk for delivery of a very low birth weight infant or those with chronic medical conditions to appropriate high-risk obstetrical and/or medical providers; review data obtained from the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Perinatal Mortality Review Program to identify modifiable risk factors for very low birth weight deliveries; continue to educate pregnant women about the "Danger Signs during Pregnancy" which encourages them to seek health care promptly when they experience them; and, continued education of prenatal care providers about the importance of counseling their pregnant clients who smoke how to quit and referring appropriate candidates to smoking cessation treatment programs. In addition, the Chairman of Maternal-Fetal Medicine at the University of Utah is interested in collaborating with the Department on prospectively tracking the relative use of a family history of problem births related to very low birth weight. The Reproductive Health Program will facilitate this collaboration to answer this important research question.

PM17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

As Utah is very close to the goal of increasing the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates to 86.7% in 2001 (86.5% in 1998) our activities will simply be to: continue to monitor the percent of very low birth weight births occurring in facilities for high-risk deliveries among health maintenance organizations contracted with the Division of Health Care Financing (Medicaid), and to continue tracking via the Perinatal Mortality Review Program deaths of very low birth weight infants delivered outside of tertiary medical facilities.

PM18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

In order to increase the percent of infants born to pregnant women receiving prenatal care in first trimester of pregnancy to 83.4% by 2001 from the current (1998) percentage of 79.7% the Reproductive Health Program has identified the following activities to focus on during this next year: Analysis of 1989-98 Utah birth certificate data in order to identify trends in the utilization of prenatal care and to identify specific groups of mothers who are less likely to receive prenatal care and then target those groups of mothers at most risk of not receiving prenatal care in the 1st trimester; establish collaborative relationships with local health departments that have a high proportion of pregnant women receiving late prenatal care to identify solutions or strategies to get women into care earlier; and, collaboration with the Baby Your Baby Program to develop strategies to improve early entry into prenatal care based on the findings of the Baby Your Baby evaluation. Suggestions from the community gleaned through the public comment process include the development of training/marketing goals to address reasons why women do not seek care during their first trimester. The Pregnancy Risk Assessment Monitoring Survey (PRAMS), recently implemented in Utah, will provide excellent data this year to guide us in developing appropriate interventions to promote increased early prenatal care.

SP9 Percent of pregnant women with adequate weight gain who deliver live born infants.

Inadequate weight gain during pregnancy has been associated with poor pregnancy outcomes. In order to increase the percent of pregnant women with adequate weight gain who deliver live born infants from 80.4% (1998 data) to 81.7% in 2001 the Maternal Child Health Bureau has planned the following activities for this year: dissemination of information about the impact on outcomes to illustrate the importance of adequate weight gain during pregnancy, especially to providers; encourage prenatal health care providers to refer women who are having difficulty gaining an adequate amount of weight during pregnancy to nutritionists for dietary consultation; and seek publication of Utah's adequate weight gain report in a peer review journal. In addition, WIC will continue its support of women with inadequate weight gain.

PM12 Percent of children without health insurance.

During FY01, the Covering Kids Utah Project staff will collaborate closely with the Utah CHIP staff, Medicaid eligibility staff and partnering agencies in planning and implementing activities specifically designed to target special populations and ethnic groups in outreach efforts. This will include the development and dissemination of outreach materials targeted toward ethnic minorities and special populations. These outreach materials include application instructions for CHIP and Medicaid in several languages and a Spanish language informational video. Outreach activities will be facilitated and implemented in neighborhoods and schools through the three funded pilot projects and partnerships with community agencies. Covering Kids Utah will also continue to encourage CHIP and Medicaid outreach and referral through local WIC Programs, immunization clinics, early childhood nurse home visitation and Head Start programs, schools, and child care facilities, implementing best practices learned through past efforts and other state efforts.

The Child and Adolescent Health (CAH) Program Manager and the School and Adolescent Health Nurse Consultant will continue to reinforce the importance of requiring CHIP information and outreach activities to be addressed in applications for School Nurse Incentive Program Funding to the State Office of Education.

During 1999-2000, a requirement was built into the P-5 Nurse Home Visitation Contracts to report on health insurance status of clients at the time of entry into the program and at the time of closure from the program. This reporting requirement was developed as one means of assessing

program effectiveness, and as a reminder to home visitation nurses to ask about health insurance status and to provide information and initiate referrals as appropriate. This requirement will continue to be in place for FY01 P-5 Home Visitation contracts, and will be reinforced to local health department nurses during technical assistance and consultation visits conducted by the CAH Program manager and the Home Visitation/Early Childhood Nurse Consultant.

PM13 Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

During FY01, the Covering Kids Utah Project staff will continue to encourage local WIC programs, immunization clinics, early childhood nurse home visitation and Head Start programs, school nurses, and child care providers to identify children and families needing services and to refer as appropriate. Covering Kids Utah staff will work with the CHIP staff and Medicaid eligibility staff to promote the design and implementation of CHIP outreach activities and materials that also facilitate the identification and enrollment of both CHIP and Medicaid eligible children.

Promotion and implementation of outreach activities for children needing health care and other related services is an integral component of Families, Agencies and Communities Together (FACT) site-based programs, and a required component of FACT nursing contracts held with eleven of Utah's twelve local health departments. CFHS, in collaboration with Utah Medicaid, will continue to emphasize the importance of these outreach activities by FACT nurses in the over one hundred FACT schools throughout the state.

The CFHS Maternal and Child Health Bureau and Child and Adolescent Health Program staff will continue their collaboration with Utah Medicaid in the recently awarded Commonwealth Fund/National Academy For State Health Policy grant directed toward enhancing the capacity of Medicaid in providing child development services. This effort, which will involve joint collaboration between the Divisions in the development of nurse home visiting standards and guidelines, will also involve the development of strategies for improving access to and utilization of needed services for Medicaid children served through local health department conducted nurse home visitation programs.

PM16 The rate (per 100,000) of suicide deaths among youths 15-19.

Suicide is the second leading cause of death among Utah adolescents and the leading cause of death among Utah males age 15-19. In an effort to better understand and prevent these tragic deaths,

the Violence and Injury Prevention Program (VIPP) will continue to provide funding and staff support for the Suicide Prevention Task Force and the Youth Suicide Study.

The Youth Suicide Study, a three-year research project, reviews every suicide death in Utah between the ages of 13-21. The goal of the study is to use the information collected to assist in developing and evaluating interventions and programs to prevent suicide. During FY2001, a second professional paper on the results of the Youth Suicide Study results will be written and submitted for publication.

As a result of a resolution passed in the Utah legislature in 1999, the Utah Department of Health has been appointed lead agency in the development of the Suicide Prevention Plan for Utah. This plan will be completed by September 2000 and at that point distribution and implementation will be coordinated by the VIPP.

VIPP will collaborate and provide input into the implementation of the GateKeeper Program recently purchased by the State Office of Education. VIPP will continue to collaborate with Utah PTA to conduct a nationwide review and investigation of suicide prevention programs for the purpose of finding successful models that may be adapted to Utah's suicide prevention efforts.

Based on the findings of the Youth Suicide Study and the recommendations of the Suicide Prevention Strategic Plan, VIPP will work to increase public awareness of youth suicide risks and prevention through media activities, community presentations and by providing information on the UDOH internet site.

PM11 Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care.

The CSHCN staff will be actively involved with Medicaid staff, in outreach and quality assurance activities for the CHIP program, especially through the outreach health satellite sites. CSHCN staff, specifically resource specialists, social workers and nurses will continue to be actively involved in assisting families in obtaining and utilizing their private insurance or Medicaid to cover health care for their special needs children. CSHCN will identify and refer uninsured clients to CHIP/Medicaid eligibility workers. CSHCN will continue to advocate for special needs children within the expanding managed health care system in Utah. CSHCN will also continue its involvement

in identifying and assuring health care coordination services to high risk populations, including children living in rural Utah, children who are technology dependent, and children in foster care.

PM14 The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

CSHCN will increase family and minority advisory and program planning participation. Parents will continue to be involved in different advisory capacities, participating in the MCH Advisory Committee and the Baby Watch Early Intervention Program Advisory Committee. CSHCN will continue to work closely with consumers and parents of children with special needs through the Governor's Council of Persons with Disabilities, the Legislative Coalition of Persons with Disabilities and the Utah Parent Center. Additionally, the Utah Parent Center will hire a Family Voices parent representative. CSHCN supports its parent advisors whenever possible, by subsidizing the cost of travel, lodging, childcare and registration incurred by parents during their participation in advisory meetings. In order to solicit information from parent consumers who are involved in our clinics, CSHCN programs conduct yearly parent satisfaction surveys which provide information in tailoring the clinic services to meet family needs.

CSHCN has established an ad hoc cultural diversity committee, which includes representative from Primary Children's Medical Center, University of Utah Medical Center, Americorps, CSHCN and others who provide services to culturally diverse people. The committee has developed plans to deal with statewide barriers which include the training of community providers. Additionally, the committee plans to continue to improve the Bureau's level of cultural sensitivity through cultural sensitivity training, establishment of policy, and establishment of a translation/interpretation protocol for clients. CSHCN will continue to improve participation in program development by ethnic minority parents.

Family advocacy and support continues to be a priority area for Community Based Services. Contracts with LINCS (Liaisons for Individuals Needing Coordinated Services) and Family Voices will continue. The LINCS contract will assure parent representation at CSHCN clinics. LINCS staff will train and employ local parent advocates in several areas around the state. Parent advocates will provide support and resource information for families and children attending clinic. Family Voices will continue to advocate for special needs children and families through representation on numerous boards and committees including the Legislative Coalition for People with Disabilities. A project that

would extend parent advocacy into the schools is being developed through Family Voices in partnership with CSHCN and Medicaid.

Outcome Measures

OM1 The infant mortality rate per 1,000 live births.

OM2 The ratio of the black infant mortality rate to the white infant mortality rate.

OM3 The neonatal mortality rate per 1,000 live births.

OM4 The postneonatal mortality rate per 1,000 live births.

OM5 The perinatal mortality rate per 1,000 live births.

Each of these outcome measures is related and therefore proposed activities are discussed together. Utah's infant mortality rate is among the lowest in the nation at 5.7/1000 live births per year (1998). However, there are populations within Utah whose infant mortality rates far exceed the overall state rate. For instance, comparing the Black infant mortality ratio to the White infant mortality ratio in Utah we see that between 1996-1998 there was a ratio of 1.6 to 1. In order to reach the goal of a rate of 5.65/1000 live births during 2001, the Reproductive Health Program will attempt to decrease the disparity between the Black infant mortality rate and the White infant mortality rate to a ratio of 1.3 to 1. The following activities have been planned: promote cultural sensitivity among prenatal healthcare providers; analyze and review data obtained from the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Perinatal Mortality Review Program (PMRP); including data from Utah Black and Native American births to identify modifiable risk factors for infant mortality and develop appropriate interventions; and, continue to promote the Maternal and Child Health Information Internet-Query Module (MatCHIIM) database and the Reproductive Health Website to interested researchers, students, healthcare professionals and the general public to increase awareness of factors associated with infant death.

As neonatal mortality contributes to the largest proportion of infant mortality in Utah with a rate of 3.6 per 1,000 live births in 1998, it is imperative that we continue activities to reduce this devastating event. As previously mentioned in relation to low birth weight births, most of the neonatal deaths that occur in Utah are due to preterm delivery of very low birth weight infants. Although strategies to prevent these very low birth weight births are limited at this time, several have been

identified through the work of the Perinatal Mortality Review Committee (PMRC) that indicate some promise. Therefore, the Reproductive Health Program plans to implement the following activities during 2001: healthcare provider education regarding antibiotic use for the prevention of preterm birth; outreach education to facilities identified through PMRC case reviews on fetal heart rate monitoring and neonatal resuscitation issues; and, public education regarding danger signs of pregnancy and the importance of prompt action when recognized.

Although postneonatal mortality contributes a lesser proportion of the overall infant mortality rate, these events are no less devastating to parents and families. Utah's postneonatal mortality rate was 2.1/1000 live births during 1998. In order to reach the goal of 2.0/1000 live births in 2001, the following activities will take place: continued data collection and review of postneonatal deaths to identify strategies that may be effective in preventing future deaths; continuation of the "Back to Sleep" and sleeping safety public education campaign; education of pediatric health care providers about the importance of reducing second hand smoke around infants to reduce the risk of SIDS and prevent other respiratory illnesses; and lastly, assurance of the provision of grief support to families experiencing an unexpected sudden infant death.

Another of Utah's goals is to decrease the perinatal mortality rate (neonatal and fetal deaths) to 8.0 per 1,000 live births in 2001. According to the most recent data (1998), Utah's perinatal mortality rate was 8.1 per 1,000 live births. Since we have addressed neonatal mortality above, the focus of our activities for perinatal mortality will be targeted at the reduction of fetal deaths. Activities that we have planned during 2001 include: education of prenatal care providers about the need for appropriate antepartum assessment for the reduction of late term fetal deaths using PMRC data from case reviews, and promotion of adequate post-mortem assessment of late term fetal deaths to improve identification of cause of deaths among late term fetuses.

OM6: The child death rate per 100,000 children aged 1-14.

In Utah, as throughout the nation, injury is the leading cause of death among children in this age group. To reduce injury related deaths among children, the Violence and Injury Prevention Program will continue to collaborate with numerous state and local partners to conduct prevention activities related to a wide range of childhood injuries. Prevention efforts will address child car seat and booster seat use; adolescent seat belt use; bicycle helmet use; pedestrian safety; school and playground safety; poison prevention; child abuse prevention; and youth violence prevention.

Activities will include conducting car seat and booster seat inspections; providing free and/or low-cost car seats for low income families; bicycle helmet and pedestrian safety education for school age children and youth; school playground inspections; funding and staff support for the Suicide Prevention Task Force and the Youth Suicide Study; providing coordination and staff support for the Child Fatality Review Committee; and, conducting school based violence prevention training.

The 1998 Utah State Legislature enacted legislation to fund the Poison Control Center through a surcharge on 911 calls. The injury prevention funds, which had been used to support the PCC, are now used to strengthen community based injury prevention through contracts with local health departments and other community partners. This funding has provided a significant increase in injury prevention resources at the local community level. To encourage and facilitate collaboration between local health departments and local community partners, LHDs are required to use a portion of these MCH funds for mini-grants that support injury prevention efforts of other local agencies and organizations.

Although VIPP no longer funds the Poison Control Center at the University of Utah, the VIPP program manager will continue to serve on the PCC Oversight Board; and VIPP will continue to work with PCC to monitor accidental poisoning rates, investigate causes and make recommendations for prevention. VIPP will continue to promote poison prevention awareness by distributing brochures, conducting media interviews, providing news articles, and providing information on the UDOH Internet website.

Although the Utah Department of Health is not the lead agency in addressing issues of child abuse and family violence, these are priority public health issues and VIPP will continue to support prevention efforts. VIPP will continue to provide staff support and funding for the interagency Child Fatality Review Committee (CFRC). CFRC meetings are held every other month to review information on the deaths of all children under the age of 19, as well as children through age 21 who commit suicide. In addition, a CFRC Core Committee, made up of members from the larger committee including representatives from the Attorney General's Office, Utah Department of Health, Utah Division of Human Services, Guardian Ad Litem, Medical Examiner's Office, and members of the Child Protection Team from Primary Children's Medical Center, meets twice monthly. These members receive notification immediately following deaths referred to the Office of the Medical Examiner. After being notified of these deaths, members of this committee check records they may have on the case. Based on that information, a decision is made to meet to share information and occasionally aid in investigations. The investigating agencies are invited to these meetings.

VIPP will continue to provide funding, training and technical support to local health department injury prevention programs through periodic site visits, meetings of the Utah Local Association of Community Health Education Specialists, semi-annual Injury Prevention Partnership Conferences and providing information about injury prevention conferences, training materials, data and resources.

VIPP and local health departments will continue to collaborate with state and local partners for the prevention of family and community violence. Activities will include: increasing awareness of child abuse and family violence issues; training law enforcement and health care providers; conducting school based violence prevention education; distributing brochures; conducting media interviews; providing articles for newspapers; and, providing information on the VIPP internet website.

VIPP will continue to collaborate with the Utah School Boards Association and State Office of Risk Management to provide training and consultation for playground safety design, equipment installation and inspection, supervision, injury reporting, etc.

VIPP will continue to seek improvement in the quality and availability of injury data for use in state and local injury prevention planning and evaluation. These efforts will include maintaining the Student Injury Report System and the Traumatic Brain Injury Registry, coordinating with the UDOH data resources and other agencies data resources. Potential data sources include the Student Injury Report System; Utah Hospital Discharge Database; Emergency Room Log data; Spinal Cord Injury Registry; Traumatic Brain Injury Registry; Child Fatality Review Committee reports; Medical Examiner reports; Utah Department of Health Vital Records; Utah CODES data; Utah Office of Highway Safety; Behavioral Risk Factor Survey; and Utah Health Status Survey, etc.

SO1 Maternal Mortality rate per 100,000 live births

Utah's maternal mortality rate has appeared to increase over the past several years. This increase is due to a result of better case finding of these deaths. Pregnancy-related mortality review began in Utah in 1995. At that time, the Reproductive Health Program enlarged the definition of maternal deaths from those that had occurred during a 42-day period to include all those that occurred within 1 year of a birth event. In addition, collaboration with the Office of Vital Records and Statistics provided an opportunity to better identify pregnancy-related deaths by computer matching all death certificates for women of reproductive ages to live births and fetal deaths that occurred within the year of their death. As a result, many more pregnancy-associated deaths were identified and reviewed by

the Perinatal Mortality Review Committee. In order to impact the rate of these rare but devastating events from its current level of 26.5 deaths per 100,000 live births to our goal of 25.9 deaths per 100,000 live births in 2001 we plan to implement the following activities: to encourage providers to assess for risk of Factor V Leiden (intergenerational history of blood clots during pregnancy) and if a positive history is reported, perform laboratory screening to identify those women at risk of pulmonary embolism, one of the most frequent causes of pregnancy related deaths; to encourage prenatal care providers caring for women with histories of chronic disease to consult and refer to an appropriate specialist during the pregnancy; to educate healthcare providers regarding the importance of screening pregnant patients for a history of depression and to refer as appropriate; especially during the postpartum period; and lastly, to collaborate with the Office of Health Care Statistics and the Office of Vital Records and Statistics of the Utah Department of Health to expand the process for identification of pregnancy-associated deaths through record linkage using the hospital discharge database to include the identification of women who died as a result of a pregnancycomplication that did not result in a live birth or a fetal death.

4.2 Other Program Activities

Toll-free telephone number [505(a)(5)(E)]

CFHS has maintained the toll-free Baby Your Baby hotline, 1-800-826-9662**,** since 1988. More than 185,000 calls have been made to the hotline. For the first two years the Baby Your Baby hotline was used mainly for maternal information with emphasis on prenatal care. In 1990, the hotline expanded to include child health and well child care. Between 1993 and 1995 the Baby Your Baby campaign emphasized nutrition and the WIC program. In 1999, a total of 16,284 calls were logged by the hotline. Of these, 6449 prenatal care referrals were made—40% of the total calls. Nearly 400 children were referred to the EPSDT/CHEC program through the Baby Your Baby hotline in 1999.

The Baby Your Baby program also promotes the Pregnancy RiskLine, 1-800-822-2229. All women calling the Pregnancy RiskLine are screened for entry into care. Women who need prenatal care are referred to Baby Your Baby for information on qualified providers and financial assistance. In 1999, there were about 9,000 calls received by the Pregnancy RiskLine.

Hotline services provided by the CFHS division have expanded significantly since 1995. The same team of operators who answer the Baby Your Baby or maternal and child health hotline now provide information and referral services for four additional hotlines. Operators answered 27,025 calls

from these hotlines. Each of these hotlines is connected with a separate media campaign aired on the local CBS, NBC or ABC television affiliates. The hotlines include:

- Health Resource Line, previously Check Your Health, 1-888-222-2542. This campaign targets the primary health decision-makers in a family, women from 25-55 years of age. Market research indicates that this target group determines both the health habits and the health care utilization in a majority of families in the US. This influence often extends beyond the spouse and children to include aging parents as well. Making good decisions regarding healthy behaviors and getting needed checkups and screenings are the two main topics of this campaign. Callers are sent appropriate information and are referred to health experts within the health department.
- The Immunize By Two Hotline, 1-800-275-0659, refers callers to immunization clinics throughout Utah, answers non-technical questions about immunization and refers calls to CFHS experts. There were 1,490 calls in 1999.
- Truth about Tobacco Hotline, 1-888-567-TRUTH - the purpose of this campaign is to prevent adolescent tobacco use and to encourage those using tobacco products to quit.
- CHIP Outreach and Coordination - the purpose of this hotline service is to answer questions regarding eligibility and coverage for Utah's children with CHIP. Brochures and flyers have been developed collaboratively between Medicaid and MCH. The hotline has been incorporated into an existing telephone number. There were 18,841 calls to this hotline in 1999.

An extensive resource system is in place for those who answer the phone. Operators refer callers to subject matter experts in maternal and infant health, child and school health as well as services for children with special health care needs. There are also experts in financial and other resources. These experts link clients to Title XIX, Title XXI, WIC, EPSDT/CHEC, and other public and private providers. Clients speaking languages other than English are served using AT&T's Language Line.

In addition to the Department hotlines, CSHCN maintains a toll free telephone number for families and providers in rural Utah (1-800-829-8200). Individuals may call for general CSHCN information or may call through the hotline to reach CSHCN Bureau providers for clinic follow-up and information.

CSHCN and Baby Watch Early Intervention Program continue to provide funding for ACCESS Utah, a toll free information line and computer website through the Governor's Center for

People with Disabilities. This information service is designed for adults and children with a broad range of disabilities and provides them with information on resources for services, equipment and funding.

Title V - XIX coordination agreements [505 (a)(5)(F)(i and ii)]

Utah's Title V agency (CFHS) and Title XIX agency (Division of Health Care Financing or Medicaid) are sister divisions within the Department of Health and work closely on many issues affecting mothers and children. A coordination agreement is in place to formalize and strengthen the relationship in areas of mutual interest and concern, avoid duplication of effort, improve access to Title XIX and Title V by eligible Medicaid clients, enhance the quality of Medicaid and MCH services, enhance program coordination and information exchange to the extent possible, and enhance Medicaid funding for MCH services.

Utah's EPSDT program is called Child Health Evaluation and Care (CHEC). The CFHS/Medicaid agreement provides for collaboration between MCH and CHEC outreach strategies and activities. Via the agreement, MCH staff and resources can be used to assist in Medicaid's assessment of the barriers to CHEC participation and in the development of MCH activities that will support and complement those of the CHEC Program. Families are informed about the availability of CHEC services during the Medicaid enrollment process and by a follow-up mailing. Periodic mailings serve as reminders. Local health departments statewide perform outreach activities.

Specific staff members in CFHS and Medicaid are assigned responsibility to function as contact points for coordinating efforts in both MCH and CSHCN areas. For example, one significant area of cooperation is in the prenatal care program. CFHS certifies qualified providers of prenatal care and maintains Memoranda of Agreement with them to ensure the provision of high quality prenatal care and cooperation with Medicaid in provision of presumptive eligibility for Medicaid and enhanced services for Medicaid recipients. CFHS staff work with Medicaid staff to identify strategies to reduce barriers to women accessing Medicaid in an expeditious manner. Presumptive Eligibility, though designed to assist women to access early prenatal care, sometimes serves as a barrier to early care due to long delays in appointments. The Department is still waiting for the response to the 1115 Waiver but is working with Medicaid to develop solutions to this problem. One solution is the expansion of a pilot project to train Medicaid Bureau of Eligibility workers, whose salary is covered in-part by CFHS, to provide presumptive eligibility screening for clients of private providers in Salt Lake County. Seven workers at five different sites around Salt Lake County are being cross-trained to provide this service.

This should provide an additional 28 to 35 appointment slots per week to serve women wanting to enroll in the Presumptive Eligibility Program.

Also, CFHS has worked closely with Medicaid over the past few years to enhance Medicaid coverage of special services for medically involved children. The services include not only medical support services, but also care coordination and early intervention services for disabled children. CFHS is represented on the Medicaid Expanded Services Committee, which decides whether services requested through the CHEC Program which are outside the scope of Medicaid, are medically necessary and thus authorized to be covered. During 1998, the Medicaid CHEC Expanded Service Committee was combined with the Medicaid Utilization Review Committee. CSHCN will continue to provide pediatric specialty staff to consult to this committee.

The Division will continue linkage with Medicaid to monitor quality assurance for services provided to the Medicaid population through managed care organizations (MCOs). Since the MCOs contracting with Medicaid also serve a commercial population, any MCH recommendation can be applied to their commercial clients.

Collaborative quality assurance activities conducted by CFHS and Medicaid evaluate maternal health services CHEC/EPSDT and CSHCN clients provided by Medicaid MCOs.

The Community Based Services program will continue to be involved with the Medicaid special needs survey team and MCO quality monitoring staff. Site visits and/or conference calls are planned for this coming year with the 5 MCOs that contract with Medicaid. Specific Medicaid standards with additional questions are used to evaluate access and quality of care for special needs children and their families enrolled in the various MCOs.

The Travis C. Waiver for Technology Dependent Children continues to grow with 20 new slots being added for FY2001. The total number served in the waiver program next year will be 107. Recipients under this waiver program continue to have very complex needs and situations and require intense case management and service coordination. Skilled nursing respite continues to be the highest utilized service under this waiver and a shortage of qualified skilled nursing providers continues statewide.

The Travis C. Waiver Program in conjunction with a group of volunteer parents will implement the Parents Helping Parents project this next year. The project will link more experienced parents with parents who are new to the system and the struggles of having a technology dependent child. Parents will offer one another suggestions on day-to-day issues as well as offering friendship and support. The waiver program will also develop and implement a quarterly newsletter to families.

Other significant areas of cooperation

In July 1999, the Dental Coalition for People with Disabilities was folded into the Salt Lake Valley Oral Health Task Force (OHTF). The special needs subgroup of the OHTF continues to assess the needs of people with disabilities on a statewide basis. Both clients and dentists are being surveyed and interviewed in order to develop strategies to better serve the oral health care needs of this population. A discussion of the data the subgroup is collecting will appear in the September 2000 annual report of the OHTF.

The Smile Factory Program conducted by Oral Health Program (OHP) staff continues to be an effective program in improving the oral health behaviors of young children enrolled in FACT schools. Children in FACT schools also benefit from the Weekly Fluoride Mouthrinse Program conducted by the OHP. OHP staff serve on the health advisory boards of the Bear River Head Start and Salt Lake Community Action Head Start Programs.

Systems to address the needs of the child population, in addition to Utah's successful Family, Agencies, and Communities Together (FACT) Initiative, include the local health department conducted Prenatal to 5 Nurse Home Visiting program. Since FY 1999, CFHS has contracted a designated amount of MCH Block Grant funds to eleven of the local health departments to provide home visiting services by nurses for at-risk pregnant women and children from birth to 5 years of age. The overall purpose of this program component is to provide and/or assist families, through nurse-conducted home visits, in gaining access to services, information, and knowledge that support and strengthen the family's capacity to meet their own health needs and those of their children. Also as part of these contracts, designated public health nurses conduct Utah's Health and Safety Training for Early Childhood Providers, which was previously developed under the auspices of Utah's Health Systems Development in Child Care (HSDCC) grant administered by CFHS. Local health departments coordinate services provided through the nurse home visiting program with other community agencies/providers serving young children and families (e.g., early intervention, Head Start, preschool special education, child care providers, community health centers, local hospitals, home health, mental health, and Workforce Services). Technical assistance, consultation, standards and guidelines, and state-level monitoring for both these program components are provided to local health departments by the CFHS Child and Adolescent Health Program.

CFHS is also currently collaborating with a variety of public and private partners in efforts to educate legislators, policy makers and others on the potential benefits of various home visiting

programs in terms of enhancing the overall well-being of young children and their families, and to explore various coordinated funding strategies to develop and/or improve current home visiting programs throughout the State. Partners in these efforts include, but are not limited to: Division of Health Care Financing (Medicaid); Families, Agencies, and Communities Together; Prevent Child Abuse Utah; Primary Children's Medical Center Child Protection Team; State Office of Education; Utah Head Start-State Collaboration Project; Department of Human Services, Division of Child and Family Services; Early Intervention Research Institute, Utah State University; and Department of Workforce Services.

Although CFHS no longer directly funds the Poison Control Center (PCC) with MCH funds, the MCH staff maintain ongoing involvement with the Utah PCC Oversight Board and the National MCH PCC Advisory Board.

The Baby Watch Early Intervention Program (BWEIP), although not funded by MCH, is located within the CSHCN Bureau. The program provides complementary developmental services to children birth to 3 years throughout Utah. Being located within CSHCN allows for a seamless delivery of services to parents including reciprocal referrals between BWEIP and CSHCN, complementary child find efforts and improved delivery of evaluation and treatment services to children with special health needs living in rural Utah. BWEIP and CSHCN will continue to collaborate on projects such as the joint funding of a Central Resource Directory for Special Needs Children (ACCESS Utah, part of the Governor's Council for People with Disabilities).

BWEIP and CSHCN, where the Foster Healthy Children Program (FHCP) is located, are also working together with the Divisions of Child and Family Services (DCFS) and Mental Health (DMH) to improve the identification and treatment of young children's developmental and mental health needs. The CSHCN Child Development Clinic also collaborates with DCFS and DMH by providing multidisciplinary developmental and mental health evaluations for 0-3 year olds who are in the foster care system.

Additionally, BWEIP will work with the Birth Defect Network (BDN) to provide earlier and more comprehensive child find services to Utah children with congenital or genetic conditions, to ensure their early entry into appropriate treatment services. New this year will be the transfer of the BDN and the Pregnancy RiskLine to the Bureau of CSHCN. This move will facilitate the collaboration of the CSHCN data staff with the BDN.

CSHCN is continuing to employ the Family Voices representative for Utah. This position is jointly funded by the Utah Parent Center (UPC), the UDOH and MCH Grant which support the

expansion of Utah's Family Voices chapter. Activities for this year will include parent advocacy, education, referral and support and develop a parent to parent project, parent representation on numerous committees such as the Legislative Coalition of People With Disabilities. In the upcoming, CSHCN, Family voices and the UPC will continue to seek funding for ongoing develop of the Family Voices activities.

Coordination with related grant programs [505(a)(5)(F)(iii)]

CFHS administers directly several health programs related to mothers and children which are not funded by the MCH Block Grant, such as WIC funded by the US Department of Agriculture; 101-17; Part C program (previously part H) of the Individuals with Disabilities Act; and, the Immunization Program, funded by the Centers for Disease Control and Prevention. Thus, coordination is assured among these programs through CFHS program and bureau organization structure. For programs outside CFHS, there are both formal and informal ties at the program level. Where appropriate, there are written agreements. The pediatric AIDS program is administered by a sister division, Epidemiology and Laboratory Services; the pediatric EMS program is administered in another division, Health Systems Improvement (HSI). HSI also oversees the work of the Bureau of Primary Care and Rural Health Systems (BPCRHS). CFHS staff has participated in BPCRHS needs assessment process during 1999-2000. Both the MCH Bureau Director and the State Dental Director participated in the process through meetings and input on MCH and dental health issues. CFHS staff have had a long history of involvement with these staff and interact closely on a number of important projects, such as the creation of their state plan. Our National and State Performance Measures and MCH Annual Plan have been shared with them to ensure non-duplication of effort, especially to dental health and the entire MCH population.

The local health departments, using MCH and other funds where appropriate, attempt to ensure services and activities through health clinics and programs for the MCH client mentally ill, substance abusers, and the homeless.

Utah's Abstinence-only Education Program funded through federal Title V abstinence education funds targets youth between 9 and 14 years of age. The Program continued funding 11 projects during the second funding cycle with project funding ranging between $5000 and $58,000. Each agency, which included local health departments, school districts, a mental health agency and private not-for-profit organization, awarded federal funds was required to provide the non-federal match. Funded projects include those that promote self-confidence and self-esteem among youth,

parent training in educating their children in abstinence, communication between parents and youth, resisting pressure to become involved in sexual activity, prevention of sexual abuse including date rape, and programs that target high risk youth. Each project is required to develop a parent and an evaluation component.

Ten of the eleven projects have been functioning well. Reports for the second funding year indicate that at least 16,000 youth have been reached with these funds. The barriers to implementing projects have included: obtaining school district approval for the programs in the schools, due to reported concerns that parents would not approve of the program, getting parents involved in the programs, and finding sources for the required non-federal match.

During FY01 the Program, assuming that the state is awarded continuing monies, will continue to fund the projects that were started during FY98 and FY99. Since all of the awarded monies have been allocated, we will continue to fund all current projects that submit an updated prospectus for the coming year.

Utah's Head Start-State Collaboration Project is administered by the Child and Adolescent Health Program within the MCH Bureau. This organizational placement has provided an excellent opportunity for CFHS to collaborate with a broad array of agencies and providers in addressing the comprehensive needs of young children, and has facilitated improved collaboration between Head Start and state agencies.

As of June 1, 2000, CFHS was awarded a three year Healthy Child Care America (HCCA) grant. Funds from this grant will be used to hire a child care nurse consultant, who will also serve as Utah's HCCA Project Coordinator. Activities over the next three years will build upon those achievements of the previous grant-supported project and will focus on improvements to the current Health and Safety Curriculum and training process and development of a child care health consultant network.

Another related focus on the needs of young children is the Early Childhood Integrated Services Committee which is involved with linking the DOH with other state agencies and public and private groups that are concerned about the needs of the 0-5 population.

The SSDI grant for this year allowed Utah to implement the Utah 2000 Child Health Survey which collected information on the CSHCN population along with the general child population for ages birth through 17 years of age. Since this was a very extensive statewide random telephone survey the analysis is in the preliminary stages. We continue to be in contact with individuals nationally that have implemented the FACCT Living With Illness questionnaire to collaborate on the

data analysis. Since Utah's survey was one of the first to be implemented to the general population, instead of an insured population, the comparisons with previous data have not been consistent. Hopefully our data should be comparable to the upcoming national MCHB Child Health Survey.

The SSDI grant has been of the assistance of a pilot project looking at the linkage of three data sets. Vital records, newborn hearing screening and newborn (metabolic) screening have plans to use a unique identifier number (that will be the issued metabolic number) which will be input into a field in each of the data sets. When the three-month pilot is completed in the fall of 2000, then the information will be analyzed to assess the effectiveness of this approach.

In response to last year's recommendation that we promote cultural sensitivity and coordinate with partners to assure access to culturally diverse populations, we availed ourselves of a qualitative survey of five ethnic populations in Utah. It is felt that our current health information systems do not adequately represent health status, health problems and health care needs of our ethnic populations. One way in which MCH partnered with our community-based ethnic populations was to invite Khando Chazotsang, the coordinator for the Department's Office of Ethnic Health, serve on the MCH Advisory Committee. She also is part of a larger ethnic committee that provides feedback to the health department and this group participated directly in assuring adequate representation from the ethnic community on our recent PRAMS survey.

The DREAMM Grant (Developing Reservation-based Efforts Addressing Mortality & Morbidity) was obtained in 1997 by the Ute Tribe at Fort Duchesne to provide health promotion and disease prevention education and training and, provide screening services to community members. To achieve these objectives, a series of tribal health fairs were developed. During FY99, five tribes held DREAMM Fairs: Paiute Tribe, Navajo Tribe, Goshute Tribe, White Mesa Ute Tribe, Ute Tribe

Various health care professionals from state, local and the tribal health agencies along with tribal leaders of the host tribe met together to exchange information regarding their programs and services. The host tribe provided information on their history, traditions, culture and health care perceptions and beliefs. A block of time was specifically earmarked for discussion focusing on development of working collaborations among the participating agencies. Unmet health care needs of the tribe were identified and potential solutions discussed. During the second day, a health fair was provided to tribal members by the participating agencies. Health education and screening was offered free of charge to enrolled tribal members along with social activities. Special presentations by agencies chosen by the tribe were held for all participants and networking among the various agencies continued.

The Oral Health Program continued to participate in the DREAMM Grant (Developing Reservation-based Efforts Addressing Mortality & Morbidity) health fairs held during the past year by distributing oral health education materials, conducting oral screenings, making referrals for preventive and treatment care and linking uninsured participants with Medicaid and CHIP eligibility workers. Information from the screenings is reported to tribal leaders in order to assist in follow-up for participants in need of dental treatment services.

Representatives from the State Health Department's Pregnancy RiskLine, Baby Your Baby, Reproductive Health, Immunization, and Domestic Violence programs, along with members of the oral health team and the Bureau of HIV/AIDS, Tuberculosis/Refugee Health participated in the DREAMM Fairs (Developing Reservation-based Efforts Addressing Mortality & Morbidity). Additional DREAMM Fairs will be held by the following tribes in FY2000:

- Paiute Tribe at Cedar City, Utah
- Northwest Shoshoni Band at Brigham City, Utah
- Navajo Tribe at Monument Valley, Utah
- White Mesa Ute Tribe at White Mesa, Utah

As a result of the DREAMM Fairs a MOA was signed between CFHS and the Montezuma Creek Clinic to permit trained clinic personnel to screen pregnant women for presumptive eligibility at that clinic and their satellite clinic in Monument Valley, Utah. This has improved access into early prenatal care and testing for women on the Navajo Indian Reservation. Awareness has been increased among MCH staff participating in DREAMM Fairs of the need to develop more culturally sensitive means of promoting healthy behaviors and of delivering health care services. Returning to participate in successive DREAMM Fairs for the tribes has enhanced networking among tribal, local and state public health providers.

CSHCN continues to collaborate with the Division of Child and Family Services (DCFS) to provide nursing care coordination to children in DCFS Foster Care. DCFS is the single-state agency for Title IV-E of the Social Security Act, providing foster care for children in the custody of the Division and adoption assistance for children with special needs. This Division also administers child welfare services, promotes safe and stable families programs under Title IV-B of the Social Security Act, and provides child protective services. Through the care coordination project, Fostering Healthy Children Program, CSHCN nurses and support staff provide health care tracking and consultation to DCFS caseworkers on health care issues, such as medical, dental and mental health for children in out of home care. CSHCN provides these services through contractual agreement with DCFS, and uses

state funds to draw down federal Medicaid funds for CHEC/EPSDT related activities. Together with DCFS, CSHCN is will help to develop health training and protocol for caseworkers in DCFS, as well as working on a DCFS Health Care Advisory Board, to assist in improving the health care for all children served in the DCFS system.

CSHCN Bureau will continue to develop the Telehealth Outreach Program that will establish a telehealth video network to provide health services to children with special needs. The network connects CSHCN in Salt Lake City to two rural local health department offices in Vernal and Richfield, Utah. Specific services to be offered include physical and occupational therapy, initial and follow-up speech pathology testing and intervention and neurological follow-up examinations. The network also will be used for training and continuing education of nurses in Baby Watch Early Intervention Program. In collaboration with the Utah Telehealth Network clinical telehealth protocols for medical, psychology, occupational and physical therapy, and speech pathology services will continue to be developed.

During FY2001 the CSHCN Bureau will be responsible for coordinating the clinical aspects of telehealth activities for its patients. This coordination includes determining local health department needs, lining up the appropriate health care professionals to see patients via interactive videoconferencing and assisting with scheduling. CSHCN Bureau will develop onsite videoconferencing capability and technology skills. CSHCN Bureau will also coordinate the development and delivery of pertinent continuing education and training of rural health personnel via interactive video-conferencing. Working with the Division of Health Care Financing/Medicaid, CSHCN Bureau will assist in a pilot project evaluation including the use of encounter information to assess utilization of services by Medicaid patients. CSHCN Bureau will continue to establish and evaluate reimbursement of telehealth activities implementing the statewide telehealth billing codes established by the Utah Health Information Network.

Efforts will be made to promote understanding of the uses and value of telehealth among medical, educational, communication, or others that control resources or that potentially may provide telehealth services, including health care providers, health insurance companies, and public users or patients. The CSHCN Bureau will closely monitor the efforts of the newly formed Utah Telehealth Commission.

Transition planning is a key focus for the CSHCN Bureau. Although the Intermountain Outreach Training Initiative grant with Shriners Hospital for Children has ended, the Systems Development Program (SDP) will continue to expand its efforts in the development of a comprehensive transition system in Utah. The program will continue to work with Shriners in

presenting community transition fairs, since they have been popular and well attended, and provide a mechanism for disabled young adults to meet with service providers in the community (for example, Medicaid, Independent Living Services, and Vocational Rehabilitation). Additionally, the SDP plans to expand agency-wide training on transition issues to build the bridge that will carry many of our disabled young adults to employment.

The Department has a MOU (Memorandum of Understanding) with CDC for PRAMS technical assistance since this program was initiated with state funds. There are plans to submit a funding request when CDC releases a RFP in fall 2000 that would bring additional funding for PRAMS to begin in April 2001.

Identification of pregnant women and infants [505(a)(5)(F)(iv)]

To encourage early entry into comprehensive, coordinated prenatal care and to facilitate access to financial assistance for care, the Presumptive Eligibility/Perinatal Program (PE/PP) was initiated in October 1987. Through this program, a qualifying, pregnant woman may receive financial assistance for outpatient care while her Medicaid application is being processed. In April 1990, eligibility for the PE/PP was extended from 100% of the federal poverty level to its present level of 133%. During state fiscal year 1998, 6,847 women were enrolled in the PE/PP Program. These women represent approximately 15.2% of the live births in Utah during this time (based on Utah Vital Records data for 1998 indicating 45,128 births to Utah residents). Of the women qualifying for the PE/PP Program in state FY 1998, 4,947 or 72.3% qualified for Medicaid benefits. Some PE/PP sites with perinatal care coordinators track women and assist them in obtaining coverage for perinatal care. Women not qualified for presumptive eligibility, without insurance or sufficient personal funds may receive care at a reduced fee through community health centers or through local funds or MCH Block Grant moneys at the option of the local health departments. Women of undocumented citizenship status are referred to either Medicaid outreach workers or the Department of Workforce Services to obtain coverage for delivery expenses through Medicaid's emergency medical program.

In addition to the phone banks used during the televised documentaries, the State maintains a 1-800 Baby Your Baby (BYB) Hotline described previously. Requests for financial assistance are referred to presumptive eligibility sites, thereby promoting rapid access to Medicaid eligibility determination and services.

CFHS has contracted with the University of Utah to conduct a comprehensive evaluation of the BYB program. The Division recognizes the need for credible information about BYB's processes,

outcomes, and cost-benefits. Such information can be useful to program managers, the Legislature, private sponsors, and planners in other states.

The evaluation plan is comprehensive in scope and designed to address a variety of research questions that are related to several key elements. The nature, quality, distribution and impact of the BYB hotline, Keepsake books, media messages and other educational strategies, related Medicaid eligibility processes and services, health outcomes, and program cost-benefits will be evaluated.

The analysis of existing quantitative data will reflect a pre-post contemporaneous comparison group design, involving within-state, matching-state, and (potentially) across state comparisons of BYB program participants and non-participants. Medicaid and vital records data will be linked and matched. Analysis of population-based survey data will compare in-state participant and non-participant groups. Analysis of interview and group session results will not be intended to identify group differences or generalize qualitative findings, but to assist in interpreting quantitative results and to inform refinements in program design and implementation. A final report of evaluation findings and recommendations will be completed by later in 2000.

In Utah, family planning services are available through eleven of the twelve local health departments using MCH Block grant and local funds with the remaining health department using only local funds for their family planning services. Some health departments provide direct family planning services to their clients, mainly through nurse practitioners. Others contract with private providers to provide the medical portion of the service, while the local health department staff provide the counseling and education. In addition to services available through the local health departments, Planned Parenthood Association of Utah, the state's Title X agency, provides services to low income women throughout the state in a similar arrangement. Family planning services are also available through community health centers that utilize sliding fee scales for clients. The Reproductive Health Program has produced a brochure that outlines all public sources of family planning services in the state, including Planned Parenthood clinics, local health departments and community health centers.

For the more rural health departments or districts with a relatively small number of clients, the Reproductive Health Program provides supplies of oral contraceptives and condoms. These local health departments do not have enough clients to utilize the reduced price offered by some drug companies for public clinics offering services to low income women. A small grant has also been awarded to one rural health department to assist in the purchase of oral contraceptives at the public health discount price. Since Utah's Medicaid Program has moved into mandated managed care along the most populous part of the state, health departments are reporting that most of the clients they

serve are without any third party payer for family planning services. Some have reported such high demand for services that they have had to restrict the numbers of clients due to limited funds available for services. Clearly, the need for family planning services outweighs the system's current capacity.

The Department does not, at present, plan to seek a Medicaid waiver for expansion of eligibility past the postpartum period covered through the prenatal Medicaid program. Managed care organizations providing services to minors on Medicaid are advised that they can provide information and services without parental consent, in compliance with federal Medicaid regulations. In 1998, the LDS Church, the predominant church in Utah, issued a statement on family planning in its new handbook for lay leadership stating that family planning is a decision "between the couple and the Lord", and that the decision as to how many children to have and when to have them is private. The Division has worked with Planned Parenthood Association of Utah and the Department of Workforce Services to develop training programs for employment counselors to provide them with information and skills to facilitate discussions with their clients about family planning and its relationship to employment success.

The Reproductive Health Program will conduct annual site visits with each of the local health departments to evaluate reproductive health services and provide technical assistance as needed. All clinic sites screen prenatal clients for presumptive eligibility and offer financial counseling and referrals to Medicaid for application for benefits. Program consultants will work with local health departments to assist them in addressing the federal and state MCH performance measures. The program will continue to emphasize local health department needs assessment capacity development. Other technical assistance will be provided to local health departments and community agencies on an as needed basis.

Currently, CFHS maintains 11 contracts with local health departments to provide perinatal programs at the local level. Other contracts or memoranda of agreement are maintained to provide presumptive eligibility screening with community health clinics, migrant health programs, an adolescent pregnancy program, University of Utah, Montezuma Creek Clinics, and St. Mark's Health Care Foundation. All clinics sites screen prenatal clients for presumptive eligibility and offer financial counseling and referrals to Medicaid for application for benefits.

The number of Medicaid deliveries increased from 4,495 in calendar year 1987 to 11,513 in federal fiscal year 1998. Of these deliveries, 73% occurred in the MCO system with the remaining 27% occurring in the fee-for-service system. It is anticipated that the percentages of deliveries in the

managed care organization (MCO) systems will increase as more clients are enrolled in these health care organizations.

Review of ongoing interagency agreements

Interagency agreements are reviewed and renewed annually as appropriate by CFHS Program Managers in cooperation with appropriate personnel in these organizations. Other interagency linkages are informal and do not have or require a formal agreement. Some of these are listed below.

Interagency Collaboration

The following is a list of agencies with which the Maternal and Child Health programs within Community and Family Health Services collaborates, coordinates and provides/receives consultation at the Division or program level. They are presented alphabetically.

- Local health departments
- Community health centers
- American College of Obstetricians and Gynecologists (ACOG)
- Association for Utah Community Health (AUCH), Utah's Primary Care Association
- Boys and Girls Club of Murray/Midvale
- Catholic Diocese
- CBS, NBC, ABC television affiliates
- Child Fatality Review Committee
- CHIP
- Community Services Council (food bank)
- Coordinated Birth Defects Network
- Covering Kids Utah
- Early Childhood Integrated Services Committee
- Families, Agencies and Communities Together (FACT)
- Family Support Center
- Family Voices
- Genetics Advisory Committee
- Governor's Council for Persons with Disabilities
- Head Start and Migrant Head Start
- Hold on to Dear Life Campaign, Primary Children's Medical Center

- Intermountain Pediatric Society (Utah Chapter of American Academy of Pediatrics)
- Liaison for Individuals Needing Coordinated Services (LINCS)
- Mayor's Task Force on Access for People with Disabilities
- MCH Advisory Committee
- Occupant Protection Programs, Utah Highway Safety Office
- Office of Child Care, Department of Human Services
- Primary Children's Medical Center, Outpatient Clinics
- School Districts
- Scientific Vaccine Advisory Committee
- Shriners Hospitals for Children
- SIDS Alliance
- State Coordinating Council for Persons with Disabilities
- State Office of Education
- State PTA
- The Children’s Center
- University of Utah Departments of Pediatrics and Obstetrics and Gynecology; Teen Mother and Child Program
- University of Utah Medical Center, Specialty Clinics
- Utah Assistive Technology Program, Center for Persons with Disabilities, Utah State University
- Utah Children, child advocacy organization
- Utah Department of Human Services (DHS)
- Utah Emergency Medical Services for Children Project
- Utah Interagency Coordinating Council for Infants and Toddlers with Special Needs and Their Families
- Utah Issues, low-income advocacy organization
- Utah Nonprofits Association
- Utah Parent Center
- Utah Poison Control Center
- Utah State Deaf Blind Team
- Westminster College School of Nursing
- WIC Advisory Committee

4.3 Public Input [Section 505(a)(5)(F)]

4.3 Public Input

In preparation for the FY01 grant application, several actions were taken to obtain public input. First, the language used in the local health department Action Plans and the Special Provisions Contracts for the local MCH block funds is coordinated directly with the federal requirements for state MCH Block Grant Application and Annual Report. The local health departments report annually on their accomplishments in impacting the health status indicators for their communities' MCH population. The public input from these local partners strengthens the Division's strategic approach at the state level.

Second, proposed activities to address each of the core performance measures, state negotiated performance measures and outcome measures were sent to approximately 250 individuals statewide with whom we interact regularly to coordinate plans and efforts toward maternal and child health. These individuals include our counterparts in local health departments; community health centers; the State Primary Care Association; health professionals in the community and academia; voluntary health agencies; and, our partners in the education and human services systems. As in previous years, with this mailing we enclosed a brief response form, entitled "Reviewer Response" with which individuals may respond and provide feedback and input on the proposed activities. A copy of this response form is included.

In past years, the response rate on the proposed efforts to address the performance and outcome measures has been low. In order to increase the response rate for this year's plan, we solicited input from the MCH Advisory Committee. Members of the committee were very helpful in providing feedback on the public comment. The public comment process was reviewed and adapted based on the feedback received. Changes included: mailing list changes; changes in formatting and wording of the public comment document to eliminate language that non-MCH individuals aren't familiar with; and simplification of the process. As a result, the response rate did increase this year with some significant input provided on the annual plan efforts. The response rate was 25%. The feedback was provided to program staff to incorporate comments as appropriate into adaptations to the annual planning efforts.

Third, the Maternal and Child Health Advisory Committee also participated in the public comment process through their responses. The MCH Advisory Committee has three subcommittees concerned respectively with 1) pregnant women and infants, 2) preventive and primary care for children, and 3) children with special health care needs. The MCH Advisory Committee's focus this past year has been developing health priorities for the annual plan. Each subcommittee participated separately in a prioritization process and developed a list of 3-4 top priorities for the Division. These priorities are included in the Priority Needs Section 3.2.1 and will be fully addressed through the coming year in terms of review of state performance measures and funding allocation. Comments received from these meetings as well as responses received in the mail have been incorporated into CFHS plans and into the grant application wherever feasible.

Fourth, public notice was placed in each of six newspapers published in Utah: The Salt Lake Tribune and the Deseret News (Salt Lake City); the Standard Examiner (Ogden); the Herald Journal (Logan); the Daily Herald (Provo); and, the Richfield Reaper (Richfield). The notices ran for four days in the five newspapers that are published daily, and for two days in the newspaper that is published weekly. The public was invited to contact either their local health department or CFHS to obtain a copy of the annual plan for review.

Fifth, the annual plan was placed on a web page on the Internet. The web page, **http://hlunix.hl.state.ut.us/cfhs/mchblock,** contains an e-mail address for responses from individuals who accessed the information via the website. While only a few e-mail messages have been received it is anticipated that this will be an excellent source of public input, especially from colleagues in other agencies, as the use of the Internet increases.

The following section includes specific comments that were received as a result of the request for input on the proposed activities for each of the core and state performance and outcome measures.

- Are there additional activities you would suggest that might deal with the issues better?
  - Decrease the death rate in the workplace for children and adolescents 16-20 years.
  - Increase waiver services. Increase SSI use.
  - Substance abuse and violence prevention behaviors activities for children, adolescents and mothers.
  - Injury prevention activities for all ages.

- Specific processes for screening pregnant and parenting women for substance abuse problems. Training for health care providers on the screening process and benefits of treatment.

- Are there areas that you feel need to be included, but are not?
  - Establishing benefits for families. Outreach in people of color with families with disabilities.
  - Children and gun safety. Too many young children and teens are injured because of the careless use of guns.
  - I was impressed with the proposed activities. Here are some issues that came to mind: 1) Mothers and infants--no comments. 2) Children and adolescents
  - Consider a priority to address obesity, promote healthy eating habits and exercise (Dr. Satcher impressed me with the importance of addressing this from a public health standpoint! Additional priority--Do you want to build in "ensuring that youth with CSHCN receive services necessary to make appropriate transitions to adult life?" I know this has been identified at the Subcommittee C meetings; perhaps you're saving it for the next year. I hope this is useful feedback. Contact me if I can offer further clarification.
  - Drug - particularly methamphetamine use among adolescents. Mental health issues. Physical/sexual abuse.
  - Availability to address mental health issues that go left unattended related to lack of availability and high health care cost and high cost of medications and therapy.
  - Goals for physical activity, obesity, nutrition.

- Do you have other comments on the enclosed materials or the process for asking for your input?
  - Thank you for soliciting our input.
  - Very good document.
  - No, I felt somewhat overwhelmed by everything there is to do!
  - Materials are good. I don't feel 100% certain that all eligible families know about CHIP. Increased public education is maybe a process to expand.
  - Thank you for the opportunity to review and comment upon the activities outlined in Utah's Maternal and Child Health Block Grant Application for fiscal year 2001. The format used in this document has a greater focus on activities than numbers

with issues abbreviated and goals listed without target levels or current levels for comparison. Producing this document to get the greatest possible range of community members to review and comment is a delicate balance and we appreciate efforts by your staff to incorporate suggestions from your advisory committees. However, it is not clear that we communicate the importance of each goal without those numbers.

- In past years, we have commented on the lack of activities which address collaboration with the Medicaid program. We appreciate including collaborating activities with our Division in several areas within this document. We have found through our collaborative efforts that we have been able to do more for the families we serve. Thank you again for the opportunity to comment on your proposed activities, we look forward to a continued productive relationship with the Division of Community and Family Health Services.
- It's very comprehensive for health needs of families with small children. Activities are very vague. There are no measurements. Words like "support", "look at", "promote" don't mean much.
- I would like to see all of the goals be measurable so there could be an evaluation of the progress at the end of the year.
- Good process.

- Getting PMDs to want/use CASA not successful here - need doctor to educate/encourage them about all aspects of increasing immunizations. Need more access to health care for our 15.6% uninsured (most of whom are low income). Need state/locals to team to promote fluoridating water statewide. Need state/locals to partner to really educate public and politicians about the past and ongoing successes of public health, the future issues public health may be dealing with, and make them aware that PH is not Medicaid only (which is funded fairly adequately). We need to make sure they understand why adequate funding of other PH prevention and early intervention activities is so vital. We cannot continue to do more and more with level funding, or worse, cut funding. Get CHIP, Medicaid, HMOs and PH to sit at one table and iron out the issues of payment, referral, etc.

The following are comments on specific performance measures:

- Decrease teen births.
  - Wish we had <u>any</u> effective strategies to help prevent teen pregnancy. We do intervention to prevent second teen pregnancy, but state and community mores have tied our hands.
  - More action needs to be taken on decreasing the teen birth rates. Much more pro-active activities. Particularly on abstinence-only education. Burying our heads in the sand is <u>not</u> the answer.
  - There needs to be more on prevention of teen pregnancies and repeat pregnancies. There also needs to be goals on helping teen and single mothers to avoid repeat pregnancies and to teach them parenting skills with the first baby.
  - Support local health department efforts to prevent teen births. Need to bump this up, i.e., FP dollars. More coordination with WIC.
- Start prenatal care in the first three months of pregnancy.
  - Some of our physicians encourage low income and Medicaid women from 1st trimester prenatal care. Need influential doctor to educate and encourage them.
  - Fund research on why some women enter prenatal care late in Utah. Educate providers who refuse one prenatal care appointments until after 12 weeks because of SABS.
  - Yes, if we were provided with funding. Because of funding cuts in recent years we have had to: decrease services, (such as unable to pay for ultra sound for prenatal pts.). Begin charging women below poverty levels in family planning or cease existing services or education materials provided.
- Increase breastfeeding at hospital discharge.
  - All efforts seem focused on mothers in lower social economic groups. Consider additional efforts focused on other groups.
  - A monitoring function would be useful for the breast feeding activities to ensure that the trained staff is able to appropriately support new mothers who want to breastfeed.
- Reduce very low birth weight live births. (under 1500 grams or under 3.5 pounds)

- What is the relative risk of a family history of preterm births? I would be very interested in tracking this prospectively with you.

- Reduce all infant deaths.

  - Update your usage from 'black' or 'Black' to African American!
  - Do other race/ethnicity groups have elevated rates? Include them.

- Increase the percent of third graders who have dental sealants.
  - More education for new mothers on baby bottle tooth decay prevention. Specific programs to educate about this problem. Development of fluoride varnish use in infants identified to be at high risk for caries.
  - Consider including something on water fluoridation in relationship to child dental care.
  - Dental activities targeting preschoolers - I see a lot of bottle mouth caries in toddlers and pre-schoolers of low-income populations. Very few places to refer for treatment.

- Decrease the death rate for children ages 1-14 years.
  - Work with the Utah Labor Commission to inform teenagers to develop their desire to “Take safety seriously” through injury prevention training and education.
  - Conduct safety and health awareness training.
  - Compile injury and illness statistics for teenage employees.

- Decrease the percent of children without health insurance.

  - Take steps needed to encourage CHIP Program to allow dental coverage to eligible children even if they have health insurance but not dental. Do not deny dental because they have health insurance.
  - Explore the scope of children not enrolled in their parent’s employer based health insurance. Inventory child health benefits coverage of Utah's major commercial ERISA insurance plans.

- Increase the percent of Medicaid eligible children who enroll in Medicaid and obtain needed services.
  - We need to have some discussion as to how this may apply to children who are waiting for DSPD services, but primarily need medical card. The question is worded fine.

- (a) Agencies making referral to Medicaid or CHIP should check status of application and provide assistance to client where needed. (b) Make Medicaid application process easier by providing the necessary forms Medicaid requires in addition to the application at time of initial application. Use a simple checklist that specifies exactly what documentation is required and what forms need to be completed and returned with application. This would eliminate making applicants return information 2-3 times after initial application.
- Work with CHIP to help design activities that also help to enroll Medicaid-eligible children in Medicaid. Assist Local Health Departments with outreach activities.

- Decrease suicide deaths among 15-19 year olds.
  - Work with the local substance abuse providers who serve adolescents to reduce suicide risks due to depression and substance use.
- Provide CSHCN services to more children receiving SSI disability benefits.
  - Conduct outreach through DDS.
- Increase the percent of CSHCN children with a “medical home”.
  - Increase the numbers of minority CSHCN children with a medical home. Track them explicitly in the proposed survey.
  - Consider additional wording to read "Increase the percent of CSHCN children who have a usual health care provider to go to when they are sick as well as to monitor overall health and promote wellness (or something to ensure that the medical home addresses routine well care, monitors overall health).
  - Increase uses of telehealth capacity and include primary care providers.
  - Increase the numbers of minority CSHCN children with a medical home. Track them explicitly in the proposed survey.
- Assure statewide newborn screening for PKU, hypothyroidism and galactosemia.
  - Evaluate and recommend additional tests.
- Improve family participation in CSHCN activities.
  - Offer use of new CSHCN conference facility to parent support groups.
  - The state could do more to coordinate with non-profit CSHCN providers to build a comprehensive approach to servicing these families. Easter Seals is interested in helping with this.

- OT and PT services for CHCN. Increase services for CSHCN's especially with Medicaid.

- Assure statewide newborn screening for hearing impairment.
  - Consider adding an activity to ensure connections with further diagnostic evaluations/interventions for those newborns who fail screening. According to Karl White, apx. 1/3 of kids who fail hearing screening do not get further testing or connected with appropriate services. This highlights the importance of follow-up and tracking for any screening effort.

4.4 Technical Assistance [Section 509 (a)(4)]

During FY 2001, Utah is requesting MCH Technical Assistance to support the further development of our State's LHD-conducted Prenatal to 5 Home Visitation Program. As noted earlier in this document, the Prenatal to 5 Home Visitation Program is fairly new in Utah, having been established in FY 1999 with MCH Block Grant funding previously dedicated to the Infant Development Program. A state nurse consultant has recently been hired (November 1999) to serve in the capacity as Home Visitation and Early Childhood Nurse Consultant. This nurse consultant and the Child and Adolescent Health Program Manager have developed basic contract requirements and program standards for LHDs involved in providing services through this new program component. They are currently working with Medicaid/Early Childhood Project staff and LHD nursing staff to assess training needs and begin to develop a training program and materials for LHD-employed home visiting nurses.

An opportunity for CFHS and local health department staff to meet with representatives of one or two other states with established and successful nurse home visiting programs would be particularly helpful for Utah over the next year. A number of other state health departments and agencies have demonstrated expertise in setting up and implementing home visitation programs and/or related training. These include Colorado Department of Public Health and Environment, the Vermont Department of Health, and the Florida State University Center for Prevention & Early Intervention Policy, to name a few. Technical assistance and consultation from one or more of these agencies/programs (or others as identified) would be of great assistance to Utah in the development and/or refinement of our home visitation program model; development of standards, guidelines and training; establishment of appropriate evaluation methods; and the identification of various funding resources and mechanisms. An ever-present challenge is promotion of the benefits of home visiting

programs to communities and policy-makers. Understanding how other states meet this challenge would also assist us in building a successful statewide program.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy-making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aim at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors
tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-

(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may

result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

This section includes:

- Division Director's curriculum vitae
- Maps of Utah that illustrate location of various local health departments; community and migrant health centers; community based services for children with special health care needs; underserved areas for medical, dental and mental services.
- Pyramid of Core Public Health Services Delivered for each of the three MCH populations
- Needs assessment tools
- Review response form for public comment process
- Key MOAs
- References

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

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[1] Utah Population Estimates Committee, 1999
[2] U.S. Bureau of the Census
[3] Governor's Office on Planning and Budget (GOPB), Utah Data Guide, Winter 2000
[4] Utah Department of Health Public Health Outcome Measures Report, 1999
[5] Utah's Vital Statistics: Births and Deaths, 1998, Utah Department of Health
[6] Utah Data Guide, Autumn 1999, Governor's Office on Planning and Budget
[7] U.S. Bureau of the Census, CPS, 1997-1999
[8] BSA, 1999 **(need to spell out)
[9] State office of Education, School Finance and Statistics
[10] Utah State Office of Education, Finance and Statistics, and the U.S. Department of Education, National Center for Education Statistics
[11] Utah Office of Vital Records and MatCHIIM statistics, Utah Department of Health

[12] Division of Community and Family Health Services. Report on Maternal and Infant Health in Utah. Salt Lake City, UT: Utah Department of Health. 1997.
[13] MatCHIIM Internet Database. Maternal and Child Health Bureau, Utah Department of Health
[14] MatCHIIM Internet Database, (Medicaid Module), Maternal and Child Health Bureau, Utah Department of Health
[15] Report on Maternal and Infant Health in Utah, Utah Department of Health, 1997
[16] 1996 Utah health status survey report: health insurance coverage. Haggard LM, ed. Bureau of Surveillance and Analysis, Utah Department of Health. 1997.
[17] Ozer et al. (1998), America's Adolescents: Are They Healthy?
[18] MatCHIIM Internet Database, Hospital Discharge Module, Maternal and Child Health Bureau, Utah Department of Health
[19] Youth Behavioral Risk Factor Survey, 1999
[20] Utah Child Health Survey, 2000
[21] Utah Health Status Survey, 1996, Utah Department of Health