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Utah Health Improvement Plan 2017–2020

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For more information, contact:

Utah Department of Health
Office of Public Health Assessment
Center for Health Data
288 North 1460 West
Box 142101
Salt Lake City, Utah 84114-2101
Phone: (801) 538-9191
chdata@utah.gov

This report is also available online at https://ibis.health.utah.gov/pdf/opha/publication/UHIP.pdf.

We invite anyone to provide feedback on this report. Please do so through email (chdata@utah.gov).

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Contributing Groups & Agencies

Several individuals representing multiple agencies gave guidance and input into the Utah State Health Assessment process, prioritization of the health issues, and development of the Utah Health Improvement Plan. We acknowledge their contributions and thank them sincerely for their efforts. This report would not have been possible without their efforts. We also wish to thank all of the community members who attended the community input meetings around the state; their insights regarding the needs of their communities were invaluable. Groups and agencies involved in the process are listed below. Individuals are listed in the Acknowledgments section.

As there were so many people who contributed to this process we may have inadvertently left someone off the list. If you participated and we do not have you listed we apologize, please let us know so we can update the list.

Photos on front cover courtesy of Utah Travel Council.

Groups

(see page 8 for description of groups)

Community Advisory Panel

Minority Community Representatives

Students/Interns

State Health Assessment Workgroup

Utah Health Improvement Plan Coalition

Utah Health Improvement Plan Executive Committee

Utah Health Improvement Plan Operational Committee

Utah Health Improvement Plan Workgroup Co-Chairs

Agencies

American Cancer Society Cancer Action Network

American Heart Association of Utah

Bear River Health Department

Brigham Young University

Central Utah Health Department

Commission on Criminal and Juvenile Justice

Comunidades Unidas

Davis County Board of Health/School District

Davis County Health Department

Division of Occupational and Professional Licensing

Division of Substance Abuse and Mental Health, Utah Department of Human Services

Get Healthy Utah

HealthInsight

Huntsman Cancer Institute

Intermountain Healthcare

International Rescue Committee

National Association of Local Boards of Health

Regence BlueCross BlueShield of Utah

Sacred Circle Facility (Confederated Tribes of the Goshute Reservation)

Salt Lake Community College

Salt Lake County Health Department

San Juan Public Health Department

SelectHealth

Skull Valley Band of Goshute

Southeast Utah Health Department

Southwest Utah Public Health Department

Summit County Health Department

Tooele County Health Department

TriCounty Health Department

United Way

University of Utah

University of Utah College of Nursing

University of Utah Health

University of Utah Health Sciences & School of Medicine

Urban Indian Center of Salt Lake

Utah Association of Local Health Departments (UALHD)

UALHD Affiliate Group Chairs

Utah Commission on Aging

Utah County Health Department

Utah Department of Environmental Quality

Utah Department of Health (UDOH)

Utah Department of Transportation

Utah Health Advisory Council

Utah Health Policy Project

Utah Hospital Association

Utah House of Representatives

Utah Indian Health Advisory Board

Utah Navajo Health Systems

Utah Poison Control Center

Utah State Board of Education

Utah State University
Voices for Utah Children
Wasatch County Health Department
Wasatch Front Regional Council
Weber-Morgan Health Department
Weber State University

Executive Summary

The Utah Health Improvement Plan (UHIP) is a statewide collaborative plan to address chosen priority health issues by the people and agencies in the state interested in the health of the population. The goal of the UHIP is to positively impact complex health concerns and reduce duplicative work by collaborating to align goals and maximize resources. The Utah Department of Health (UDOH) and local health departments (LHDs) take the lead role in facilitating the collaborative efforts.

A State Health Assessment (SHA) was conducted during 2015–2016. The SHA was a collaborative process including the UDOH, LHDs, and several partner agencies. The process included:

- Reviewing more than 100 health data indicators
- Receiving input during 27 community meetings held around the state
- Conducting a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the state health system with multiple partner agencies
- A multi-stage prioritization process which included many partner agencies
- Providing opportunity for public feedback

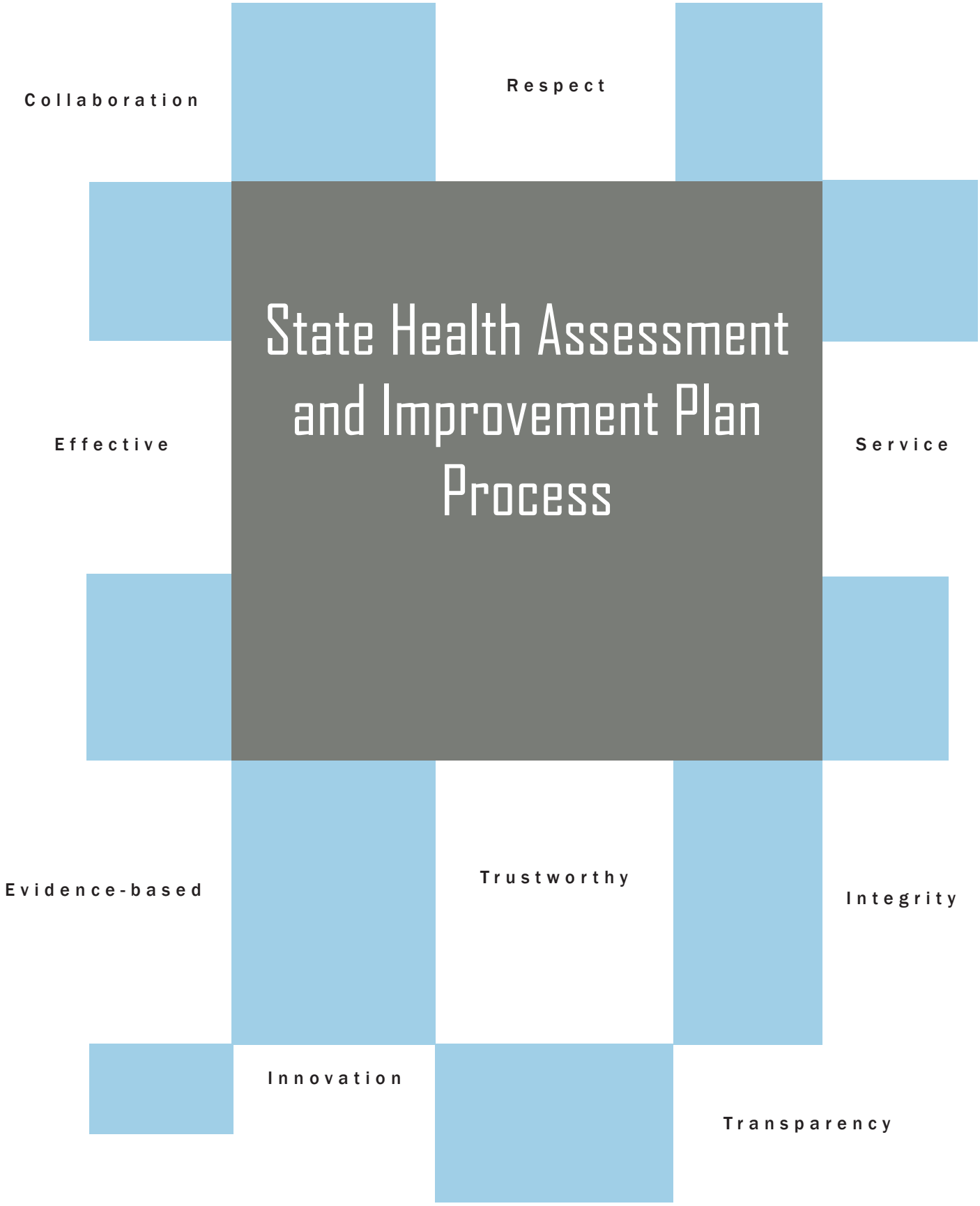
The Utah State Health Assessment was completed and posted online in the Fall of 2016.
http://ibis.health.utah.gov/pdf/opha/publication/SHAReport2016.pdf

The prior State Health Improvement Plan (SHIP), covering the years 2012–2017, can be located at http://utphpartners.org/ship/plan.pdf. The SHIP was the initial plan for the state of Utah and primarily involved the UDOH and the LHDs. One of the goals of the initial SHIP was that Utah would have a unified and effective public health system which included having effective local and state partnerships. This goal was met and the relationships between the state and LHDs were strengthened. The steering committee for the SHIP decided to update the plan for multiple reasons; (1) to reassess that the priorities were still the greatest health needs in the state based on the SHA, (2) to expand involvement of partner health agencies, and (3) to update the structure to reflect involvement of the new partner agencies. The new structure involves an Executive Committee, Operational Committee, and workgroups for the priority areas, as well as a broader coalition of community members to provide input. Additionally, the SHIP was rebranded as the UHIP.

The following three priority health areas were chosen as the focus of the 2017–2020 UHIP. The UHIP Executive Committee based this decision on the analysis during the SHA process, feedback from the UHIP Coalition, to align with partner agencies' focus areas, and because it was felt these broad and complex issues would benefit from the UHIP statewide collaborative process.

1. Reducing obesity and obesity-related chronic conditions
2. Reducing prescription drug misuse, abuse, and overdose
3. Improving mental health and reducing suicide

Workgroup leaders were chosen, workgroups formed, and plans developed for each of these three priority health areas. The specific plans are included in the following pages of the report. Included in the plans are the goals, objectives, and strategies that are targeted for improvement along with the measures that will be utilized to track progress. Progress will be reviewed regularly by the UHIP Executive Committee and plans modified as needed to address concerns. Additionally, progress will be reported annually to the UHIP Coalition for feedback. The UHIP is a collaborative effort and workgroups include members from multiple agencies and communities. Improvement in these complex health issues will only occur with united efforts involving multiple partners.



State Health Assessment and Improvement Plan Process

This section describes the process followed by the Utah Department of Health (UDOH) as it facilitated the Utah State Health Assessment (SHA) and the Utah Health Improvement Plan (UHIP).

Purpose

The initial state assessment was completed in 2012. In late 2014, Intermountain Healthcare approached the UDOH and the local health departments (LHDs) to collaborate on their needs assessment, and it was decided that this collaborative process could benefit all agencies' needs assessment processes. In May 2015, a meeting of the State Health Improvement Plan (SHIP) committee resulted in a decision that it was time to complete a new SHA to reassess the highest priority needs and update accordingly. Thus the purpose of the SHA is to update the old assessment, foster collaboration, and inform the SHIP update.

In the update process, it was decided to rename the State Health Improvement Plan to the Utah Health Improvement Plan. In this report you will see the term State Health Improvement Plan or SHIP referring to the old plan and supporting committees or to the general process of conducting a state health improvement plan. The term Utah Health Improvement Plan or UHIP refers to the updated plan and supporting committees.

State Public Health System

The Centers for Disease Control and Prevention (CDC) define the public health system as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.[1]" The SHA is assesses the geographic area of the state of Utah and its population. The state health system for this process is defined as "all entities that contribute to the health and well-being of the residents in the state." While the UDOH took on the role as convener and facilitator for the SHA process, the assessment represents the needs of the entire State of Utah public health system. The figure below represents potential entity types that are involved in the state system and interactions between the entities.

Figure 1. State Public Health System

The public health system in Utah is decentralized. It consists of the state UDOH and 13 LHDs. The UDOH along with the LHDs work to detect and prevent outbreaks of infectious disease, promote healthy lifestyles and safe behaviors, protect

1 CDC—Public Health System and the 10 Essential Public Health Services. National Public Health Performance Standards. Accessed online 5/10/16 at http://www.cdc.gov/nphpsp/essentialservices.html.

citizens from man-made and natural disasters, and provide access to healthcare services for Utah's most vulnerable populations.[1]

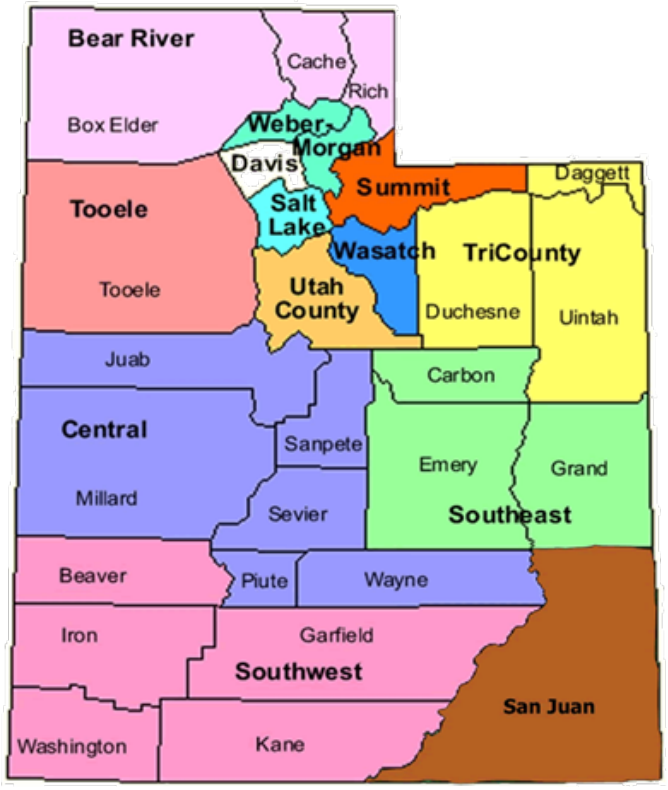
The public health capacity in Utah is provided by state and local public health entities, healthcare systems, tribal health-care services, community health centers, other government agencies, and community-based organizations.

At the local level, **public health services** in Utah are organized into 13 health districts. Seven of the 13 local health districts are single county and six are multi-county districts. The San Juan Health District was formed in 2015.

The local health districts in Utah include the following:

- Bear River (Box Elder, Cache, Rich counties)
- Central Utah (Juab, Millard, Piute, Sevier, Wayne, Sanpete counties)
- Davis County
- Salt Lake County
- San Juan County
- Southeast Utah (Carbon, Emery, Grand counties)
- Southwest Utah (Garfield, Iron, Kane, Washington, Beaver counties)
- Summit County
- Tooele County
- TriCounty (Daggett, Duchesne, Uintah counties)
- Utah County
- Wasatch County
- Weber-Morgan

Map 1. Local Health Districts



LHDs provide many essential health services including investigation of disease outbreaks, regulation of known sources of health hazards such as food establishments, and health education and prevention services such as immunizations and preventive health screenings.

The highest priority health problems vary among health districts, especially between the more urbanized Wasatch Front districts and the more rural and frontier districts.

LHDs are often the front line for reporting communicable diseases and other events, such as signs and symptoms of exposure to biologic agents of terrorism. The Utah Notification and Information System (UNIS), Utah's health alert network, consists of a network of local, state, and private health providers who share information through instantaneous electronic transmission to provide a timely response to disease outbreaks whether natural or the result of terrorism. UNIS has expanded to include many emergency management, homeland security, and other response partners.

For more information about local public health in Utah, see the Utah Association of Local Health Departments website at www.ualhd.org.

The **private healthcare systems**, including hospitals, physicians, health plans, schools, and private-non-profit agencies, deliver many important local public health services as well. The UDOH and LHDs collaborate with the private healthcare system to improve the overall health of the population.

The Utah Indian Health Advisory Board advises and makes recommendations for **tribal healthcare services** and related policy to the UDOH, the Utah Native American Legislative Liaison Committee, and the Governor's office on behalf of American Indians and Alaska Natives in Utah. The Tribes and Tribal Epidemiology Centers are recognized public health authorities in Utah. The UDOH has an Office of Indian Health that works with the Tribes to raise the health status of the American Indian/Alaska Native population in Utah to that of the state's general population.[2]

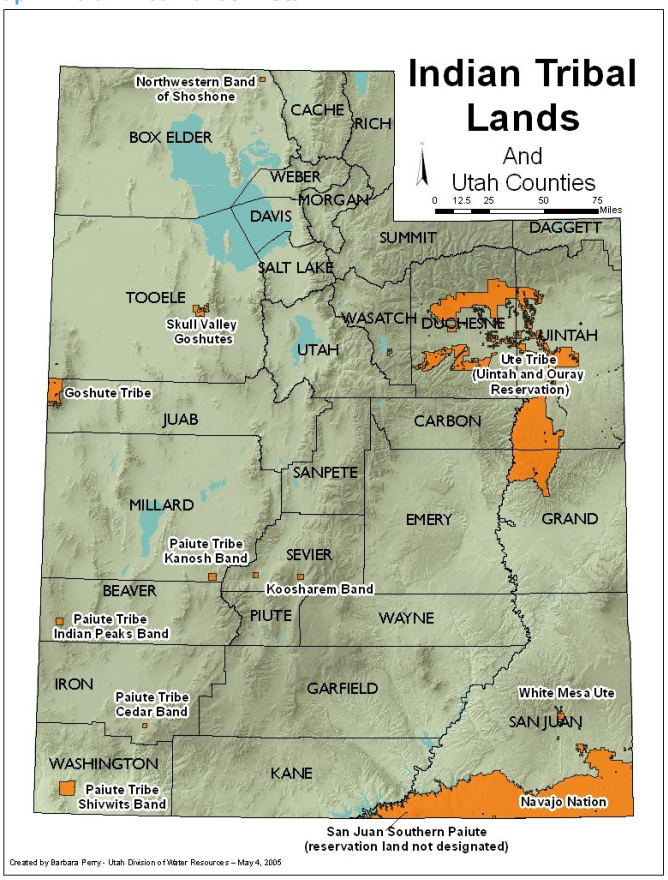
1 About the Utah Department of Health. Accessed online 5/18/16 at http://health.utah.gov/about/index.html.
2 Indian Health. Utah Department of Health. Accessed online 5/18/16 at http://health.utah.gov/indianh/.

Community health centers are available to provide care to vulnerable populations. The Association for Utah Community Health (AUCH) is a private, non-profit membership alliance of community health centers and other organizations committed to the accessibility of high-quality, family-oriented, affordable, and community-sensitive healthcare. There are 13 health centers and five affiliate members. Members include Federally Qualified Health Center (FQHC) grantees who provide comprehensive primary and preventive healthcare services to all individuals, regardless of ability to pay.[1]

In addition to health agency partners, the Utah health system includes **other state agencies** as well. Following are examples of collaboration with some of the other state agencies. The Department of Environmental Quality works with the UDOH and LHDs on issues related to air and water quality and contaminants. The Utah Division of Substance Abuse and Mental Health (DSAMH) collaborates with the UDOH to assess behavioral health needs across the state and develop interventions. The Utah State Office of Education collaborates on school-based assessment and interventions.

There are several **community-based organizations** that work on health issues for target populations, that work in specific geographic areas, or that focus on specific health concerns.

Map 2. Indian Tribal Lands in Utah



Map downloaded from Utah Department of Health Indian Health website, http://health.utah.gov/indianh/history.html.

1 Association for Utah Community Health—Overview. Accessed online 5/18/16 at http://www.auch.org/about-auch/overview.

State Health Assessment and Improvement Planning Process

The state health assessment and improvement planning process was a collaborative process with community and stakeholder involvement. The Association of State and Territorial Health Officials *State Health Assessment Guidance and Resources* was used as a model for this process as well as a graphic provided by County Health Rankings.[1]

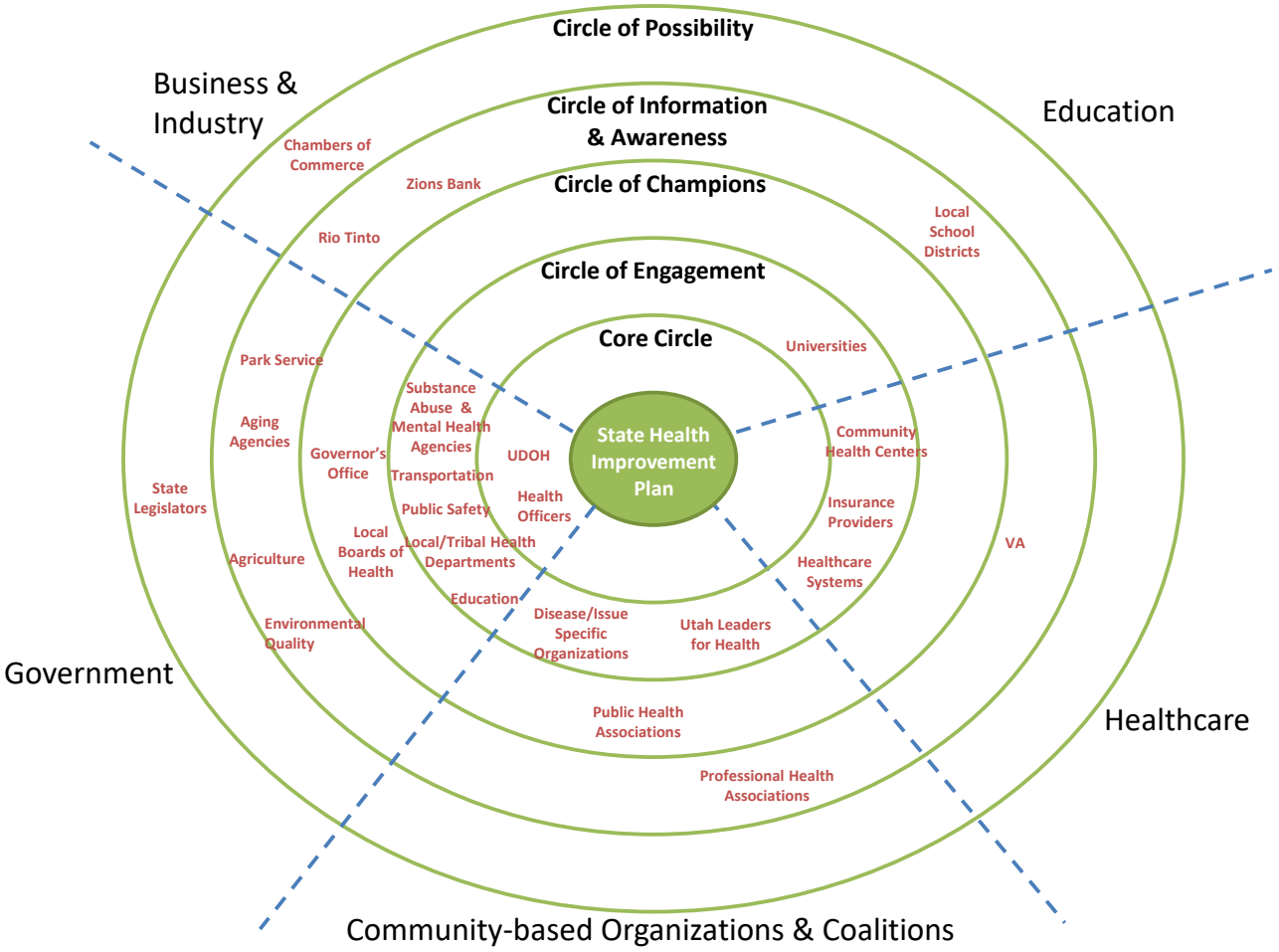
Figure 2. State Health Assessment and Improvement Plan Process

1 Take Action Cycle. County Health Rankings & Roadmaps. Accessed online 5/18/16 at http://www.countyhealthrankings.org/resources/take-action-cycle.

Collaboration

The previous SHIP included input mainly from the UDOH and LHDs. It was determined that a broader range of partners needed to be involved in the updates. The diagram below shows agencies that may be included in the state health system at different levels of involvement.[1]

Figure 3. Utah Health Improvement Plan Stakeholder Asset Map



Core Circle:
The Core Circle of participants are those that plan and facilitate the implementation of the UHIP. They also coordinate the participation of individuals in all the circles. They are most heavily involved in the development of the plan and the creation of its objectives. They organize the next steps in the implementation of the plan; decide who needs to be involved; call the meetings; prepare the materials, processes, and reports; and enlist the support of others. Core Circle participants have the real dedication to the plan, and see themselves as responsible for monitoring and coordinating its various components.

Circle of Engagement:
The Circle of Engagement includes individuals committed to the plan who can be called on to help with specific tasks at particular times. They don't see themselves as the primary drivers of the implementation effort but are willing to assume their fair share of responsibility for specific aspects of it, although it is up to the Core Circle to follow-up and ensure completion of assignments. This circle includes individuals who may or may not have been involved in the development of the plan. It also includes individuals who can become increasingly engaged in its implementation and leadership, and who may eventually move into the Core Circle.

1 Modified from Technology of Participation's Circle of Involvement

Circle of Champions:
The Circle of Champions includes individuals who typically hold positions of leadership in their respective organizations and are, or need to be, committed to the plan. They may not be very involved in the daily activities of its implementation. They are the authorizers of the effort, advocates for it, the ones whose blessings can clear away some of the roadblocks. They are cheerleaders who can appear when it is strategically helpful, to affirm the work that has been done, and to provide top-level support. They need to be kept informed of what's happening (big picture) and where to plug in strategically without having to be involved in the details.

Circle of Information and Awareness:
The Circle of Information and Awareness includes individuals who aren't very close to the plan or its implementation but should be kept in the loop as things progress. They are able, because of their positions and roles, to lend support to the efforts or to raise questions about it and slow it down. They may be people who weren't involved in the development of the plan but are impacted in some way by it. Occasional visits and reports that allow them to see the value in what is happening and to have their questions about it answered are important to maintaining progress. Sometimes, people in this circle can move into the Circle of Engagement.

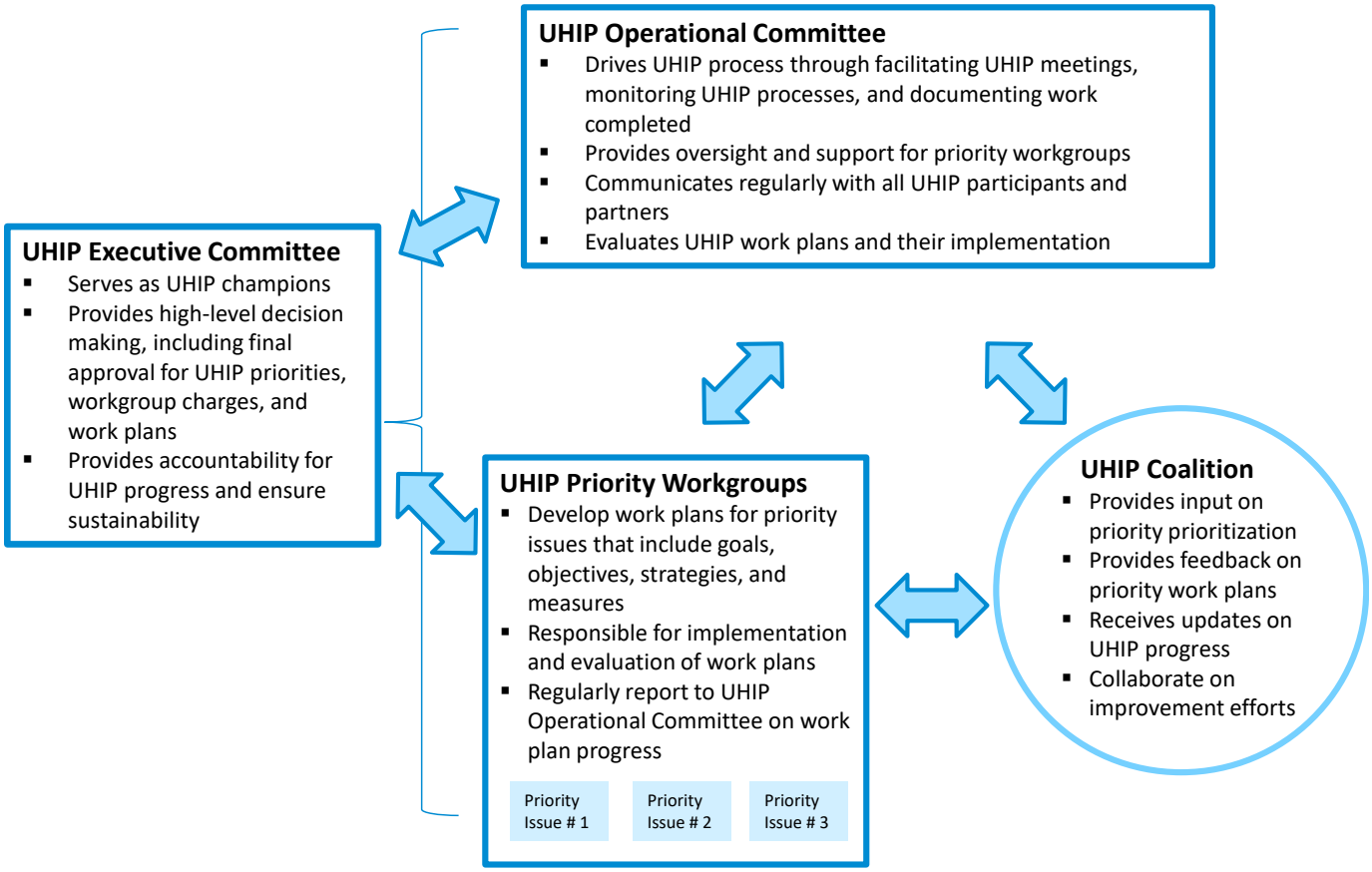
Circle of Possibility:
The Circle of Possibility includes individuals you wouldn't immediately think of as being at all related to the plan or its implementation but who could be interested in partnering, be able to provide helpful resources for it, or give it some kind of boost. Coming up with these names is an exercise in creative brainstorming that expands a group's thinking. These are relationships with individuals/groups that can be explored without assuming they will turn out to be supportive, but when they do, it can be a real gift.

Multiple groups and individuals from these circles were involved in the SHA and UHIP process. Below is a list of the collaborator groups and the contributions they made.

- The **Community Advisory Panel**. The Community Advisory Panel is a group of leaders from Intermountain Healthcare, the UDOH, LHDs, Local Mental Health and Substance Abuse Authorities, the Utah Hospital Association, and AUCH. This group was formed to collaborate and share resources for the Intermountain Healthcare Community Health Needs Assessment, the LHDs needs assessments, and the SHA. This group agreed upon a process to gather community input across the state, the list of more than 100 health indicators to review, and a data sharing process to gain access to information by local health district area and hospital catchment area. This collaborative effort reduced duplication of effort and improved collaboration between these agencies. This group also discusses the best ways to collaborate during improvement planning and implementation in order to efficiently and effectively utilize available resources. The group meets regularly, usually once a quarter or more depending on need.
- The **State Health Assessment Workgroup**. This workgroup included UDOH and LHD employees and was responsible for analyzing data on the more than 100 health indicators, feedback from the 27 community input meetings held around the state, and needs assessments conducted throughout the state over the past five years. The group decided on initial prioritization criteria and a process to apply the criteria. Upon applying these criteria, the initial list of health indicators was reduced to 30 for consideration by other groups. The SHA Workgroup also provided feedback and helped develop the process for the Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the state health system.
- **Community Input Partners**. Twenty-seven community input meetings were held around the state to gather input on health needs and to discuss the health assessment process. These meetings were held as a collaborative process between Intermountain Healthcare, the UDOH, and the LHDs. A second round of meetings were held by Intermountain Healthcare to get feedback on their identified priorities and to gather information regarding local resources that may be available to address the identified health priorities.
- **Intern**. A volunteer intern reviewed numerous health needs assessments conducted around the state by various organizations and identified common needs identified in the assessments.

As mentioned in the Executive Summary, part of the update process included an update in the UHIP oversight structure. Below are the groups that are part of that structure.

Figure 4. Utah Health Improvement Plan (UHIP) Organizational Structure



- The **Utah Health Improvement Plan Executive Committee**. This group is the decision making body for the final SHA priorities as well as the UHIP.
- The **Utah Health Improvement Plan Operational Committee**. This committee ensures that the UHIP process is moving forward. It is comprised of members of the UDOH and LHDs. This group received updates and gave feedback on the SHA process and assisted in setting up the meetings of the UHIP Coalition.
- The **Utah Health Improvement Plan Coalition**. This group includes representatives from several partner agencies including LHDs, healthcare systems, environmental health, substance abuse and mental health, transportation, academia, health insurances/payers, community organizations, business, ethnic groups—African Americans, Hispanics, Asians, Pacific Islanders, American Indian Tribes of Utah—health advocacy organizations, education systems, and religious organizations. This group assisted in the second round of prioritization of health issues (taking the reduced list from the SHA Workgroup and voting to reduce to a few priorities). This group also gave feedback on the UHIP, and will hear and give feedback on implementation and progress of the plan.

Partners interested in the health of Utahns recognize the importance of collaboration to reduce duplication of efforts, share resources, and reduce potential gaps in execution. A collective impact approach allows for priority areas to be targeted by multiple agencies through multiple paths which will increase likelihood of improvement.

Vision and Mission

The following vision and mission statements were finalized in 2015 by the prior SHIP Coalition (which included UDOH and LHD staff). The SHIP Coalition for the old plan has been replaced by the UHIP Coalition.

Vision statement: “A unified Utah public health system that improves the health of the people of Utah”

Mission statement: “To unite the Utah public health system and improve the health of the people of Utah”

Community Input

Intermountain Healthcare, the UDOH, and the LHDs worked together to host 27 focus group meetings around the state to gather feedback regarding the health needs and disparities of each community. People from the community were invited to attend. The following groups were invited to be represented:

- State, local, tribal, or regional public health departments
- Healthcare advocates
- Nonprofit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Healthcare providers
- Community health centers and other safety net clinics
- Private businesses and workforce representatives
- Representatives of medically underserved, low-income, and minority populations
- Members of the public

Attendees were asked what the greatest needs and disparities in their community were regarding:

- Weight and unhealthy behaviors
- Access to healthcare
- Behavioral health access
- Children's health
- Environment

Data Indicators

More than 100 data indicators were initially chosen by the Community Advisory Panel to review. The SHA Workgroup later added some additional measures. The health data was provided, where possible, by trend over time, gender, race, ethnicity, education, income, and local health district.

Review of Other Health Assessments

Needs assessments completed in the past five years were gathered and reviewed so that the committees could benefit from analysis that had already been conducted. Sixteen needs assessments from state health programs, LHDs, health systems, and community agencies were collected, reviewed, and priority areas identified and entered into a matrix.

Prioritization

The SHA Workgroup did the first round of prioritization. The following criteria were decided on when assessing health indicators:

- Root cause—upstream of health indicators
- Feasibility to change
- Size—how many people it affects
- Seriousness
- Disparities
- Community input
- Return on investment—health & financial

The data for these health indicators were reviewed online by the SHA Workgroup and the above criteria rated.

The top 30 scoring indicators then were mapped against:

- The UDOH Strategic Plan: Healthiest People goals
- The CDC 6|18 initiative
- Needs assessments from last five years
- Utah State Innovation Model project priorities
- Community input
- The prior State Health Improvement Plan goals
- America's Health Rankings areas of concern

The UHIP Coalition then took the reduced list of indicators and discussed and voted on priorities to recommend to the UHIP Executive Committee. The UHIP Coalition was instructed to identify statewide health improvement priorities that a) were important to the community and b) would benefit from a collaborative process to share and focus limited resources to improve the health of all Utahns.

They were asked to consider the following things:

- Size—What issues affect the most individuals?
- Disparities—Are there disparities in the issue that need to be remedied?
- Root cause—Does the issue lead to other health problems (upstream)?
- Seriousness—What is the seriousness of the health issue? (mortality, morbidity)
- Community readiness—What issues have high community interest or demand?
- Feasibility—What issues are we able to impact by working collaboratively?
- Return on investment—Which issues, if improved, would lead to the greatest health and/or financial return on investment?
- Evidence-based practices—Which issues have proven strategies?
- Should specific issues/measures be targeted or should the priorities be more general?

And answer the following questions:

- Which issues cannot be ignored or do you feel are the most urgent and why?
- Which health issues would benefit from a collaborative approach and why?
- Which issues are we ready to tackle (considering cultural, political, resources, capacity, community readiness) and why?

The UHIP Coalition members discussed the above and a round of voting was held where each participant had five votes to distribute.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

The SHA Workgroup, after reviewing relevant literature, helped format and refine the process of conducting the SWOT analysis. This analysis was done with the UHIP Coalition and information from the analysis was provided to the UHIP Executive Committee to consider as potential priorities for the UHIP or for consideration as potential supports or barriers that may impact efforts to improve the health priorities. The purpose was stated to be:

- Get feedback on system needs that should be considered as part of improvement planning
- Get feedback on factors that may impact success of targeted health issues that were prioritized

The UHIP Coalition was guided by a public health system definition of "all entities that contribute to the health and well-being of the residents in the state" while thinking about the 10 essential public health services in the following diagram.[1]

Figure 5. Public Health System and the 10 Essential Public Health Services

Regarding the internal workings of the state health system, the UHIP Coalition was asked to think about the following areas:

- Collective capabilities
- Morale, commitment, and participation norms
- Governance and defined roles
- Resources, funding, and assets
- Experience, knowledge, and data
- Innovative aspects
- Accreditations, certifications, requirements, and mandates
- Processes, systems, information technology (IT), and communications

While discussing the following questions:

- Strengths:
  - What are the characteristics of the Utah health system that will help it achieve successful outcomes or reach its goals?
  - What are health system resources and capabilities that will contribute to success?
- Weaknesses:
  - What are the characteristics of the Utah health system that might hinder successful outcomes or reaching its goals?
  - What are the health system barriers that may hinder success?

1 CDC—Public Health System and the 10 Essential Public Health Services. National Public Health Performance Standards. Accessed online 5/26/16 http://www.cdc.gov/nphpsp/essentialservices.html.

Regarding external impacts on the health system, the UHIP Coalition was asked to think about the following areas:

- Political, legislative, social, and financial environment
- Technology development and innovation
- Trends in public health that may affect health improvement planning
- Ethical and legal considerations
- Emerging best practices/science
- Cultural and behavioral norms

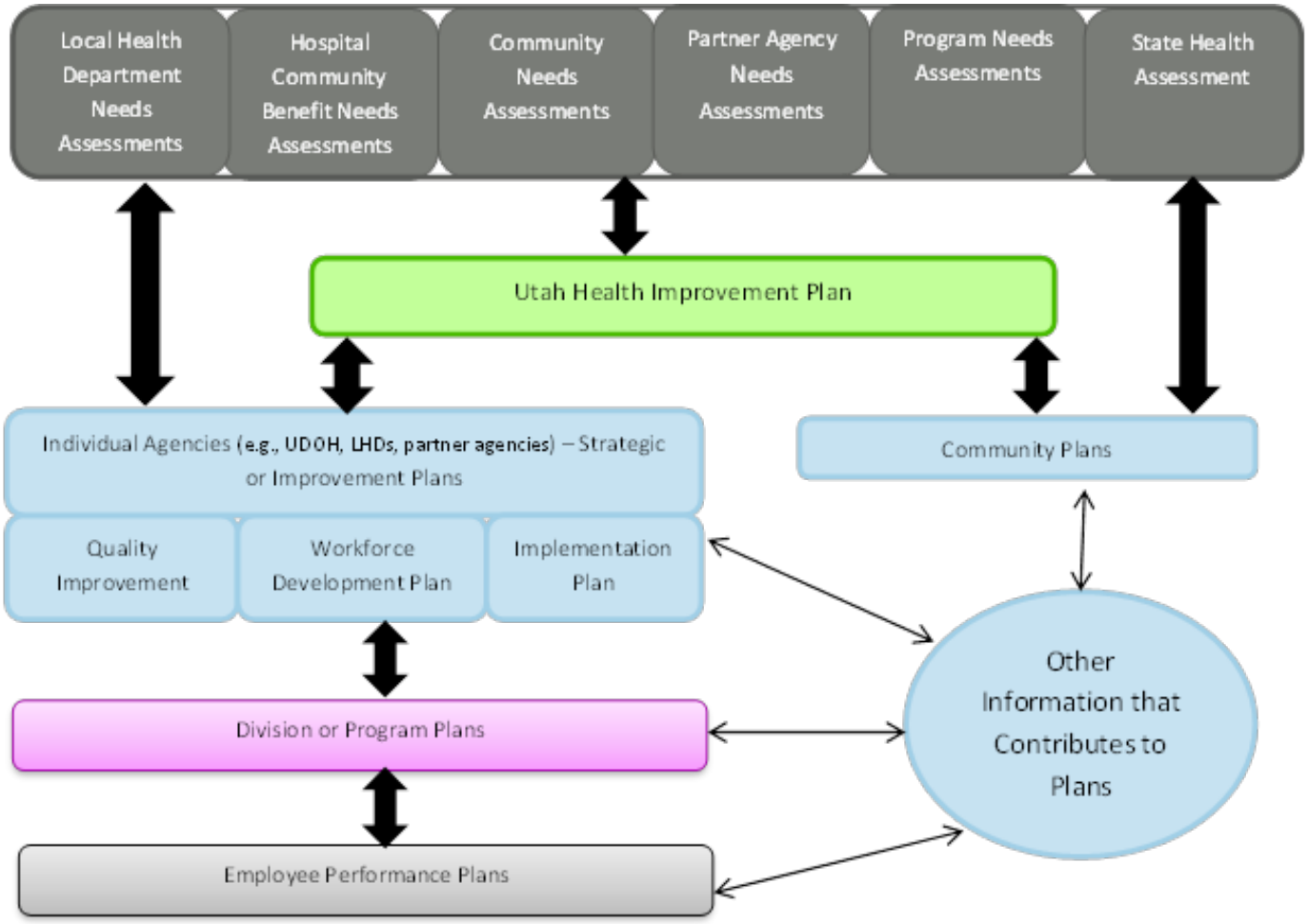
While discussing the following questions:

- Opportunities:
  * What are the factors that might influence or contribute to successful outcomes?
  * Are there any new opportunities or upcoming changes that might positively impact the status quo?
- Threats:
  * What are the factors that might prevent successful outcomes?
  * Are there any new threats or upcoming changes that might negatively impact the status quo?

Multiple Assessments and Plans

During the SHA process many people began asking how the UHIP was different from the agencies' strategic plans. The graphic below was created to explain how different plans and assessments within the state health system might interconnect.

Figure 6. State Health System Integration with Various Plans and Assessments



Priorities Chosen

As a result of these analyses, discussions, and prioritization, a list of potential health priorities was given to the UHIP Executive Committee for consideration. The UHIP Executive Committee based their decision on the analysis during the SHA process, feedback from the UHIP Coalition, alignment with partner agencies' focus areas, and because it was felt these broad and complex issues would benefit from the UHIP statewide collaborative process. The three priority areas chosen were:

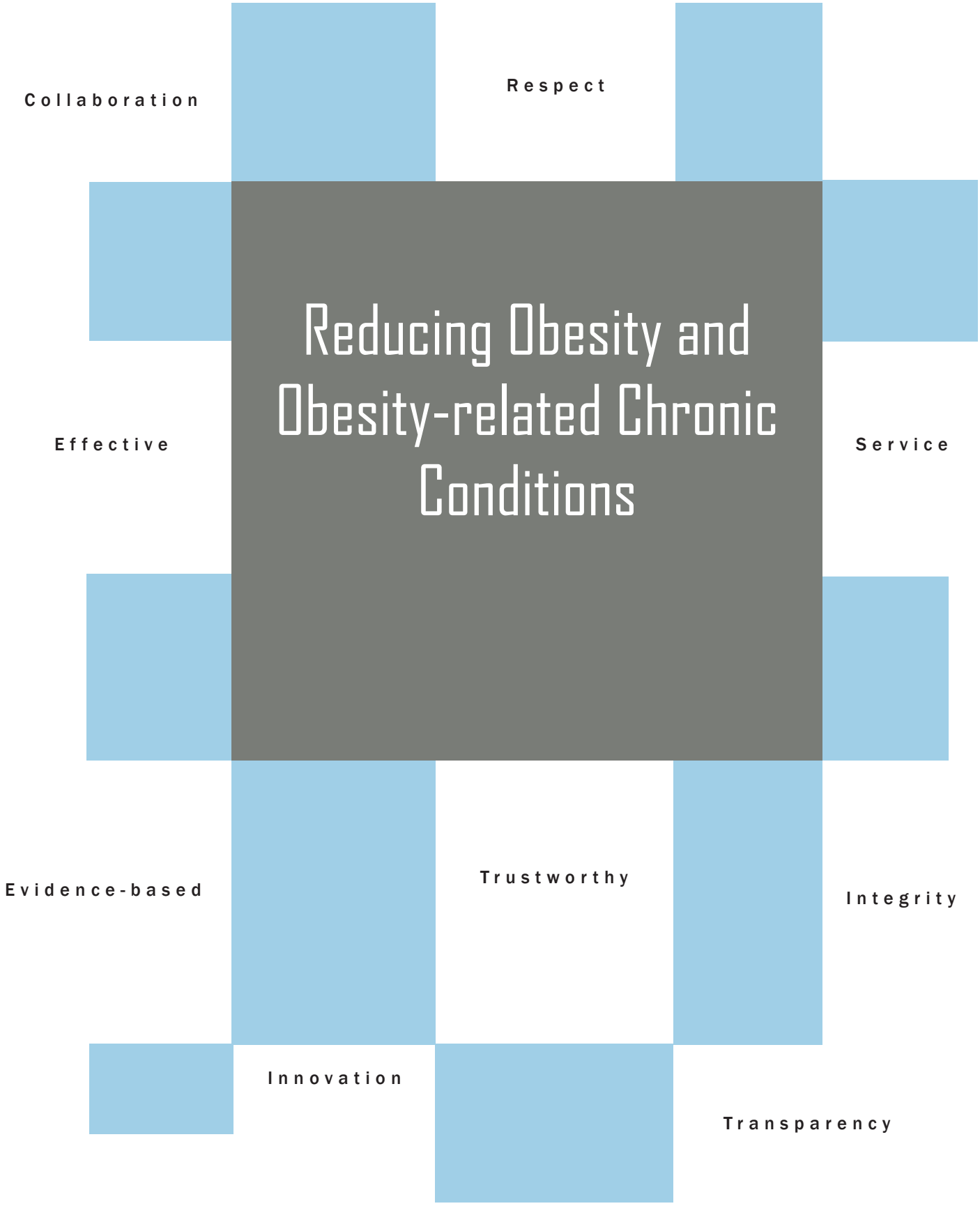
1. Reducing obesity and obesity-related chronic conditions
2. Reducing prescription drug misuse, abuse, and overdose
3. Improving mental health and reducing suicide

Although they may not have been chosen as a main priority, other areas of concern raised through the assessment process are being addressed through agencies' regular work. Efforts to improve those areas will continue.

Planning

Once the priorities were chosen, the UHIP Executive Committee determined co-chairs to lead the efforts. For all areas, there were already some existing efforts or coalitions. The UHIP Workgroups were formed and plans drafted. The workgroup plans were presented to the UHIP Coalition in May 2017 for feedback. The outcomes goals, strategies, and objec-

tives the UHIP Workgroups are focusing on do not represent all of the efforts for these priority areas. The workgroup plans address strategies that will expand or enhance current efforts, encourage broader collaboration, and that were possible to improve under existing resources. Discussions were also held regarding if the plans would reach high-risk populations for the areas and how they may need to be modified, if possible, to address disparate populations.


Collaboration
Respect
Reducing Obesity and Obesity-related Chronic Conditions
Effective
Service
Evidence-based
Trustworthy
Integrity
Innovation
Transparency

Background/Contextual Information for Health Priority

Over the past 16 years, the age-adjusted proportion of Utah adults who were obese increased dramatically, from 19.5% in 2000 to 26.2% in 2016. The highest rates of obesity were seen for adults aged 50–64. In 2016, the Native Hawaiian/Pacific Islander and the American Indian/Alaskan Native populations had significantly higher rates than the state. An estimated 32.3% of Hispanic/Latino adults were obese, compared to 25.6% of non-Hispanic/Latino adults (Table 1).

The percentage of obese children in Utah increased dramatically in the first decade of the century. From 1994 to 2010 the number of obese third grade boys increased by 97%, from 6.0% in 1994 to 11.8% in 2010. The percentage of obese third grade girls increased by 40% over the same time period. In 2010, 8.4% of third grade girls were obese compared to 6.0% in 1994. Childhood obesity in Utah seems to have leveled off since 2010. In 2016, 9.9% of third grade boys and 11.5% of girls were obese.

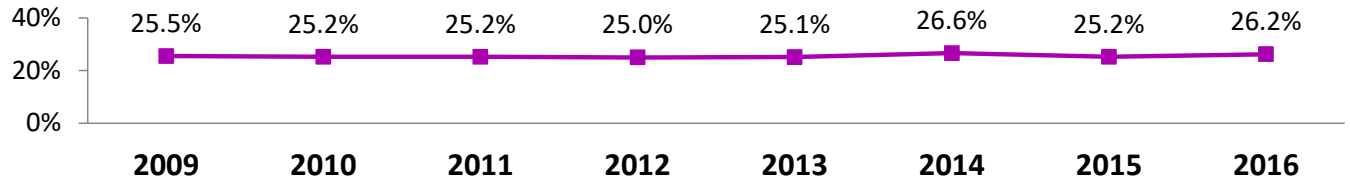
Among adolescents in 2017, 9.6% of Utah public high school students were obese; boys were more than twice as likely as girls to be obese (13.9% compared to 5.3%). Adolescent obesity rates varied dramatically by race and ethnicity. According to the 2017 Prevention Needs Assessment, Pacific Islanders (29.1%), Native Americans (15.9%), Blacks (15.2%), and Hispanics (13.9%) in grades 8, 10, and 12 all had higher rates of obesity than the state rate (9.5%). White adolescents (8.1%) had lower rates than the state rate (Table 2).

Adults who are obese are at increased risk of morbidity from hypertension; elevated LDL cholesterol; type 2 diabetes; coronary heart disease; stroke; osteoarthritis; sleep apnea; respiratory problems; and endometrial, breast, prostate, and colon cancers.

For adults, the measure is defined as the percentage of survey respondents aged 18 years and older who have a body mass index (BMI) greater than or equal to 30.0 kg/m^2 calculated from self-reported weight and height.

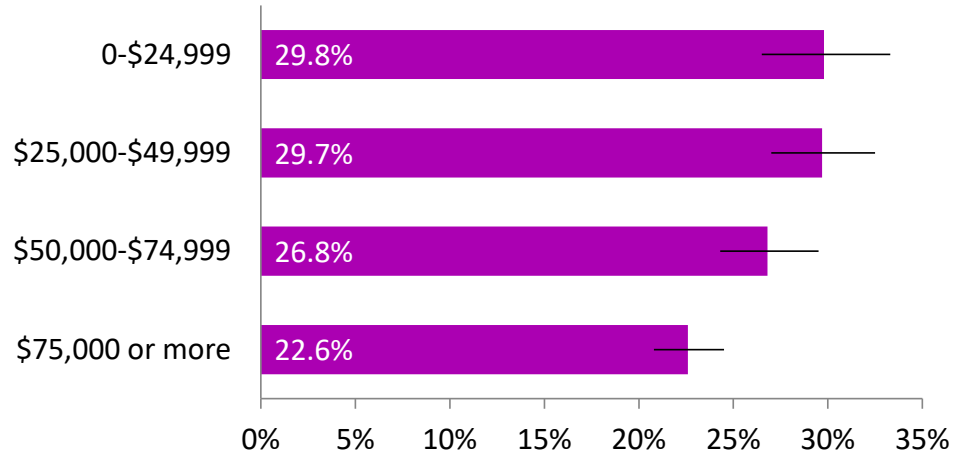
For minors, overweight and obesity is determined by calculating the individual's BMI and comparing it to age and sex standardized growth charts distributed by the CDC. Children and adolescents are considered obese if their BMI is greater than or equal to the 95th percentile for BMI by age and sex based on the 2000 CDC Growth Charts.

Figure 7. Adult Obesity by Year, Utah, 2009–2016



Trend graph depicts age-adjusted rates.

Figure 8. Adult Obesity by Income, Utah, 2016



Data source: Utah Behavioral Risk Factor Surveillance System

Table 1. Adult Obesity Prevalence State Comparison, by Age, Gender, Race, Ethnicity, Income, Education, and Local Health District

	Crude (burden)		Age-adjusted (comparison)		
STATE COMPARISON (2016)	Rate	95% CIs	Rate	95% CIs	
U.S.	29.6%	29.3% - 29.8%	29.6%	29.4% - 29.9%	
Colorado (best)	22.3%	21.4% - 23.2%	22.4%	21.4% - 23.3%	
Utah (10th of 51)	25.4%	24.2% - 26.5%	26.2%	25.1% - 27.4%	
Mississippi (worst)	37.3%	35.4% - 39.1%	38.0%	36.1% - 39.9%	
AGE IN YEARS (2016)					
18–34	16.8%	15.0% - 18.8%	–	–	✓
35–49	30.3%	27.9% - 32.7%	–	–	!
50–64	33.1%	30.7% - 35.5%	–	–	!
65+	26.8%	24.7% - 29.0%	–	–	
GENDER (2016)					
Male	25.6%	24.0% - 27.2%	26.6%	25.1% - 28.3%	
Female	25.1%	23.5% - 26.7%	25.8%	24.2% - 27.4%	
RACE (2016)					
American Indian/AK Native	34.6%	25.6% - 44.9%	37.1%	27.7% - 47.6%	!
Asian	9.3%	4.5% - 18.2%	11.1%	5.3% - 21.8%	✓
Black	30.9%	18.7% - 46.5%	33.2%	20.8% - 48.6%	
Pacific Islander	40.7%	26.3% - 56.9%	45.3%	30.8% - 60.7%	!
White	25.2%	24.0% - 26.4%	25.8%	24.6% - 27.0%	
ETHNICITY (2016)					
Hispanic	28.8%	24.7% - 33.4%	32.3%	27.6% - 37.3%	!
Non-Hispanic	24.9%	23.8% - 26.1%	25.6%	24.5% - 26.8%	
INCOME (2016)					
0–$24,999	25.8%	23.0% - 28.9%	29.8%	26.5% - 33.3%	!
$25,000–$49,999	28.2%	25.6% - 30.9%	29.7%	27.0% - 32.5%	!
$50,000–$74,999	26.6%	24.0% - 29.5%	26.8%	24.3% - 29.5%	
$75,000 or more	23.9%	22.0% - 25.8%	22.6%	20.8% - 24.5%	✓
EDUCATION—Adults 25+ (2016)					
Below High School	33.3%	27.5% - 39.7%	33.5%	27.8% - 39.8%	
High School or GED	32.9%	30.2% - 35.6%	32.8%	30.1% - 35.5%	!
Some Post High School	29.3%	27.2% - 31.5%	29.6%	27.5% - 31.9%	
College Graduate	23.6%	21.9% - 25.4%	23.8%	22.1% - 25.5%	✓
LOCAL HEALTH DISTRICT (2016)					
Bear River	27.7%	23.4% - 32.5%	29.8%	25.5% - 34.6%	
Central Utah	27.0%	22.9% - 31.6%	27.4%	23.4% - 31.9%	
Davis County	26.0%	22.8% - 29.4%	26.5%	23.5% - 29.9%	
Salt Lake County	24.7%	22.6% - 26.8%	25.1%	23.1% - 27.2%	
San Juan	32.1%	23.3% - 42.4%	31.3%	23.7% - 40.2%	
Southeast Utah	28.8%	23.3% - 35.1%	28.2%	22.5% - 34.7%	
Southwest Utah	21.4%	18.0% - 25.3%	23.0%	19.3% - 27.1%	
Summit County	12.9%	8.0% - 20.1%	14.1%	8.8% - 21.9%	✓
Tooele County	28.5%	23.2% - 34.5%	28.7%	23.5% - 34.5%	
TriCounty	34.2%	29.4% - 39.3%	33.4%	28.8% - 38.3%	!
Utah County	22.6%	20.0% - 25.3%	25.8%	23.2% - 28.6%	
Wasatch County	21.5%	15.3% - 29.3%	22.5%	16.1% - 30.4%	
Weber-Morgan	34.1%	30.3% - 38.0%	33.8%	30.1% - 37.7%	!

Data source: Utah Behavioral Risk Factor Surveillance System

Obesity - Adult: This measure is defined as the percentage of survey respondents aged 18 years and older who have a BMI greater than or equal to 30.0 kg/m^2 calculated from self-reported weight and height.

- 25.4% of Utah adults are obese (crude rate)
- Lower rates among Utahns aged 18–34; higher rates among age groups 35–49 and 50–64
- Disparities include Pacific Islander, American Indian, and Hispanic populations
- Lower rate among Asian population
- Higher rates among lower income levels
- Lower rate among college graduates
- Significantly lower for Summit County; significantly higher for TriCounty and Weber-Morgan Local Health Districts

Map 3. Adult Obesity by Local Health District, 2016

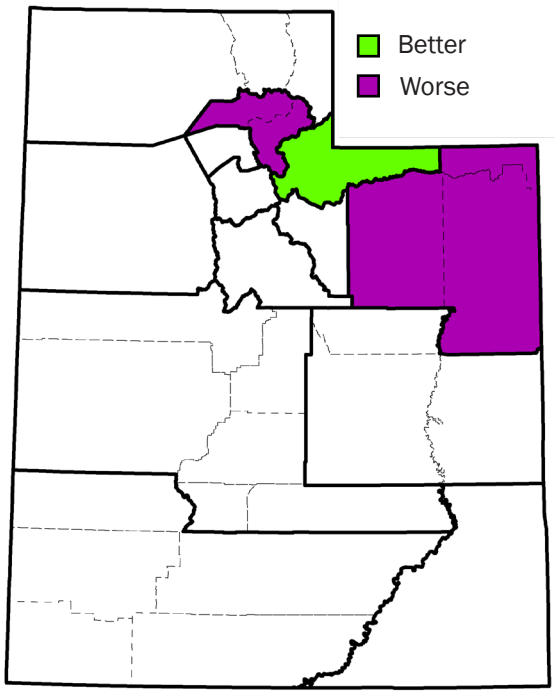
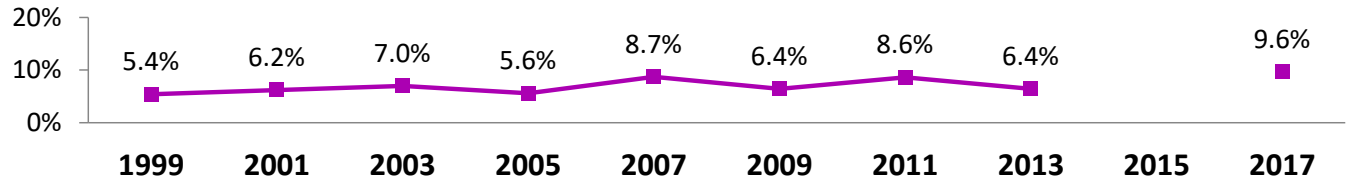


Figure 9. Adolescent Obesity by Year, Utah, 1999–2017



Utah data not available for 2015

Table 2. Adolescent Obesity Prevalence State Comparison, by Grade, Gender, Race/Ethnicity, and Local Health District

	Crude (burden)		
STATE COMPARISON (2015)*	Rate	95% CIs	
U.S.	13.9%	*12.5% - 15.5%*	
Montana (best)	10.3%	*9.2% - 11.5%*	
Utah	**	** **	
Mississippi (worst)	18.9%	*17.0% - 21.0%*	
GRADE IN SCHOOL (2017)			
Grade 9	9.4%	*6.4% - 13.4%*	
Grade 10	11.4%	*8.2% - 15.6%*	
Grade 11	7.5%	*5.5% - 10.1%*	
Grade 12	10.2%	*7.8% - 13.2%*	
GENDER (2017)			
Male	13.9%	*11.2% - 17.0%*	!
Female	5.3%	*3.7% - 7.4%*	✓
RACE/ETHNICITY (Grades 8, 10, and 12, 2017)^			
American Indian	15.9%	*10.2% - 24.0%*	!
Asian	7.0%	*4.6% - 10.6%*	
Black	15.2%	*10.2% - 22.1%*	!
Hispanic	13.9%	*12.3% - 15.8%*	!
Pacific Islander	29.1%	*22.3% - 37.0%*	!
White	8.1%	*7.4% - 8.8%*	✓
LOCAL HEALTH DISTRICT (Grades 8, 10, and 12, 2017)^			
Bear River	8.3%	*6.9% - 9.9%*	
Central Utah	9.9%	*8.2% - 12.0%*	
Davis County	8.0%	*5.5% - 11.3%*	
Salt Lake County	11.0%	*9.7% - 12.5%*	!
San Juan	12.1%	*6.0% - 23.0%*	
Southeast Utah	9.4%	*6.9% - 12.6%*	
Southwest Utah	10.0%	*8.5% - 11.7%*	
Summit County	5.4%	*2.1% - 13.2%*	
Tooele County	10.8%	*8.1% - 14.2%*	
TriCounty	6.7%	*4.1% - 10.7%*	
Utah County	8.8%	*7.2% - 10.6%*	
Wasatch County	6.8%	*5.4% - 8.5%*	✓
Weber-Morgan	8.8%	*7.2% - 10.6%*	

* 2017 national data not yet available
** Utah data not available for 2015

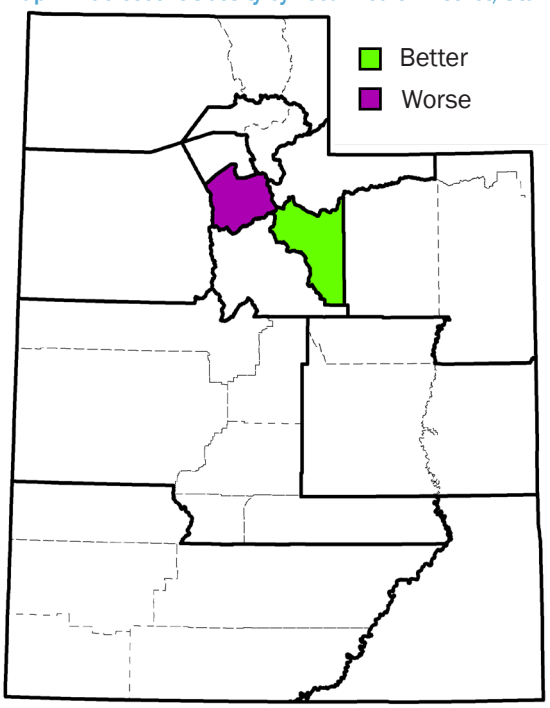
^ Data by race/ethnicity and local health district are from the 2017 Prevention Needs Assessment.
It is likely that these data, based on self-reported height and weight, under represent the prevalence of overweight or obesity among high school students.

Data source: Utah Youth Risk Behavior Survey, unless otherwise specified

Obesity - Minor: For individuals aged 2–20, overweight and obesity is determined by calculating the individual's BMI and comparing it to age and sex standardized growth charts distributed by the CDC. Children and adolescents are considered obese if their BMI is greater than or equal to the 95th percentile for BMI by age and sex based on the 2000 CDC Growth Charts.

- 9.6% of Utah students in grades 9–12 (2017 YRBS); 9.5% of students in grades 8, 10, and 12 (2017 PNA) are obese
- Higher rates among males
- Disparities include Pacific Islander (29.1%), American Indian (15.9%), Black (15.2%), and Hispanic (13.9%)
- Significantly lower in Summit County, TriCounty, Davis County, and Wasatch County; significantly higher in Salt Lake County Local Health District

Map 4. Adolescent Obesity by Local Health District, Utah, 2017



Current Efforts

In 2013, through funding from the CDC the UDOH Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program was established. The EPICC Program works in schools, worksites, communities, healthcare, and child-care to promote healthy lifestyles in Utah. The EPICC Program works with LHDs to address priority populations including those disproportionately affected by chronic diseases and the risk factors that cause them, have a high prevalence of overweight or obesity, limited access to healthy foods, or which do not obtain adequate physical activity.

The EPICC Program promotes evidence-based practices collected by the Center for Training and Research Translation (Center TRT). The Center TRT bridges the gap between research and practice and supports the efforts of public health practitioners working in nutrition, physical activity, and obesity prevention by:

- Reviewing evidence of public health impact and disseminating population-level interventions
- Designing and providing practice-relevant training both in-person and web-based
- Addressing social determinants of health and health equity through training and translation efforts
- Providing guidance on evaluating policies and programs aimed at impacting healthy eating and physical activity

Appropriate evidence-based interventions can be found at http://www.centertrt.org/?p=interventions_interventions_overview.

In the prior SHIP the focus areas for this health priority included:

- Educate schools and school districts about incorporating physical activity for students for health and educational benefits
- Promote healthy family meals

This plan is focusing on expanding worksite wellness while maintaining all of the other efforts that are currently underway to address obesity and healthy living concerns.

Goals, Objectives, and Strategies

Goal 1: Reduce Utah obesity rates by facilitating a culture of wellness within worksites by June 30, 2020 in the state of Utah.
Objective 1: By June 30, 2018, data on 60 worksites will be collected to determine needs for moving from "good" to "better" to "best" ranking.
Objective 1 Measures: Number of worksites that complete the online worksite assessment
Objective 1 Baseline: 0 worksites as of June 2017
Objective 1 Target: 60 worksites by June 30, 2018
Strategy 1 for Objective 1: Using a standardized assessment tool, collect data on worksites that need assistance with moving from good to better to best and creating a culture of wellness within their organization.
Objective 2: By October 1, 2018, wellness resources will be provided to 20 employers through personal contact.
Objective 2 Measures: Number of employers that received wellness resources
Objective 2 Baseline: 0 employers as of June 2017
Short-term Objective 2 Target: 20 employers by October 1, 2018
Strategy 1 for Objective 2: Provide wellness resources to employers.
Objective 3: By June 30, 2018, at least five representatives from agencies/businesses that have a successful wellness program will be recruited to act as wellness champions.
Objective 3 Measures: Number of representatives identified as wellness champions
Objective 3 Baseline: 0 representatives as of June 2017
Objective 3 Target: 5 representatives by June 30, 2018

Objective 3.1: By December 31, 2018, a mentor model is available to help 15 businesses move from good to better or better to best on assessment.

Objective 3.1 Measures: Number of businesses benefiting from mentor model

Objective 3.1 Baseline: 0 businesses as of June 2017

Objective 3.1 Target: 15 businesses by December 31, 2018

Strategy 1 for Objective 3.1: Increase the capacity of worksites to improve wellness scores by providing mentors, champions, and educational opportunities.

Objective 4: By June 30, 2020, at least 40 worksites will have data from three assessments documenting improvement.

Objective 4 Measures: Number of worksites completing three annual assessments

Objective 4 Baseline: 0 worksites as of June 2017

Objective 4 Target: 40 worksites by June 30, 2020

Strategy 1 for Objective 4: Reassess on an annual basis to document improvements in worksite wellness.

Other goal measures:

Percentage of Utahns aged 18+ who were obese by year

Percentage of adolescents who were obese in Utah by year

Alignment

This priority area aligns with the Healthy People 2020 goals

NWS-9: Reduce the proportion of adults who are obese
U.S. Target: 30.5%
Utah Target: 24.0%

NWS-10: Reduce the proportion of children and adolescents who are considered obese

NWS-10.2: Children aged 6 to 11 years
U.S. Target: 15.7%
Utah Target: 10.0%

NWS-10.3: Adolescents aged 12 to 19 years
U.S. Target: 16.1%
Utah Target: 10.0%

Focus on worksites aligns with the Association of State and Territorial Health Officials task force recommendations for workforce wellness programs.

Resources

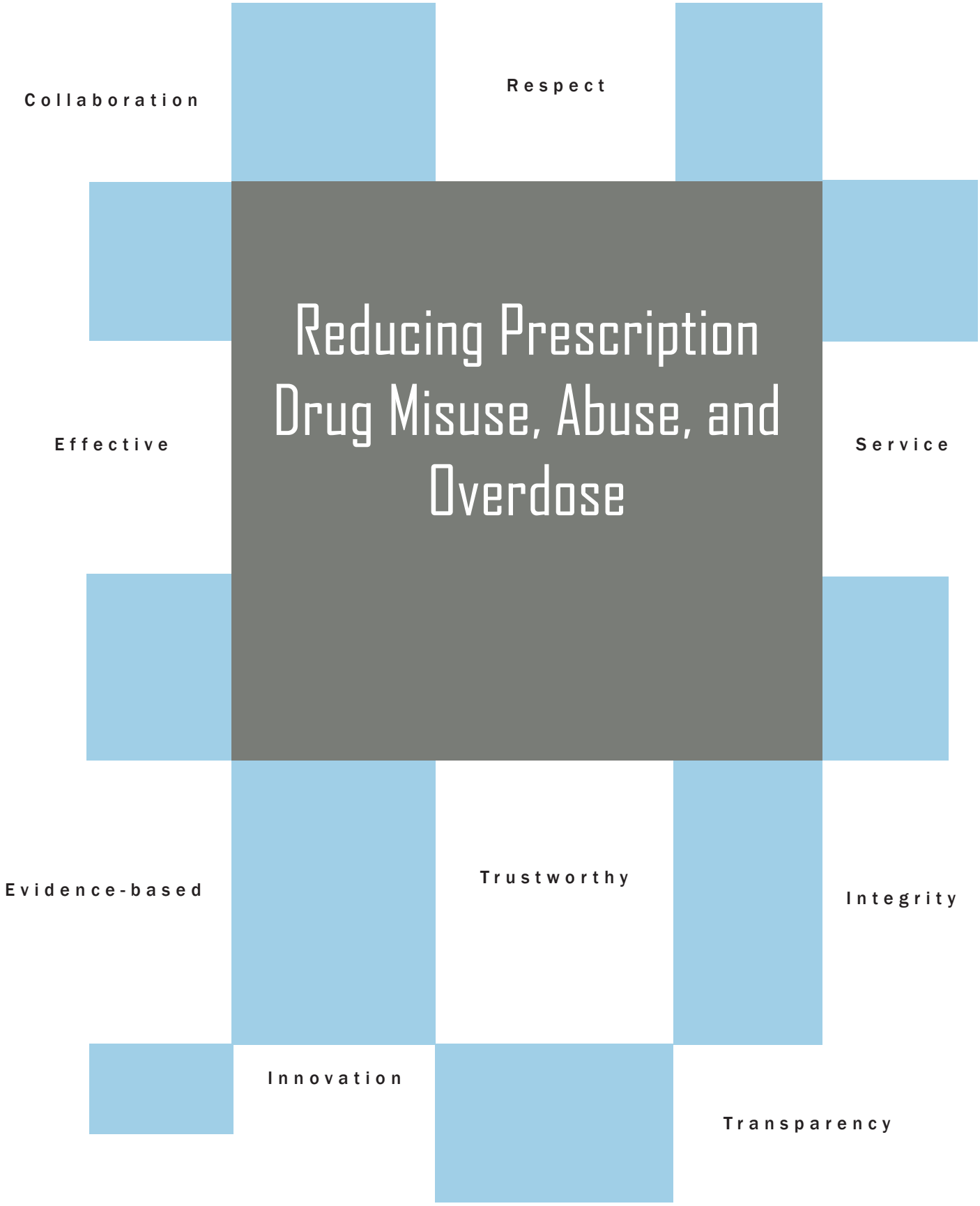
Community guides for workforce wellness

Barriers/Challenges

- Accessing email addresses for businesses and worksites
- Getting employers to complete the assessment
- Coordinating efforts between partners
- Identifying champions and mentors
- Ensuring follow-up with worksites

Partners

There are many partners involved in this priority area including LHDs (Davis County, Tooele County, Weber-Morgan, and Utah County), Davis School District, Get Healthy Utah, SelectHealth, Intermountain Healthcare, and the Utah Department of Transportation. They contribute to the long-term goals by providing appropriate resources to businesses and worksites in their areas of expertise. LHDs also provide technical assistance and model policies. Get Healthy Utah can serve as the source for email communication. All agencies can contribute business email addresses. The EPICC Program will provide updated information on the choosehealth.utah.gov website.

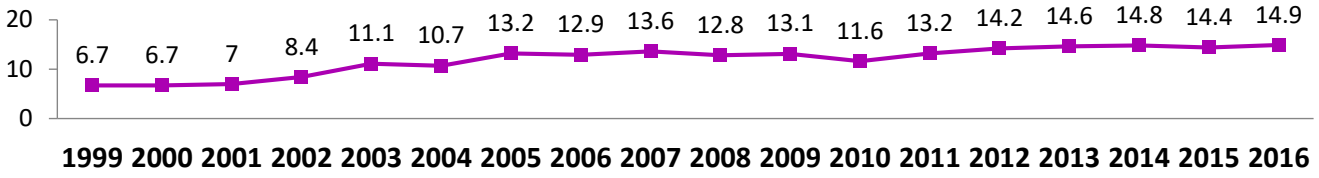

Collaboration
Respect
Reducing Prescription Drug Misuse, Abuse, and Overdose
Effective
Service
Evidence-based
Trustworthy
Integrity
Innovation
Transparency

Background/Contextual Information for Health Priority

Opioid Overdose Deaths

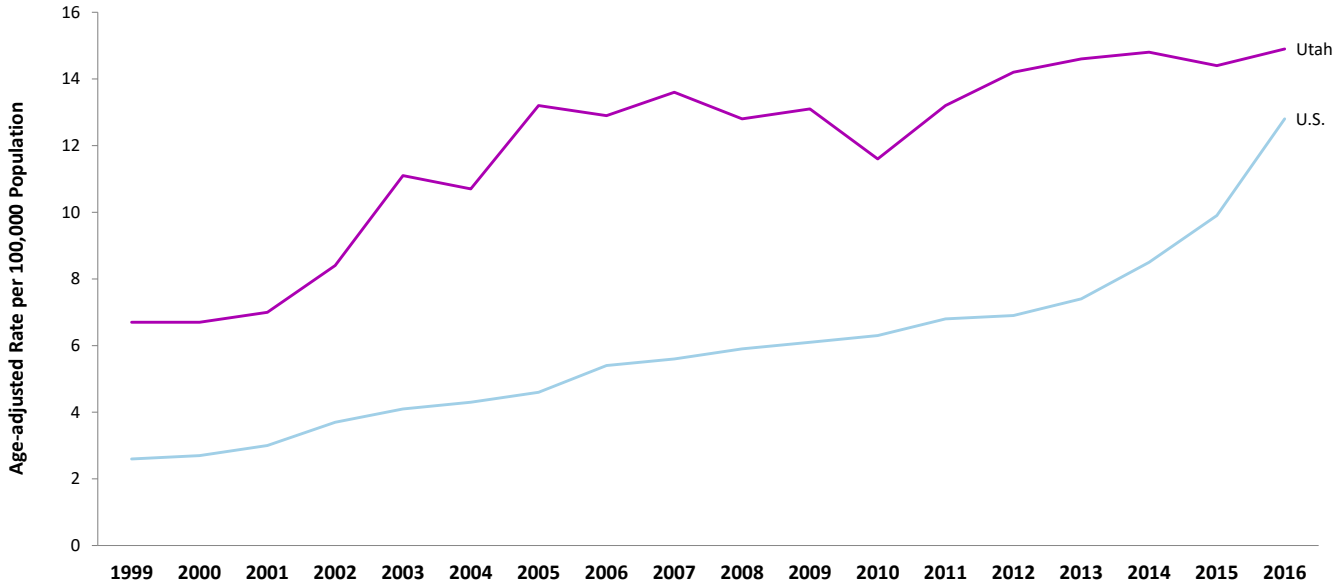
Drug poisoning is the leading cause of injury death in Utah and opioids are one of the main contributors to Utah's drug poisoning rates. The rate of drug overdose deaths has increased significantly since 1999 (Figure 10). The largest proportion of opioid deaths are unintentional or undetermined and so these are the focus of intervention efforts. The unintentional and undetermined opioid death rate in Utah has been continuously higher than the U.S., which has been increasing since 1999 (Figure 11).

Figure 10. Opioid Overdose Deaths per 100,000 by Year, Utah, 1999–2016



Trend graph depicts age-adjusted rates.

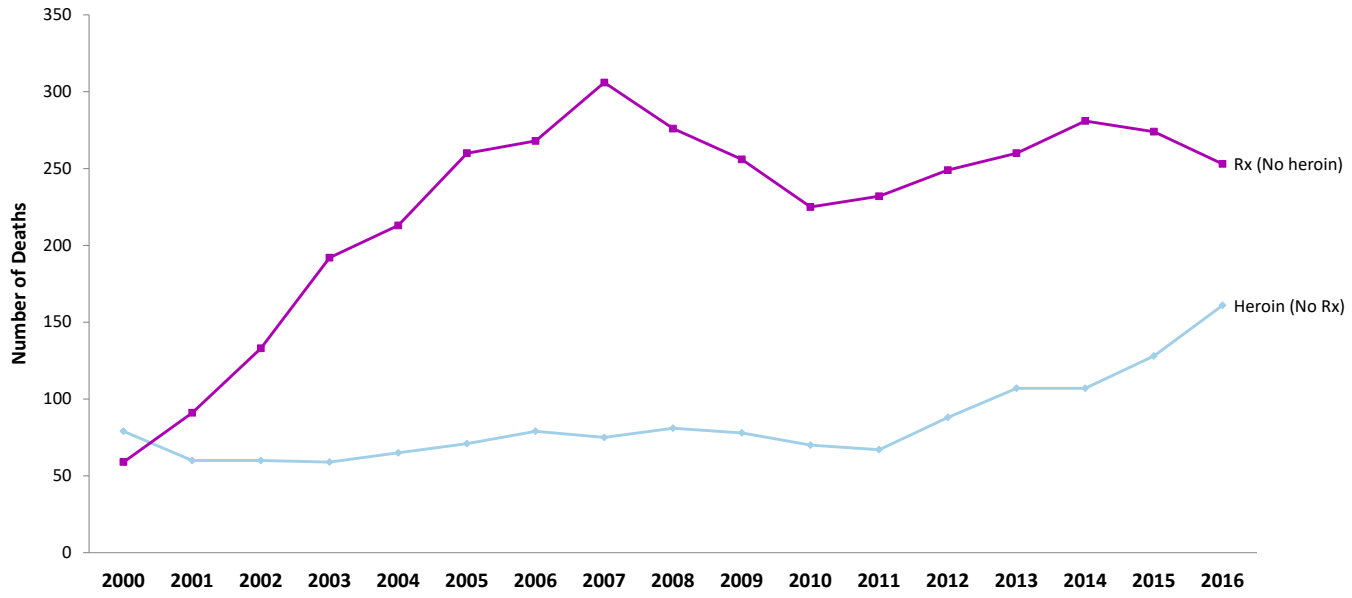
Figure 11. Unintentional and Undetermined Opioid Deaths per 100,000 Population, Utah and U.S., 1999–2016



Data source: CDC National Center for Health Statistics, age-adjusted rates

Through several concurrent efforts, an observed decrease in unintentional and undetermined prescription opioid deaths has been seen in Utah since 2014. However, the increase in deaths related to heroin and other illicit opioids is concerning (Figure 12).

Figure 12. Unintentional and Undetermined Opioid Overdose Deaths by Drug Type, Utah Adults Aged 18+, 2000–2016



Data source: Utah Office of the Medical Examiner

In Utah there were 2.2 million opioid prescriptions dispensed in 2016. Table 3 gives information about the prescribing practices in Utah.

Table 3. Prescribing Practices in Utah, 2014–2016

Mortality Indicators per 100,000 Population	2014	2015	2016
Rate of Drug Overdose Deaths	22.0	22.7	20.1
Rate of Drug Overdose Deaths Involving Opioids	16.5	15.7	14.8
Rate of Drug Overdose Deaths Involving Prescription Opioids	14.5	13.5	11.1
Rate of Drug Overdose Deaths Involving Heroin	3.7	4.2	5.1
Prescribing Indicators		**2015**	**2016**
% of Patients Prescribed High-dose Prescription Opioids		12.1%	10.3%
% of Long-acting/Extended-release Opioids Prescribed to Opioid-naïve Patients		15.7%	20.8%
% of Patients with Overlapping Opioid Prescriptions		22.0%	21.4%
% of Patients with Overlapping Opioid and Benzodiazepine Prescriptions		13.8%	14.1%
Rate of Multiple Provider Episodes (≥5 prescribers and ≥5 pharmacies in a 6-month period) per 100,000 Population		27.1	21.9

Data source: Utah Controlled Substance Database

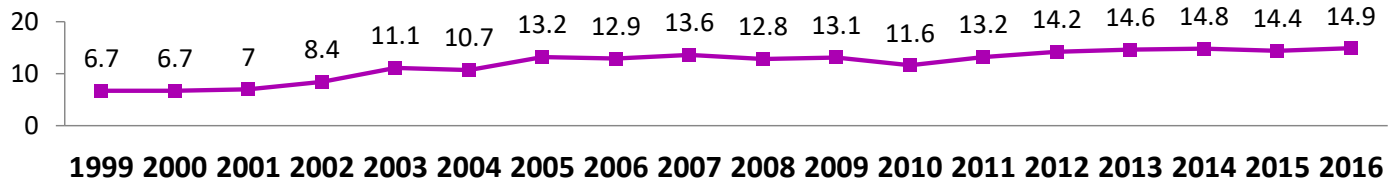
In Utah, the top five circumstances observed in prescription opioid deaths were physical health problem, substance abuse problem, current mental health problem, current mental health/substance abuse treatment, drug involvement (not a prescription), alcohol dependence/problem, and history of suicide attempts.[1]

The highest rates of unintentional and undetermined opioid overdose deaths occurred in Utahns aged 25–64 (Table 4).

Southeast Utah and Weber-Morgan Local Health Districts had significantly higher death rates from unintentional and undetermined opioid overdose deaths (29.9 and 19.7per 100,000, respectively) during 2014–2016 (Map 5 and Table 5).

1 Utah Department of Health Violence and Injury Prevention Program, Prescription Opioid Deaths Fact Sheet http://www.health.utah.gov/vipp/pdf/RxDrugs/PDODeaths2015.pdf (accessed 1/19/2018).

Figure 13. Unintentional and Undetermined Opioid Overdose Deaths per 100,000 by Year, Utah, 1999–2016



Trend graph depicts age-adjusted rates.

Table 4. Unintentional and Undetermined Opioid Overdose Deaths State Comparison, by Age, Gender, and Race

STATE COMPARISON (2016)	Crude (burden) Rate	95% CIs	Age-adjusted (comparison) Rate	95% CIs	
U.S.	12.5	*12.4 - 12.6*	12.8	*12.6 - 12.9*	
Nebraska (best)	2.1	*1.5 - 2.9*	2.2	*1.6 - 3.0*	
Utah (32nd of 51)	13.9	*12.6 - 15.2*	14.9	*13.4 - 16.3*	
West Virginia (worst)	38.8	*35.9 - 41.6*	42.2	*39.0 - 45.3*	
AGE IN YEARS (2016)					
0–14	**	** **	–	–	–
15–24	7.9	*5.6 - 10.9*	–	–	– ✓
25–34	25.4	*20.7 - 30.1*	–	–	– !
35–44	28.7	*23.5 - 33.9*	–	–	– !
45–54	24.8	*19.6 - 31.0*	–	–	– !
55–64	22.3	*17.2 - 28.5*	–	–	– !
65+	**	** **	–	–	–
GENDER (2016)					
Male	17.3	*15.2 - 19.4*	18.2	*16.0 - 20.5*	!
Female	10.4	*8.8 - 12.1*	11.4	*9.6 - 13.2*	✓
RACE (2012–2016)					
American Indian/AK Native	12.3	*8.3 - 17.4*	13.5	*9.1 - 19.2*	
Asian/Pacific Islander*	*	*1.4 - 4.2*	*	*1.1 - 3.3*	
Black*	*	*2.5 - 8.4*	*	*2.8 - 10.0*	
White	14.2	*13.6 - 14.8*	15.3	*14.6 - 16.0*	
ETHNICITY (2016)					
Hispanic	6.9	*4.6 - 9.9*	7.5	*4.9 - 10.9*	✓
Non-Hispanic	15.0	*13.5 - 16.5*	16.0	*14.4 - 17.6*	

* Death rates are flagged as unreliable when the rate is calculated with a numerator of 20 or less. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable.
** Data are suppressed when the data meet the criteria for confidentiality constraints. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality.

Data source: CDC National Center for Health Statistics

Unintentional and Undetermined Opioid Overdose Deaths: This measure reports the rate (per 100,000 population) of drug overdose deaths caused by acute poisonings that involved any opioid as a contributing cause of death, with unintentional or undetermined intent. Opioids include both prescription opioid pain relievers such as hydrocodone, oxycodone, and morphine, as well as heroin and opium.

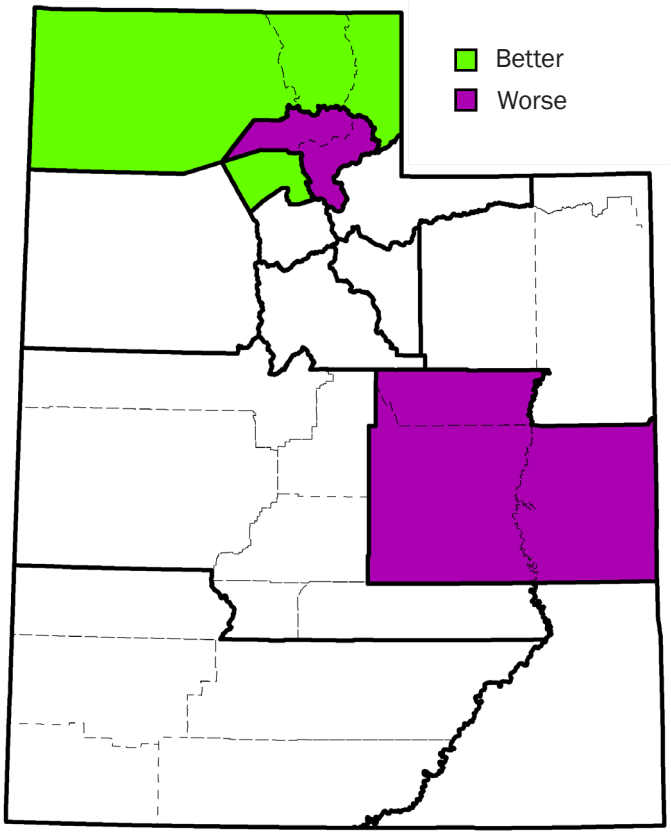
- 13.9 per 100,000 population (crude rate)
- Utah ranks 32nd in the nation
- Significantly higher rate among Utahns aged 25–64
- Significantly higher rate for males
- Significantly higher for Southeast Utah and Weber-Morgan Local Health Districts

Table 5. Unintentional and Undetermined Opioid Overdose Deaths by Local Health District

LOCAL HEALTH DISTRICT (2014–2016)	Crude (burden) Rate	95% CIs	Age-adjusted (comparison) Rate	95% CIs	
Bear River	8.4	*6.1 - 11.2*	10.1	*7.3 - 13.6*	✓
Central Utah	10.3	*6.6 - 15.4*	12.2	*7.8 - 18.4*	
Davis County	10.9	*8.9 - 13.0*	11.6	*9.4 - 13.8*	✓
Salt Lake County	15.1	*13.7 - 16.4*	15.1	*13.8 - 16.4*	
San Juan	**	** **	**	** **	
Southeast Utah	28.9	*20.1 - 40.1*	29.9	*20.6 - 42.0*	!
Southwest Utah	13.0	*10.4 - 16.0*	15.1	*12.0 - 18.7*	
Summit County*	*	*5.8 - 18.7*	*	*5.8 - 19.4*	
Tooele County	16.4	*11.1 - 23.2*	16.8	*11.4 - 23.9*	
TriCounty	15.9	*10.6 - 23.0*	18.2	*12.0 - 26.5*	
Utah County	12.1	*10.5 - 13.7*	14.2	*12.2 - 16.2*	
Wasatch County	**	** **	**	** **	
Weber-Morgan	18.4	*15.4 - 21.5*	19.7	*16.4 - 23.0*	!

* Death rates are flagged as unreliable when the rate is calculated with a numerator of 20 or less. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable.
** Data are suppressed when the data meet the criteria for confidentiality constraints. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality.
Data source: CDC National Center for Health Statistics

Map 5. Unintentional and Undetermined Opioid Overdose Deaths by Local Health District, 2014–2016



Drug Misuse and Abuse

According to the National Institute on Drug Abuse, risk factors for drug use by children and adolescents include early aggressive behavior, lack of parental supervision, substance abuse by peers, drug availability, and poverty.[1] Other risk factors include family history of substance use or addiction, genetic predisposition to addiction, having another mental health disorder, use of highly addictive drugs, and having a social environment where drugs are used.

Utahns aged 18–25 had the highest rates of pain reliever misuse (8.3%), illicit drug use (15.0%), and illicit drug use disorder (6.9%) (Tables 6, 7, and 8). National data for the applicable Healthy People objectives indicate that persons who identify as two or more races have the highest rate of illicit substance use.[2]

Among youth in 2017, Salt Lake County (12.3%) Local Health District had significantly higher rates of current marijuana use than the state (8.2%) while Bear River (3.7%), Central Utah (5.1%), Davis County (5.2%), Utah County (5.5%), and Southwest Utah (6.4%) Local Health Districts had lower rates, according to the Prevention Needs Assessment Survey (Figure 14).

1 What are risk factors and protective factors?. National Institute on Drug Abuse. Accessed 8/9/2016 from https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors.
2 Disparities Data Overview SA-13.3 by Race and Ethnicity. Healthy People 2020. Accessed 1/19/18 from https://www.healthypeople.gov/2020/data/disparities/summary/Chart/5201/3.

Pain Reliever Misuse: This measure reports the percentage of persons aged 12 and older who reported misuse of prescription psychotherapeutics in the past year. Misuse of psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

- 4.9% of Utahns misused prescription drugs
- Utah ranks 43rd in the nation
- Significantly higher rate among Utahns aged 18–25

Illicit Drug Use: This measure reports the percentage of persons aged 12 and older who reported illicit drug use in past month. Illicit drug use include the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

- 7.4% of Utahns use illicit substances
- Lower than the U.S., ranked 4th in the nation
- Higher among Utahns aged 18–25 years

Illicit Drug Use Disorder: This measure reports the percentage of persons aged 12 and older who met the criteria for illicit drug dependence or abuse in the past year. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

- 2.7% of Utahns reported illicit drug use disorder
- Similar to the U.S., ranked 19th in the nation
- Higher among Utahns aged 18–25 years
- Lower among Utahns aged 26+

Table 6. Pain Reliever Misuse State Comparison and by Age

	Crude (burden)		
STATE COMPARISON (2015–2016)	**Rate**	**95% CIs**	
U.S.	4.5%	4.3% - 4.6%	
New Jersey (best)	3.8%	3.2% - 4.4%	
Utah (43rd of 51)	4.9%	4.2% - 5.7%	
Oregon (worst)	5.4%	4.6% - 6.4%	
AGE IN YEARS (2015–2016)			
12–17	3.7%	2.8% - 4.9%	✓
18–25	8.3%	6.7% - 10.3%	!
26+	4.4%	3.6% - 5.4%	

Table 7. Illicit Drug Use in Past Month State Comparison and by Age

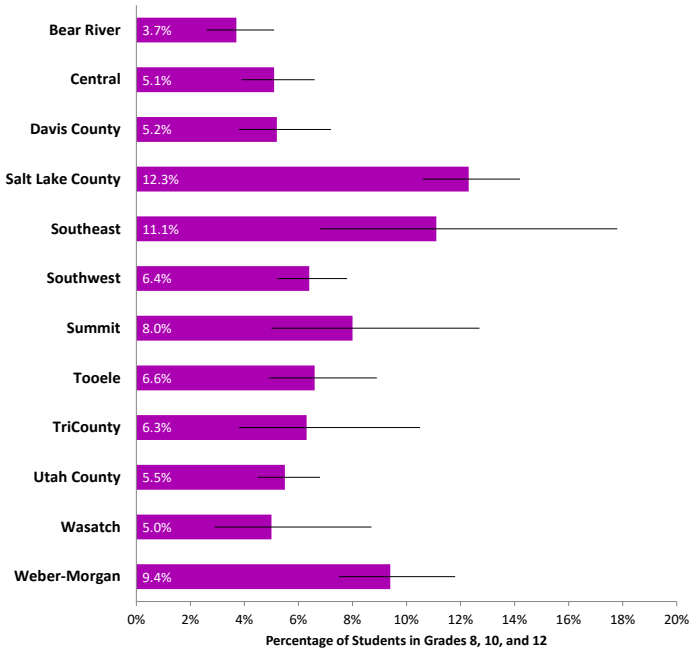
	Crude (burden)		
STATE COMPARISON (2015–2016)	**Rate**	**95% CIs**	
U.S.	10.4%	10.1% - 10.6%	
Iowa (best)	6.8%	5.7% - 8.1%	
Utah (4th of 51)	7.4%	6.2% - 8.7%	
Vermont (worst)	18.2%	16.2% - 20.4%	
AGE IN YEARS (2015–2016)			
12–17	6.0%	4.6% - 7.6%	
18–25	15.0%	12.3% - 18.3%	!
26+	5.9%	4.7% - 7.4%	

Table 8. Illicit Drug Use Disorder in Past Year State Comparison and by Age

	Crude (burden)		
STATE COMPARISON (2015–2016)	**Rate**	**95% CIs**	
U.S.	2.8%	2.7% - 2.9%	
New Jersey (best)	2.2%	1.7% - 2.7%	
Utah (19th of 51)	2.7%	2.1% - 3.4%	
Alaska (worst)	4.3%	3.5% - 5.3%	
AGE IN YEARS (2015–2016)			
12–17	2.6%	1.9% - 3.6%	
18–25	6.9%	5.2% - 9.0%	!
26+	1.7%	1.3% - 2.4%	✓

Data source: National Survey on Drug Use and Health SAMHSA
Note: Because of changes in measurement in 2015 for 7 of the 10 illicit drug categories—hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives—estimates of use of any illicit drug and these seven illicit drug categories in 2016 are not comparable with estimates prior to 2015.

Figure 14. Marijuana Use in Past Month, Utah Students in Grades 8, 10, and 12, 2017



Data source: Utah Prevention Needs Assessment Survey

Current Efforts

In July 2007, the Utah State Legislature passed House Bill 137 appropriating funding to the UDOH to establish a program to reduce deaths and other harm from prescription opiates. As a result, the UDOH launched a media campaign, Use Only As Directed, to educate the public about how to use prescription pain medications safely (useonlyasdirected.org). The UDOH also launched a statewide provider education intervention where physicians had the opportunity to receive continuing medical education credit hours (CMEs) for participation.

In 2009, the Utah Pharmaceutical Drug Crime Project (now the Utah Coalition for Opioid Overdose Prevention) was established to further efforts to reduce prescription drug overdose deaths. This project works with law enforcement and other organizations on initiatives such as the National Take Back Days, which collect thousands of pounds of unused medications turned in by community members who have cleaned out their medicine cabinets. For information about where to dispose of unused prescriptions visit http://www.useonlyasdirected.org/drop-off-locator/.

In 2010, the Utah State Legislature passed House Bill 28, requiring all prescribers of controlled substances to register to use the Utah Controlled Substance Database, take a tutorial, and pass a test on the use of the database and the prescribing guidelines of controlled substances when applying for or renewing their license.

In 2011, the Utah State Legislature passed Senate Bill 61, which requires prescribers renewing or applying for a controlled substance license to take four hours of controlled substance prescribing classes each licensing period. Information about this program can be found at http://www.dopl.utah.gov/programs/csdb/index.html.

In 2013, the Utah State Legislature passed Senate Bill 214. This law requires certain controlled substance prescribers to complete at least four hours of continuing education as a requisite for license renewal and requires that at least 3.5 hours of the required continuing education hours be completed in controlled substance prescribing classes.

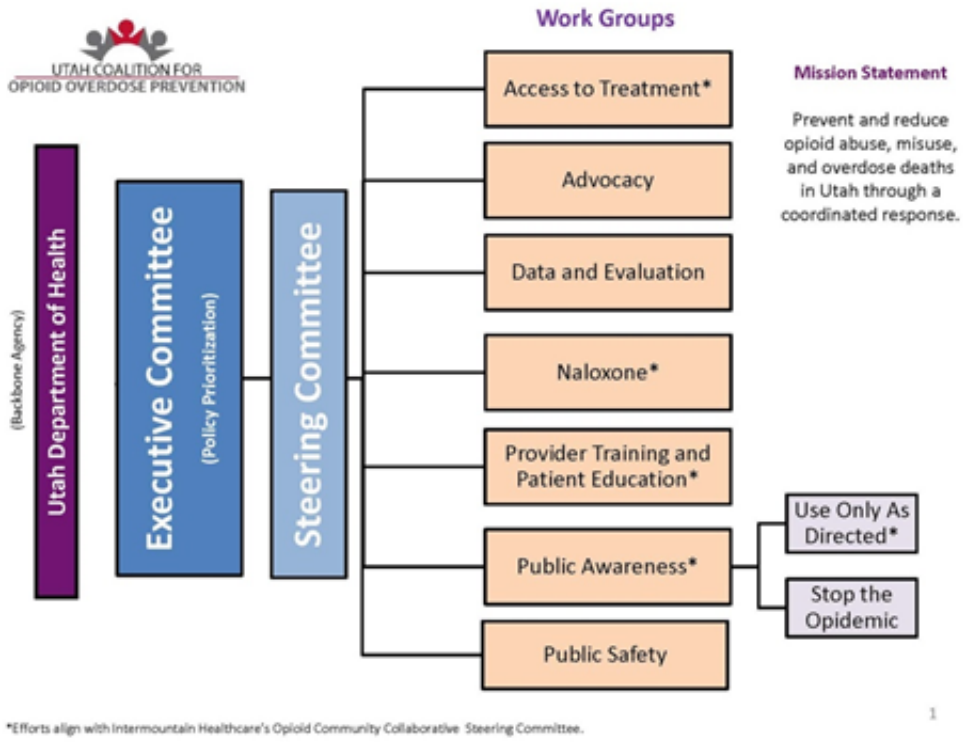
In 2014, the Utah State Legislature passed the Good Samaritan Law (House Bill 11) and the Naloxone Law (House Bill 119). The Good Samaritan Law enables bystanders to report an overdose without fear of criminal prosecution for illegal possession of a controlled substance or illicit drug. The Naloxone Law permits physicians to prescribe naloxone to third parties (someone who is usually a caregiver or a potential bystander to a person at risk for an overdose). It also permits individuals to administer naloxone without legal liability.

In 2015, the UDOH received one-time funding to address prescription drug abuse, misuse, and overdose deaths by continuing data collection efforts to help target interventions, develop provider materials, increase naloxone awareness, expand public awareness efforts, and develop provider tools and resources to address prescription drug abuse.

The Utah Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH) is charged with providing drug and alcohol abuse prevention activities in Utah. Information on the DSAMH may be found at https://dsamh.utah.gov/.

Currently, the Utah Coalition for Opioid Overdose Prevention (UCOOP) leads efforts in this area. The structure of the UCOOP is provided in the figure below (Figure 15).

Figure 15. Utah Coalition for Opioid Overdose Prevention Structure

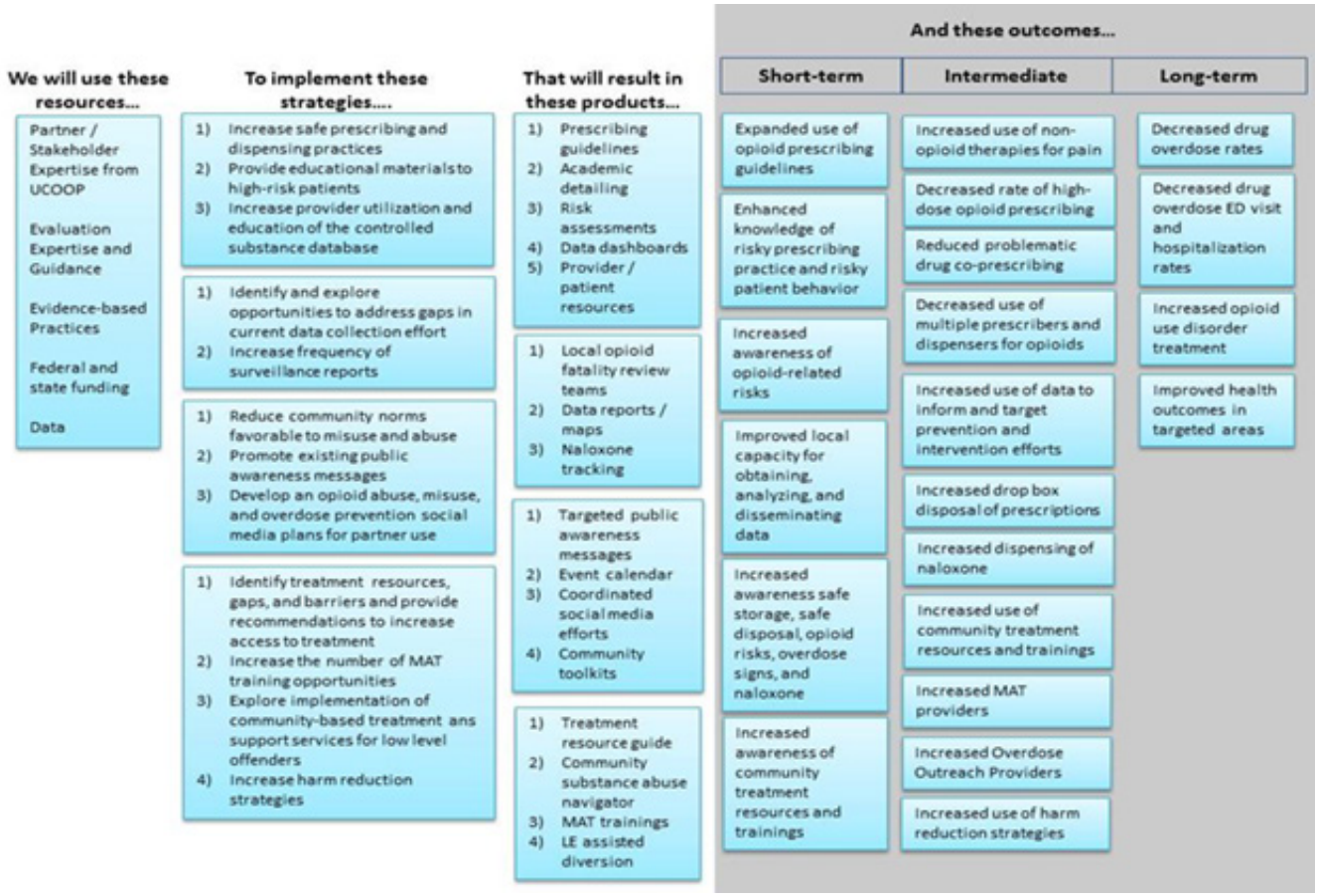


The UCOOP has developed a strategic plan to guide their efforts (Utah Coalition for Opioid Overdose Prevention Strategic Plan: Translating Data to Action) which can be found at ucoop.utah.gov. The goals of that plan align with the UHIP and are represented in the logic model below. The objectives, timeline, implementing workgroups, and performance indicators are also listed in the work plan below:

- Goal 1: Promote public awareness of safe storage, safe disposal, opioid risks, signs of an overdose, and naloxone.
- Goal 2: Increase provider education and training, including tools and resources, to positively change prescribing behavior
- Goal 3: Increase availability of and access to physical and behavioral health services, treatment, and resources.
- Goal 4: Improve timeliness of data, surveillance, and evaluation efforts.

The logic model for these efforts is shown in Figure 16.

Figure 16. Utah Coalition for Opioid Overdose Prevention Strategic Plan Logic Model



Goals, Objectives, and Strategies

Goal 1: Decrease high risk prescribing by 20% from 2015 to 2019.

Objective 1: Increase provider education and training, including tools and resources, to positively change prescribing behavior.

Objective 1 Measures: Rate of opioid prescriptions dispensed per 1,000 population

Objective 1 Baseline: 796.8 opioid prescriptions per 1,000 population in 2015

Objective 1 Target: 637.5 opioid prescriptions per 1,000 population in 2019

Strategy 1 for Objective 1: At least two health systems will implement a provider intervention (uptake of Utah Clinical Guidelines on Prescribing Opioids, implementation of a patient risk assessment, or conduct academic detailing) and provide educational materials on opioid risks, signs of an overdose, and naloxone to patients who are at increased risk of opioid overdoses in at least three high-burden areas by March 2018.

Objective 2: Increase awareness and utility of clinical risk indicators and dashboards.

Objective 2 Measures: Percent of opioid prescriptions dispensed with a daily MME >90

Objective 2 Baseline: 12.0% opioid prescriptions dispensed with a daily MME >90 in 2015

Objective 2 Target: 9.6% opioid prescriptions dispensed with a daily MME >90 in 2019

Strategy 1 for Objective 2: Increase provider utilization of the controlled substance database in at least one health system by March 2018.

Goal 2: Decrease opioid overdoses by 10% from 2015 to 2019.

Objective 1: Improve timeliness of data, surveillance, and evaluation efforts.

Objective 1 Measures: Rate of undetermined/unintentional drug overdose deaths involving opioids per 100,000 population

Objective 1 Baseline: 13.6 undetermined/unintentional drug overdose deaths involving opioids per 100,000 population in 2015

Objective 1 Target: 12.3 undetermined/unintentional drug overdose deaths involving opioids per 100,000 population in 2019

Strategy 1 for Objective 1: Identify gaps in current data collection efforts and explore opportunities to address gaps by October 2017.

Strategy 2 for Objective 1: Increase frequency of surveillance reports in three high-burden areas by March 2018.

Objective 2: Promote public awareness of opioid risks, signs of an overdose, safe storage, safe disposal, and naloxone.

Objective 2 Measures: Rate of drug overdose hospitalizations involving opioids per 10,000 population, acute care hospitals only including all opioids including heroin, unintentional, or undetermined

Objective 2 Baseline: 1.9 hospitalizations per 10,000 population in 2015

Objective 2 Target: 1.7 hospitalizations per 10,000 population in 2019

Strategy 1 for Objective 2: Reduce community norms favorable to misuse and abuse in at least three high-burden areas through public awareness messages and efforts by March 2018.

Strategy 2 for Objective 2: Target at least three high-burden areas to promote existing public awareness messages by March 2018.

Strategy 3 for Objective 2: Develop an opioid abuse, misuse, and overdose prevention social media plan and publish three social media posts each week with targeted boosts in at least three high-burden areas by July 2017.

Goal 3: Increase pharmacy-based to naloxone by 50% from 2015 to 2019.

Objective 1: Increase pharmacy based naloxone access and education.

Objective 1 Measures: Percentage of pharmacies participating in Utah's Statewide Standing Order

Objective 1 Baseline: 0% of pharmacies participating in Utah's Statewide Standing Order in 2015

Objective 1 Target: 50% of pharmacies participating in Utah's Statewide Standing Order in 2019

Strategy 1 for Objective 1: Increase pharmacy participation in the Talk to Your Pharmacist Month campaign.

Strategy 2 for Objective 1: Increase pharmacy participation in Utah's Statewide Standing Order.

Objective 2: Increase community-based naloxone access and education.

Objective 2 Measures: Number of naloxone doses dispensed through Utah's Statewide Standing Order or by enrolled Opiate Overdose Outreach Providers

Objective 2 Baseline: 0 naloxone doses dispensed through Utah's Statewide Standing Order or by enrolled Opiate Overdose Outreach Providers in 2015

Objective 2 Target: 10,000 naloxone doses dispensed through Utah's Statewide Standing Order or by enrolled Opiate Overdose Outreach Providers in 2019

Strategy 1 for Objective 2: Increase availability, access, training, and dissemination of naloxone in three high burden areas by July 2017.

Goal 4: Increase availability of treatment and recovery services by 10% from 2015 to 2019.

Objective 1: Increase the number of individuals accessing public substance abuse disorder treatment.

Objective 1 Measures: Number of individuals served in public substance abuse disorder treatment

Objective 1 Baseline: 15,049 individuals served in public substance abuse treatment in 2015

Objective 1 Target: 16,550 individuals served in public substance abuse treatment in 2019

Strategy 1 for Objective 1: Identify treatment resources, gaps, and barriers in three high-burden areas and provide recommendations to increase access to treatment by October 2017.

Strategy 2 for Objective 1: Increase the number of medication assisted treatment training opportunities and providers receiving the training in three high-burden communities by March 2018.

Other goal measures:

Pain Reliever Misuse: This measure reports the percentage of persons aged 12 and older who reported misuse of prescription psychotherapeutics in the past year. Misuse of psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Illicit Drug Use: This measure reports the percentage of persons aged 12 and older who reported illicit drug use in past month. Illicit drug use include the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Illicit Drug Use Disorder: This measure reports the percentage of persons aged 12 and older who met the criteria for illicit drug dependence or abuse in the past year. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Unintentional and Undetermined Opioid Overdose Deaths: This measure reports the rate (per 100,000 population) of drug overdose deaths caused by acute poisonings that involved any opioid as a contributing cause of death, with unintentional or undetermined intent. Opioids include both prescription opioid pain relievers such as hydrocodone, oxycodone, and morphine, as well as heroin and opium.

Alignment

The UCOOP Strategic Plan: Translating Data to Action was informed by the following:

- Colorado Plan to Reduce Prescription Drug Abuse
- Call to Action: Responding to New Hampshire's Pharmaceutical Drug Epidemic
- Utah Pharmaceutical Drug Crime Project's Plan 2008
- Utah Suicide Prevention Plan

Further, the UHIP Workgroup plan was designed to align with the following plans:

- The National Prescription Drug Abuse Prevention Strategy: Addressing the Evolution of the Epidemic
  - * Create environments that empower young people not to drink or use other drugs.
  - * Identify alcohol and other drug abuse disorders early and provide brief intervention, referral, and treatment.
  - * Reduce inappropriate access to and use of prescription drugs.

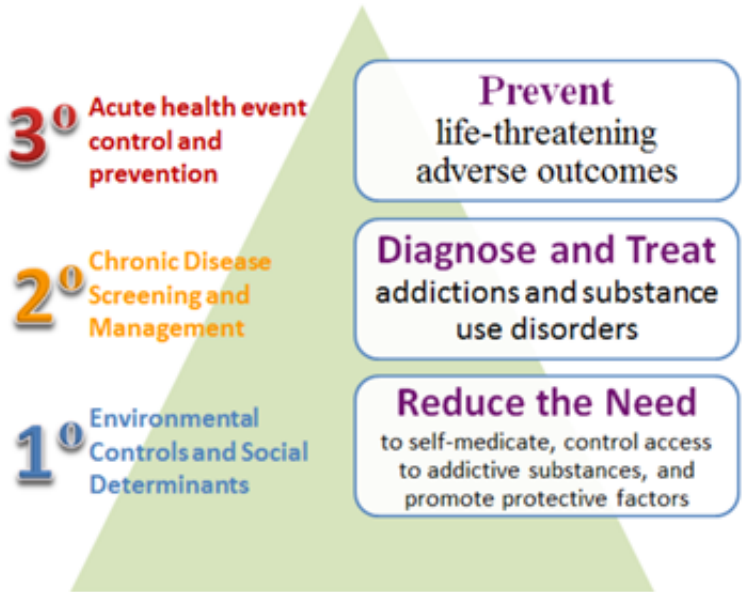
The UHIP Workgroup plan also aligns with plans from the following agencies:

- Intermountain Healthcare
- Utah Division of Human Services
- National Governor's Association: Finding Solution to the Prescription Opioid and Heroin Crisis: A Road Map for States
- Association of State and Territorial Officials 2017 President's Challenge: Public Health Approaches to Preventing Substance Misuse and Addictions National Prevention Plan (see Figure 17)

The UHIP Workgroup plan also aligns with the following Health People 2020 objectives:
SA-19.1: Reduce the past-year nonmedical use of pain relievers
U.S. Target: Not applicable. This measure is being tracked for informational purposes.

Related measure SA-13.3: Reduce the proportion of adults reporting use of any illicit drug during the past 30 days
U.S. Target: 7.1 percent for adults 18 and older

Figure 17. Substance Misuse and Addictions Prevention Framework



Resources

There are currently collaborative partnerships that can be utilized to address the UHIP goals, including the UCOOP.

There is currently federal and state funding allocated to assist with addressing this issue.

There is a grant that was awarded to enhance access to and reporting of data from the Utah Division of Occupational and Professional Licensing Controlled Substance Database.

Websites

- Stop the Opidemic http://www.opidemic.org/
- Utah Coalition for Opioid Overdose Prevention https://ucoop.utah.gov/
- Naloxone https://naloxone.utah.gov/
- Use Only as Directed http://useonlyasdirected.org/
- Naloxone http://www.utahnaloxone.org/

Barriers / Challenges

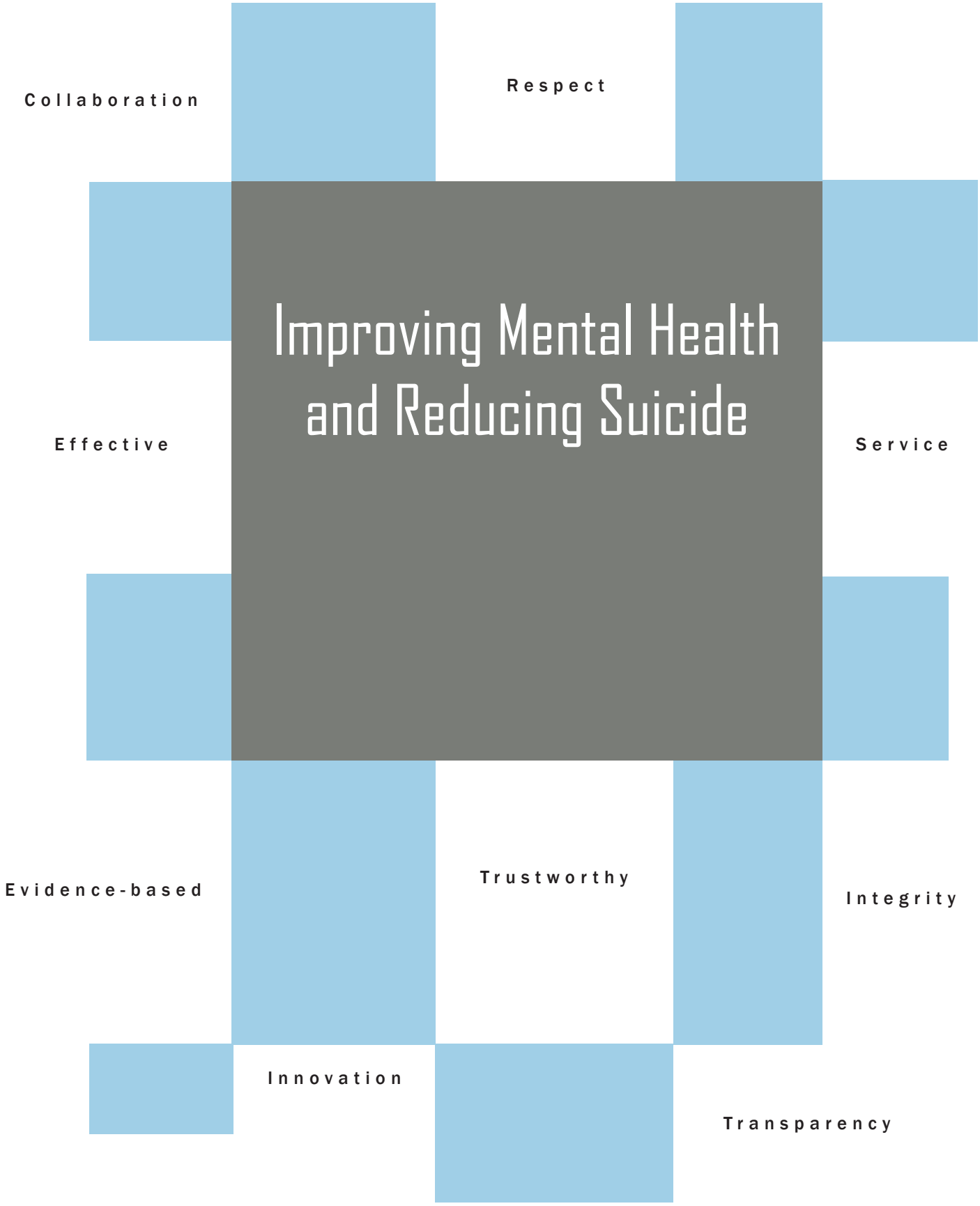
- Competing priorities
- Protective of efforts
- Prescribers may be resistant to legislation or rules that affect their prescriptive authority or capabilities

Partners

There are currently collaborative partnerships that can be utilized to address the UHIP goals, including the UCOOP. Partner agencies include:

- Intermountain Healthcare
- The Partnership for a Drug-Free America
- Utah Department of Health
- Utah Department of Human Services
- Salt Lake City Police Department
- Utah Poison Control Center
- Veteran's Administration - Salt Lake City Health Care System
- SMART - Utah County
- Bear River LHD
- Heber Valley Counseling Center

- Midvale United
- Neighborhoods United
- Salt Lake County LHD
- Summit Valley Mental Health
- Tooele Valley Mental Health
- Utah Council for Crime Prevention
- Utah Department of Commerce
- Utah Department of Environmental Quality
- Utah Division of Substance Abuse and Mental Health
- Weber Human Services
- Utah Substance Abuse Advisory Council


Collaboration
Respect
Improving Mental Health and Reducing Suicide
Effective
Service
Evidence-based
Trustworthy
Integrity
Innovation
Transparency

Background/Contextual Information for Health Priority

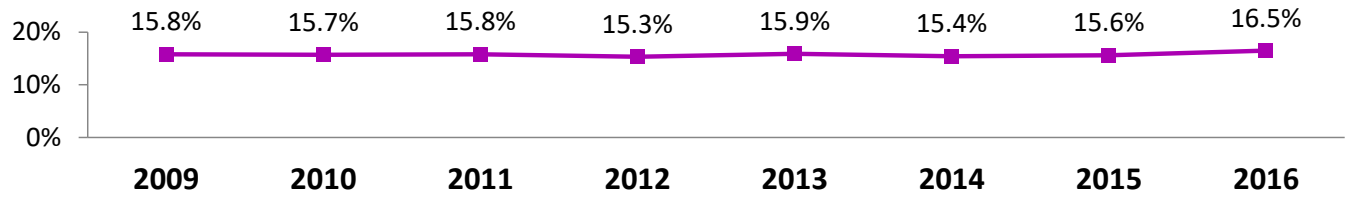
Mental Health Status

In 2016, approximately 17.1% (crude rate) of Utah adults reported seven or more days when their mental health was not good in the past 30 days. Risk factors for poor mental health may include, but are not limited to, violence in the community, extreme economic deprivation, availability of drugs, family history of issues, trauma, certain personality traits, and genetic or physiological factors.

The percentage of Utahns reporting at least seven mentally unhealthy days out of the past 30 decreased with increasing age, income, and education, and was higher for women than for men.

The American Indian/Alaska (AK) Native population in Utah reported the highest percentage of seven or more days when their mental health was not good in the past 30 days (21.2%), while Asian adults reported the lowest percentage (12.1%) (Table 9).

Figure 18. Poor Mental Health Status by Year, Utah Adults Aged 18+, 2009–2016



Trend graph depicts age-adjusted rates.

Table 9. Poor Mental Health Status State Comparison, by Age, Gender, and Race, Adults Aged 18+

STATE COMPARISON (2016)^	Crude (burden) Rate	Crude (burden) 95% CIs	Age-adjusted (comparison) Rate	Age-adjusted (comparison) 95% CIs	
U.S.	16.8%	*16.6% - 17.1%*	17.2%	*16.9% - 17.4%*	
South Dakota (best)	12.2%	*10.7% - 13.9%*	12.8%	*11.2% - 14.6%*	
Utah (21st of 51)	17.1%	*16.0% - 18.1%*	16.5%	*15.6% - 17.5%*	
West Virginia (worst)	22.0%	*20.9% - 23.2%*	23.0%	*21.7% - 24.3%*	
AGE IN YEARS (2016)					
18–34	22.9%	*20.8% - 25.2%*	–	–	– !
35–49	16.2%	*14.4% - 18.1%*	–	–	–
50–64	13.5%	*11.9% - 15.2%*	–	–	– ✓
65+	9.8%	*8.4% - 11.4%*	–	–	– ✓
GENDER (2016)					
Male	13.0%	*11.8% - 14.2%*	12.5%	*11.3% - 13.7%*	✓
Female	21.1%	*19.5% - 22.8%*	20.6%	*19.2% - 22.2%*	!
RACE (2014–2016)					
American Indian/AK Native	21.4%	*16.6% - 27.0%*	21.2%	*16.6% - 26.7%*	!
Asian	13.5%	*10.0% - 17.9%*	12.1%	*8.8% - 16.4%*	
Black	19.1%	*14.1% - 25.4%*	20.2%	*15.0% - 26.5%*	
Pacific Islander	17.7%	*12.4% - 24.7%*	18.1%	*12.4% - 25.7%*	
White	16.4%	*15.9% - 17.0%*	16.2%	*15.6% - 16.7%*	

^ U.S. data were age-adjusted using slightly different age categories, accounting for the difference in Utah's age-adjusted rate.

Data source: Utah Behavioral Risk Factor Surveillance System

Poor Mental Health Status: This measure reports the percentage of adults aged 18 years and older who reported seven or more days when their mental health was not good in the past 30 days.

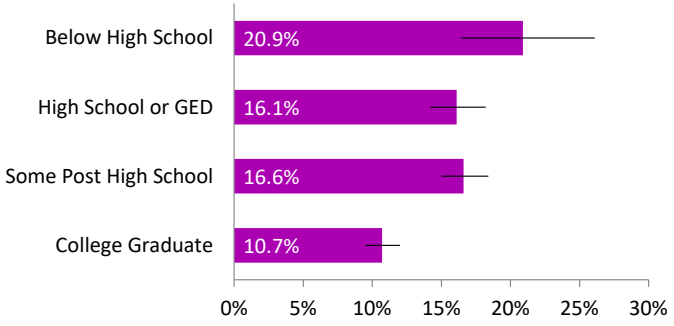
- 17.1% of Utah adults report poor mental health
- Worse for adults with low income and lower education levels
- Worse for Utahns aged 18–34; better for Utahns aged 50+
- Females had poorer mental health than males
- American Indian/Alaska Native population reported highest percentage of poor mental health
- Significantly higher rates of poor mental health for Weber-Morgan Local Health District

Table 10. Poor Mental Health Status by Ethnicity, Income, Education, and Local Health District, Adults Aged 18+

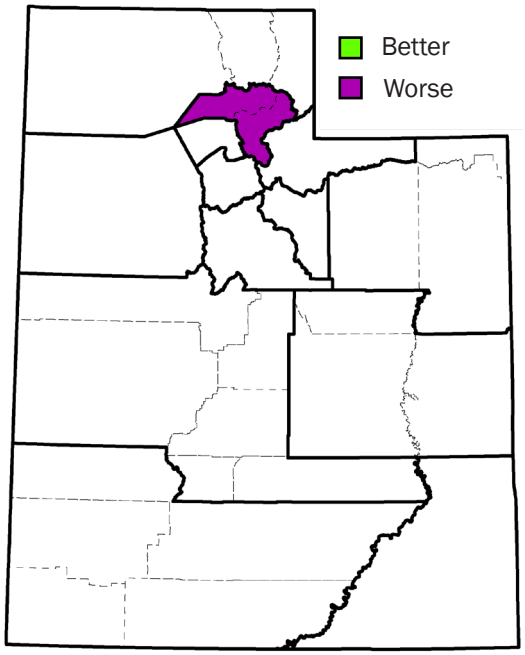
	Crude (burden)		Age-adjusted (comparison)		
ETHNICITY (2016)	Rate	95% CIs	Rate	95% CIs	
Hispanic	15.4%	*12.3% - 19.1%*	15.5%	*12.2% - 19.5%*	
Non-Hispanic	17.2%	*16.2% - 18.4%*	16.9%	*15.9% - 17.9%*	
INCOME (2016)					
0–$24,999	27.8%	*24.8% - 31.1%*	27.4%	*24.4% - 30.7%*	!
$25,000–$49,999	18.7%	*16.4% - 21.2%*	18.8%	*16.5% - 21.3%*	
$50,000–$74,999	15.6%	*13.4% - 18.1%*	15.4%	*13.2% - 17.9%*	
$75,000 or more	11.0%	*9.5% - 12.7%*	11.2%	*9.5% - 13.1%*	✓
EDUCATION—Adults 25+ (2016)					
Below High School	21.4%	*16.7% - 27.0%*	20.9%	*16.4% - 26.1%*	!
High School or GED	16.5%	*14.5% - 18.7%*	16.1%	*14.2% - 18.2%*	
Some Post High School	16.7%	*15.0% - 18.5%*	16.6%	*15.0% - 18.4%*	
College Graduate	10.9%	*9.7% - 12.2%*	10.7%	*9.5% - 12.0%*	✓
LOCAL HEALTH DISTRICT (2016)					
Bear River	17.2%	*13.7% - 21.3%*	16.3%	*13.1% - 20.2%*	
Central Utah	13.4%	*10.1% - 17.6%*	13.5%	*10.2% - 17.7%*	
Davis County	16.2%	*13.5% - 19.4%*	15.6%	*13.1% - 18.5%*	
Salt Lake County	16.6%	*14.8% - 18.5%*	16.3%	*14.6% - 18.1%*	
San Juan	17.8%	*10.8% - 27.9%*	20.0%	*12.4% - 30.8%*	
Southeast Utah	17.1%	*12.9% - 22.4%*	17.9%	*13.3% - 23.7%*	
Southwest Utah	15.0%	*12.1% - 18.5%*	15.7%	*12.5% - 19.5%*	
Summit County	13.1%	*8.8% - 18.9%*	13.1%	*8.7% - 19.1%*	
Tooele County	19.7%	*15.1% - 25.1%*	19.7%	*15.3% - 25.1%*	
TriCounty	16.8%	*13.4% - 20.9%*	16.2%	*13.0% - 20.1%*	
Utah County	17.8%	*15.3% - 20.7%*	15.7%	*13.6% - 18.0%*	
Wasatch County	11.0%	*7.1% - 16.7%*	11.2%	*7.0% - 17.5%*	
Weber-Morgan	21.5%	*18.4% - 25.0%*	21.5%	*18.4% - 24.9%*	!

Data source: Utah Behavioral Risk Factor Surveillance System

Figure 19. Poor Mental Health Status by Education, Utah Adults Aged 25+, 2016



Map 6. Poor Mental Health Status by Local Health District, Utah Adults Aged 18+, 2016



Depression

The rate of self-reported lifetime depression has been consistently higher in Utah compared to the U.S. (21.5% vs. 16.7% in 2016, age-adjusted rates). The proportion of adults who reported ever being told they had a depressive disorder varies by a number of population characteristics including age, sex, race, income, and education.

Utahns aged 65 and older had significantly lower rates of depression than other age groups. In Utah during 2016, adult females (28.3%) had significantly higher rates of doctor-diagnosed depression than males (14.8%). Hispanic (16.9%), Asian (10.1%), and Pacific Islander (11.1%) adults reported lower lifetime depression than the state rate during 2014–2016.

Utahns with a household income less than $25,000 (31.3%) and those with a household income $25,000–$49,999 (23.0%) had significantly higher rates of lifetime doctor-diagnosed depression, while adults with an income greater than $75,000 (16.7%) had lower rates of lifetime depression during 2014–2016. (Table 11)

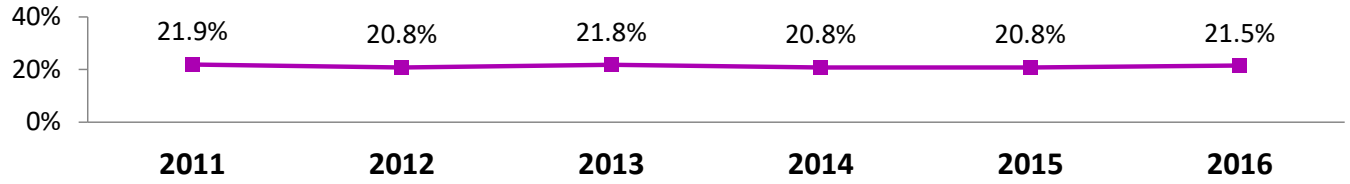
Depression also varied by education during 2014–2016. Utah adults aged 25 and older with a college education (18.0%) had a lower rate of doctor-diagnosed depression than adults with less than a high school education (21.6%), those with a high school diploma or GED (21.0%), and those with some college (23.8%). (Table 12)

Adults in Summit County (17.1%) and TriCounty (18.2%) Local Health Districts reported lower rates of doctor-diagnosed depression during 2014–2016 (Table 12).

Utah adults who reported chronic illnesses and/or poor health status in general, were also more likely to report having ever been told they had a depressive disorder. It is known that behavioral health problems often co-occur with chronic diseases and may exacerbate poor health outcomes.

Risk factors for depression may include, but are not limited to, genetic or biological factors, stressful situations or major life events, drug use, certain personality traits, lack of social support/social isolation, and trauma.

Figure 20. Depression by Year, Utah Adults Aged 18+, 2011–2016



Trend graph depicts age-adjusted rates.

Table 11. Depression State Comparison, by Age, Gender, Race, Ethnicity, and Income, Adults Aged 18+

	Crude (burden)		Age-adjusted (comparison)		
STATE COMPARISON (2016)	Rate	95% CIs	Rate	95% CIs	
U.S.	16.6%	*16.4% - 16.8%*	16.7%	*16.5% - 17.0%*	
New York (best)	11.7%	*11.1% - 12.4%*	11.8%	*11.1% - 12.5%*	
Utah (39th of 51)	21.5%	*20.5% - 22.6%*	21.5%	*20.5% - 22.6%*	
Oregon (worst)	25.0%	*23.6% - 26.4%*	25.9%	*24.4% - 27.4%*	
AGE IN YEARS (2016)					
18–34	22.6%	*20.5% - 24.8%*	–	–	–
35–49	21.7%	*19.7% - 23.8%*	–	–	–
50–64	22.9%	*20.9% - 25.0%*	–	–	–
65+	17.3%	*15.6% - 19.1%*	–	–	– ✓
GENDER (2016)					
Male	14.9%	*13.6% - 16.3%*	14.8%	*13.5% - 16.1%*	✓
Female	28.1%	*26.5% - 29.8%*	28.3%	*26.7% - 29.9%*	!
RACE (2014–2016)					
American Indian/AK Native	23.4%	*19.1% - 28.4%*	23.9%	*19.5% - 28.9%*	
Asian	11.2%	*7.6% - 16.3%*	10.1%	*7.0% - 14.2%*	✓
Black	18.8%	*14.0% - 24.6%*	19.9%	*15.0% - 26.0%*	
Pacific Islander	13.3%	*8.5% - 20.1%*	11.1%	*7.2% - 16.9%*	✓
White	21.9%	*21.3% - 22.5%*	21.9%	*21.4% - 22.5%*	!
ETHNICITY (2014–2016)					
Hispanic	15.2%	*13.6% - 16.9%*	16.9%	*15.0% - 18.9%*	✓
Non-Hispanic	21.8%	*21.3% - 22.4%*	21.9%	*21.3% - 22.4%*	!
INCOME (2014–2016)					
0–$24,999	29.3%	*27.8% - 30.8%*	31.3%	*29.7% - 32.9%*	!
$25,000–$49,999	22.6%	*21.3% - 23.9%*	23.0%	*21.7% - 24.3%*	!
$50,000–$74,999	20.5%	*19.2% - 21.9%*	20.4%	*19.0% - 21.8%*	
$75,000 or more	16.9%	*16.1% - 17.9%*	16.7%	*15.8% - 17.7%*	✓

The question asks about lifetime diagnosis and does not reflect current major depression.
Data source: Utah Behavioral Risk Factor Surveillance System

Depression: This measure reports depression as the percentage of adults aged 18 and older who have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression.

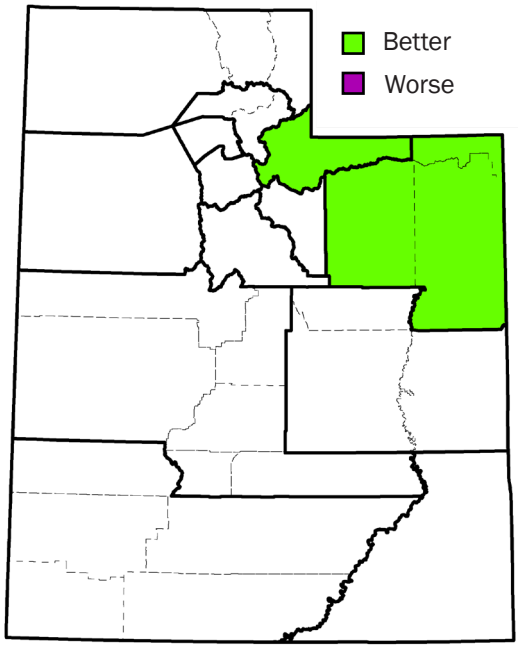
- 21.5% of Utah adults (2016 crude rate) have a depressive disorder
- Lower rates among Utahns aged 65+
- Higher rates among females; lower rates among males
- Significantly lower for Asian, Hawaiian/Pacific Islander, and Hispanic populations
- Higher rate among Utahns aged 25+ with some post high school education
- Lower rates among college graduates and $75,000 or more income level
- Significantly lower for Summit County and TriCounty Local Health Districts

Table 12. Depression by Education and Local Health District, Adults Aged 18+

EDUCATION—Adults 25+ (2014–2016)	Crude (burden) Rate	95% CIs	Age-adjusted (comparison) Rate	95% CIs	
Below High School	21.5%	*19.1% - 24.1%*	21.6%	*19.3% - 24.1%*	
High School or GED	21.2%	*20.2% - 22.4%*	21.0%	*19.9% - 22.1%*	
Some Post High School	23.9%	*22.9% - 25.0%*	23.8%	*22.8% - 24.8%*	!
College Graduate	18.0%	*17.2% - 18.8%*	18.0%	*17.2% - 18.8%*	✓
LOCAL HEALTH DISTRICT (2014–2016)					
Bear River	19.2%	*17.3% - 21.3%*	19.4%	*17.5% - 21.4%*	
Central Utah	19.3%	*17.0% - 21.9%*	19.9%	*17.6% - 22.5%*	
Davis County	22.1%	*20.4% - 23.8%*	21.7%	*20.1% - 23.4%*	
Salt Lake County	22.0%	*21.0% - 23.0%*	21.9%	*21.0% - 22.9%*	
San Juan	14.5%	*9.9% - 20.7%*	14.8%	*10.2% - 21.0%*	
Southeast Utah	21.5%	*18.4% - 24.9%*	21.1%	*17.9% - 24.8%*	
Southwest Utah	18.4%	*16.7% - 20.3%*	19.1%	*17.2% - 21.1%*	
Summit County	16.7%	*13.6% - 20.3%*	17.1%	*13.8% - 20.9%*	✓
Tooele County	24.0%	*20.8% - 27.6%*	23.8%	*20.6% - 27.3%*	
TriCounty	18.5%	*15.9% - 21.3%*	18.2%	*15.7% - 20.9%*	✓
Utah County	20.8%	*19.4% - 22.3%*	20.6%	*19.3% - 21.9%*	
Wasatch County	17.1%	*13.5% - 21.5%*	17.0%	*13.5% - 21.2%*	
Weber-Morgan	22.7%	*21.0% - 24.5%*	22.6%	*20.9% - 24.4%*	

The question asks about lifetime diagnosis and does not reflect current major depression.
Data source: Utah Behavioral Risk Factor Surveillance System

Map 7. Depression by Local Health District, Utah Adults Aged 18+, 2014–2016



Suicide

Suicide is a major preventable public health problem in Utah and the 8th leading cause of death in Utah (2010–2016 inclusive). The suicide rate in Utah has been consistently higher than the national rate (Figure 21). Every suicide death causes a ripple effect of immeasurable pain to individuals, families, and communities. From 2014 to 2016, the age-adjusted suicide rate in Utah was 21.2 per 100,000 persons. This is an average of 592 suicide deaths per year. Suicide was the leading cause of death for Utahns aged 10–17 in 2016 and the second leading cause of death for Utahns aged 18–39. One in 18 Utah adults (5.6%) report having had serious thoughts of suicide in the past year (SAMHSA National Survey on Drug Use and Health, 2015–2016). According to the 2017 Youth Risk Behavior Survey, 21.6% of youth in grades 9–12 reported seriously considering suicide, 17.1% made a plan about how they would attempt suicide, and 9.6% attempted suicide one or more times in the prior year.

In Utah from 2014 to 2016, males had significantly higher suicide rates than females in every age group (Figure 23). During this time period, males (32.0 per 100,000 population) had a significantly higher age-adjusted suicide rate compared to females (10.7 per 100,000 population).

Utah males aged 75 and older, followed by males aged 45–54 and 35–44, had the highest suicide rates among other male age groups. Utah females aged 45–54, followed by females aged 35–44, had the highest suicide rates among other female age groups (Figure 23).

From 2014 to 2016, Central Utah, Southeast Utah, TriCounty, and Weber-Morgan Local Health Districts had significantly higher age-adjusted suicide rates compared to the state rate (Table 14).

Significant risk factors for suicide ideation among Utah youth were being bullied at school or online and substance use in the previous month. Multiple logistic regression identified being female, in 10th grade, non-White, and low parental education as risk factors for suicide ideation and attempt. Youth in the TriCounty Local Health District also were at higher risk. Students who reported participating more frequently in religious activities and those from Bear River, Southwest, Summit, and Wasatch Local Health Districts had lesser risk of suicide ideation. Supportive social environments were found to be protective for suicide ideation and attempts. Supportive social environments are characterized by ones in which youth feel

involved, valued, and able to ask for and receive help when they need it. Supportive family environments had the biggest impact on reducing suicide ideation, followed by community environments, school environments, and peer environments.[1]

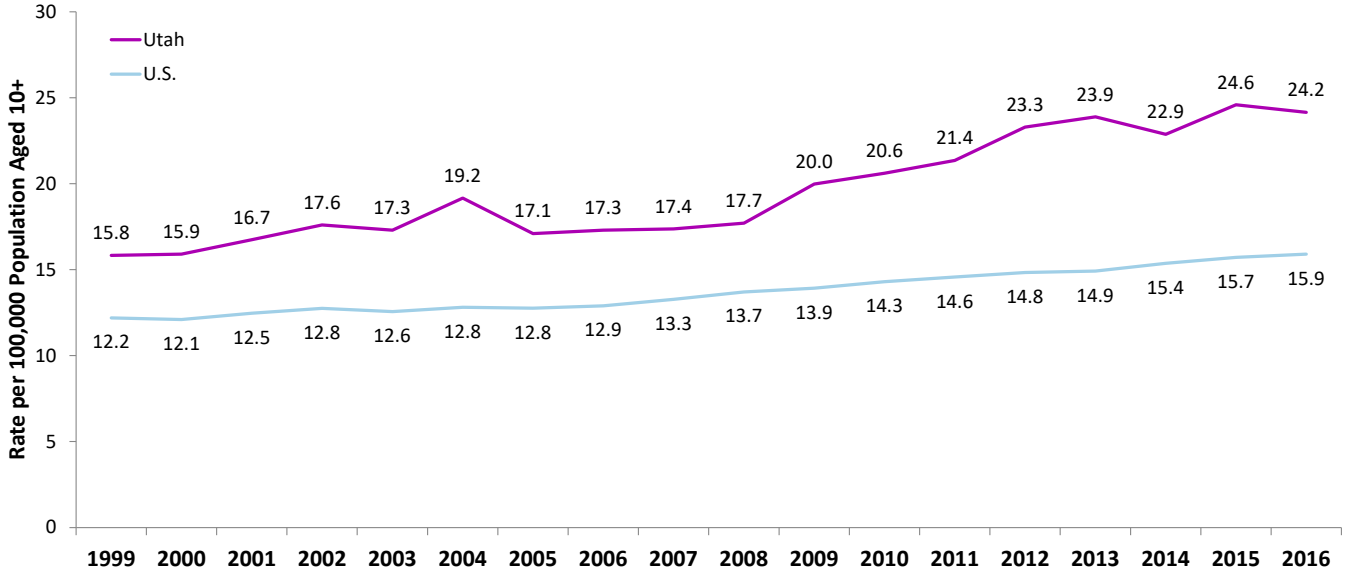
Other conditions and stressors that may be related to suicide include:[2]

- Previous suicide attempt(s)
- History of depression or other mental illness
- Alcohol or drug abuse
- Family history of suicide or violence
- Physical illness
- Local epidemics of suicide

Firearms and suffocation were the two most frequent methods of suicide in 2014–2016 (Figure 24).

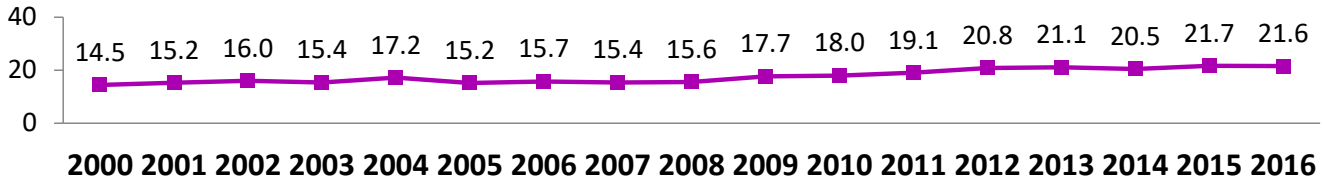
Suicide data is frequently reported with the entire population and including only those 10 years of age and older. The figure below includes rates for the 10+ years population (Figure 21), the rest of the data includes the total population (Figure 22).

Figure 21. Suicides per 100,000 Population Aged 10+ by Year, Utah and U.S., 1999–2016



Data sources: Utah Death Certificate Database; National Center for Health Statistics Vital Statistics System (WISQARS)

Figure 22. Suicides per 100,000 Population by Year, Utah, 2000–2016



Trend graph depicts age-adjusted rates.
Data source: Utah Death Certificate Database

1 Utah Health Status Update: CDC Investigation Shows Youth Suicides in Utah Increasing. Accessed 3/14/2018 from https://ibis.health.utah.gov/pdf/opha/publication/hsu/SE04_SuicideEpiAid.pdf.

2 Suicide: Risk and Protective Factors. Centers for Disease Control and Prevention. Accessed 11/19/2015 from http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html.

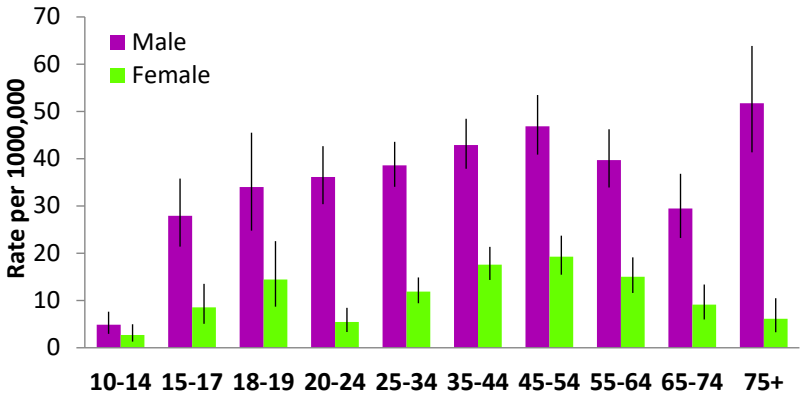
Table 13. Suicide State Comparison, by Age, Gender, Race, and Ethnicity

STATE COMPARISON (2016)^	Crude (burden) Rate	Crude (burden) 95% CIs	Age-adjusted (comparison) Rate	Age-adjusted (comparison) 95% CIs	
U.S.	13.9	*13.8 - 14.0*	13.5	*13.3 - 13.6*	
District of Columbia (best)	5.9	*4.2 - 8.0*	5.2	*3.7 - 7.2*	
Utah (47th of 51)	20.1	*18.5 - 21.7*	21.6	*19.9 - 23.4*	
Montana (worst)	25.6	*22.5 - 28.7*	25.9	*22.7 - 29.1*	
AGE IN YEARS (2016)					
10–14*	3.9	*1.9 - 7.2*	–	–	✓
15–17	14.9	*9.3 - 22.5*	–	–	
18–19	21.0	*12.7 - 32.9*	–	–	
20–24	22.9	*17.4 - 29.6*	–	–	
25–34	27.2	*22.6 - 32.5*	–	–	!
35–44	31.2	*26.0 - 37.0*	–	–	!
45–54	35.0	*28.8 - 42.2*	–	–	!
55–64	25.1	*19.7 - 31.5*	–	–	
65–74	19.9	*14.1 - 27.3*	–	–	
75+	24.6	*16.8 - 34.8*	–	–	
GENDER (2016)					
Male	29.9	*27.2 - 32.8*	32.4	*29.5 - 35.6*	!
Female	10.1	*8.6 - 11.8*	10.8	*9.1 - 12.7*	✓
RACE (2014–2016)					
American Indian/AK Native	24.6	*17.0 - 34.4*	23.2	*15.8 - 32.8*	
Asian	9.6	*5.9 - 14.6*	9.7	*5.9 - 14.9*	✓
Black*	8.4	*4.0 - 15.4*	8.8	*3.5 - 18.3*	✓
Pacific Islander*	8.8	*3.8 - 17.4*	8.5	*3.5 - 17.1*	✓
White	20.4	*19.4 - 21.4*	20.8	*19.8 - 21.8*	
ETHNICITY (2014–2016)					
Hispanic	9.7	*8.1 - 11.6*	11.2	*9.0 - 13.7*	✓
Non-Hispanic	21.3	*20.3 - 22.3*	21.6	*20.5 - 22.6*	!

^ National data from CDC WONDER. Utah rate shown differs from the rate reported on CDC WONDER. The rate from WONDER was used for the state ranking although the rate shown here is from the Utah Death Certificate Database.

* Use caution in interpreting, the estimate has a relative standard error greater than 30% and does not meet UDOH standards for reliability.

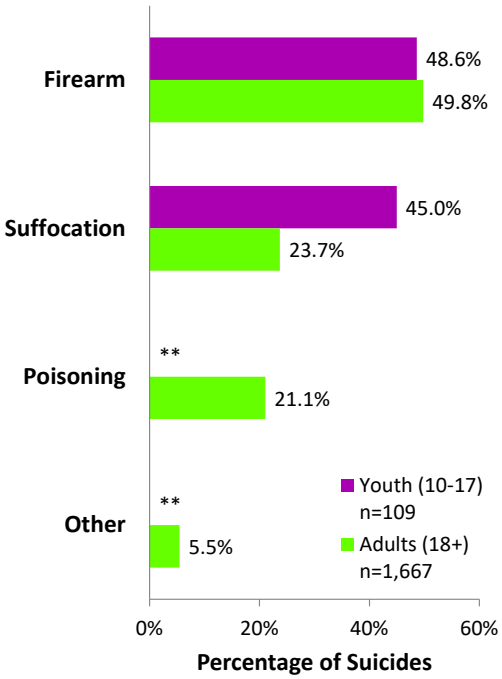
Figure 23. Suicide by Age and Gender, Utah, 2014–2016



Suicide: The suicide rate is the number of resident deaths resulting from the intentional use of force against oneself per 100,000 population.

- 20.1 suicides per 100,000 population
- Higher rates among Utahns aged 25–54; lower rate among those aged 10–14
- Higher for males than females
- Significantly lower rates among Black, Asian, Pacific Islander, and Hispanic populations
- Significantly higher among non-Hispanic population
- Significantly higher for Central Utah, Southeast Utah, TriCounty, and Weber-Morgan Local Health Districts
- Significantly lower for Davis County and Utah County Local Health Districts

Figure 24. Suicides by Age Group and Method of Injury, Utah, 2014–2016



** Data suppressed because the observed number of events is very small and not appropriate for publication.

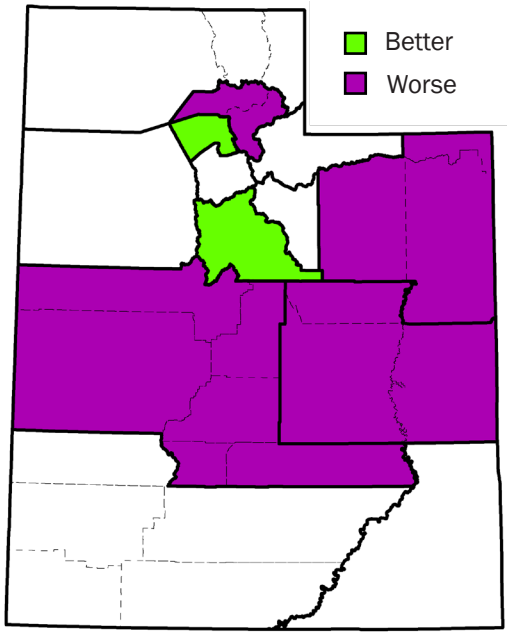
Data source: Utah Death Certificate Database

Table 14. Suicide by Local Health District

LOCAL HEALTH DISTRICT (2014–2016)	Crude (burden) Rate	Crude (burden) 95% CIs	Age-adjusted (comparison) Rate	Age-adjusted (comparison) 95% CIs	
Bear River	17.5	*14.1 - 21.5*	18.7	*14.9 - 23.1*	
Central Utah	29.3	*22.8 - 37.2*	31.3	*24.1 - 39.9*	!
Davis County	14.3	*12.1 - 16.8*	15.3	*12.9 - 18.1*	✓
Salt Lake County	21.4	*19.9 - 23.0*	22.4	*20.8 - 24.2*	
San Juan*	16.7	*7.2 - 33.0*	19.4	*8.1 - 38.9*	
Southeast Utah	32.2	*22.9 - 44.0*	33.4	*23.5 - 46.0*	!
Southwest Utah	22.1	*18.7 - 26.0*	24.4	*20.5 - 28.8*	
Summit County	16.8	*10.3 - 26.0*	15.6	*9.4 - 24.3*	
Tooele County	22.7	*16.4 - 30.6*	25.2	*18.1 - 34.2*	
TriCounty	31.3	*23.6 - 40.7*	34.8	*26.0 - 45.5*	!
Utah County	14.4	*12.7 - 16.3*	16.4	*14.3 - 18.7*	✓
Wasatch County	19.4	*11.3 - 31.1*	19.9	*11.6 - 32.0*	
Weber-Morgan	23.9	*20.6 - 27.7*	24.9	*21.4 - 28.8*	!

* Use caution in interpreting, the estimate has a relative standard error greater than 30% and does not meet UDOH standards for reliability.
Data source: Utah Death Certificate Database

Map 8. Suicide by Local Health District, Utah, 2014–2016



Current Efforts

The Division of Substance Abuse and Mental Health (DSAMH) in the Utah Department of Human Services coordinates state efforts for mental health and substance abuse prevention and intervention. You can learn more about their initiatives at dsamh.utah.gov.

The UDOH Violence and Injury Prevention Program (VIPP) is funded by the CDC to implement the Utah Violent Death Reporting System (UTVDRS). The UTVDRS is a data collection and monitoring system that informs decision makers about the magnitude, trends, and characteristics of violent deaths such as suicide, and to evaluate and continue to improve state-based violence prevention policies and programs. Data are collected from the UDOH Office of the Medical Examiner, UDOH Office of Vital Records and Statistics, and law enforcement agencies and are linked together to help identify risk factors, understand circumstances, and better characterize perpetrators of violent deaths. The UTVDRS is currently in its 11th year of data collection.

The VIPP partners with the DSAMH to facilitate the Utah Suicide Prevention Coalition. The Utah Suicide Prevention Coalition created a Utah Suicide Prevention Plan for 2017–2021. The plan is available at https://www.health.utah.gov/vipp/pdf/Suicide/SuicidePreventionCoalitionPlan2017-2021.pdf.

Goals, Objectives, and Strategies

Goal 1: Increase availability and access to quality physical and behavioral healthcare.

Objective 1: Increase formal adoption of the 'Zero Suicide' framework by health and behavioral healthcare providers statewide by ten health systems/organizations.

Objective 1 Measures: Number of health systems/organizations formally adopting the Zero Suicide framework

Objective 1 Baseline: Zero organizations have adopted the Zero Suicide framework as of January 2017

Objective 1 Target: Ten health systems/organizations in Utah have formally adopted the Zero Suicide Framework by December 2020

Strategy 1 for Objective 1: At least 10 new organizations will formally adopt the Zero Suicide Framework systematic approach to quality improvement in health and behavioral healthcare settings.

Goal 2: Increase social norms supportive of help seeking and recovery.

Objective 1: Train at least 10% of the population of Utah in an evidenced-based gatekeeper training.

Objective 1 Measures: Number of people trained in an evidence-based gatekeeper training

Objective 1 Baseline: 25,000 (estimated) as of January 2017

Objective 1 Target: A minimum of 299,592 Utahns are trained in an evidence-based gatekeeper training by December 2020

Strategy 1 for Objective 1: Evidence-Based training will be offered to Utahns in a variety of settings. These include training programs such as Connect, QPR, Mental Health First Aid, ASIST, Working Minds, and others.

Goal 3: Reduce access to lethal means of suicide death.

Objective 1: Partner with at least 30 firearm retailers, concealed carry instructors, and/or firearm enthusiasts to incorporate consumer suicide awareness and prevention materials as a basic tenet of firearm safety and responsible firearm ownership.

Objective 1 Measures: Number of formal partnerships established

Objective 1 Baseline: Zero partnerships have been established as of January 2017

Objective 1 Target: Ten firearm retailers, instructors, enthusiasts in Utah have incorporated suicide education, prevention, and awareness efforts into their businesses by December 2020

Strategy 1: Thirty firearm retailers, instructors, or enthusiasts will have formal policies and protocols established to educate staff and clients and customers on suicide prevention, safe storage of firearms and reducing access.

Other goal measures:

Percentage of adults aged 18 years and older who reported seven or more days when their mental health was not good in the past 30 days.

Percentage of adults aged 18 and older who have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression.

Number of resident deaths resulting from the intentional use of force against oneself per 100,000 population.

Alignment

Aligns with the following Healthy People 2020 objectives:

MHMD-9: Increase the proportion of adults with mental disorders who receive treatment

MHMD-9.1: Increase the proportion of adults age 18 years and older with serious mental illness (SMI) who receive treatment
U.S. Target: 72.3%

MHMD-9.2: Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment
U.S. Target: 75.9%

MHMD-4.2: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes
U.S. Target: 5.8%

MHMD-1: Reduce the suicide rate
U.S. Target: 10.2 suicides per 100,000 population
Utah Target: 13.3 suicides per 100,000 population

Resources

- Utah Suicide Prevention Coalition
- Champions (e.g. Utah State Legislature)
- Local health and behavioral health agencies
- Local coalitions
- Non-profit groups
- Some state funding
- Passionate community members

Barriers/Challenges

- Stigma
- Fear
- Research to practice
- Access to care
- Workforce shortages
- Limited funding

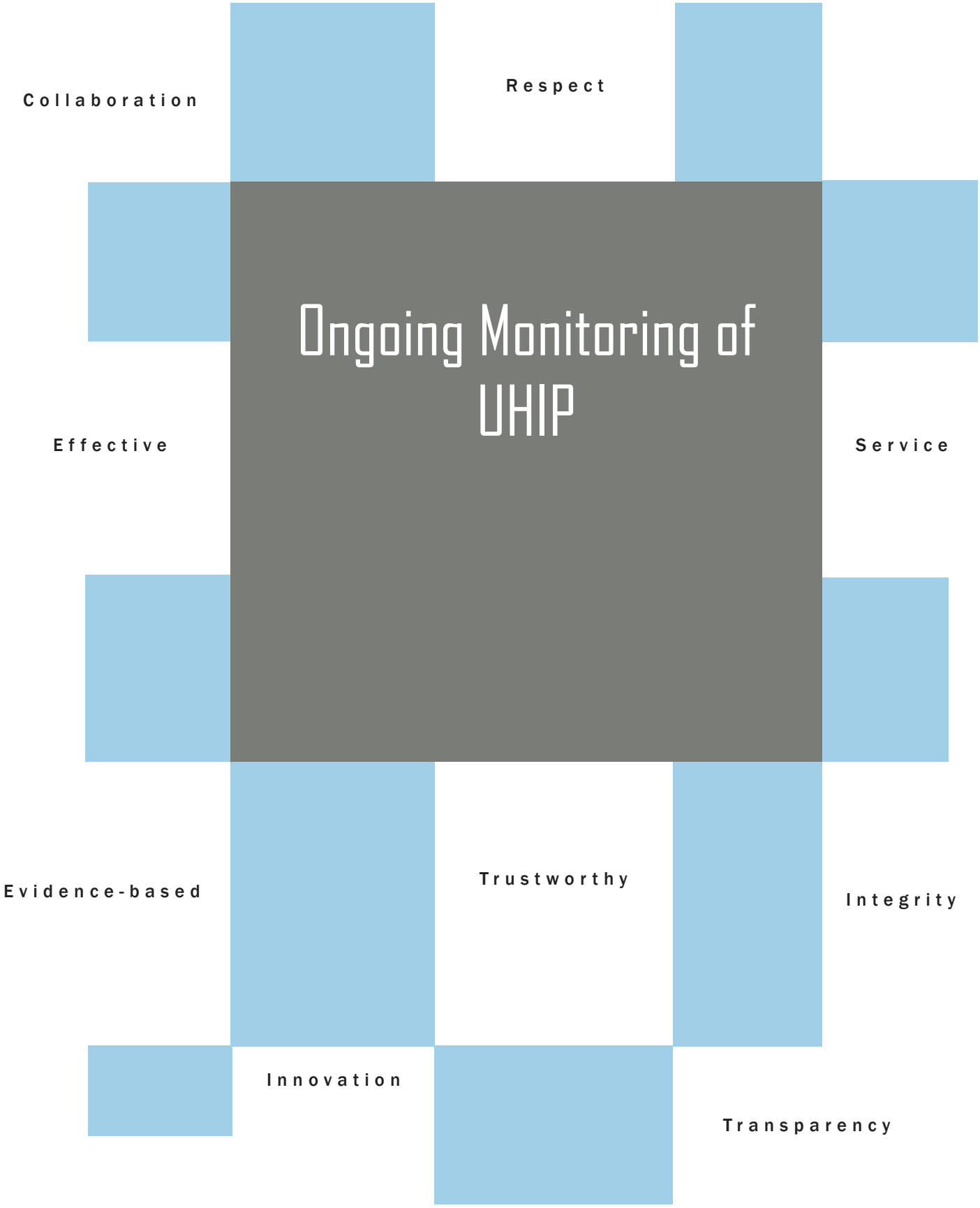
Partners

A main goal of the Utah Suicide Prevention Coalition is to "develop and sustain public-private partnerships to advance suicide prevention." It is comprised of community members, suicide survivors, service providers, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah. Current workgroups of the coalition include: Youth, LGBTQ, First Responders, Community Awareness, Firearm Safety, Workplace, Zero Suicide, and an Executive Committee. Additionally, the Utah Suicide Prevention Coalition provides support and technical assistance to community coalitions statewide to improve infrastructure and the ability to address suicide prevention in their local communities.

Additional Participation

In order to successfully implement this plan, several additional partnerships will have to be established. For example, the Zero Suicide initiative will require that partnerships are established with health systems across the state including primary care practices, hospitals, emergency departments, behavioral healthcare, and substance abuse treatment. Research shows that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted healthcare system.

Additionally, new partnerships will need to be established with firearm retailers across the state. Our goal is to partner with the retailers to provide suicide prevention training to staff who in turn can educate their customers.


Collaboration
Respect
Ongoing Monitoring of UHIP
Effective
Service
Evidence-based
Trustworthy
Integrity
Innovation
Transparency

Ongoing Monitoring of UHIP

Annual UHIP Coalition Meetings

The UHIP Coalition last met May 23, 2017 so that the workgroup chairs could present the priority areas, goals, measures, and plans for improvement. After the main presentations, focus groups were held for each priority area so that members of the coalition could provide feedback regarding the specific details of the plan and any gaps or concerns identified with the plans. The UHIP Coalition will meet annually to review UHIP progress and provide input. Additionally, updates will be provided at least once between the annual UHIP meetings.

UHIP Executive Committee Quarterly Meetings

The UHIP Executive Committee meets quarterly. Workgroup chairs present updates to the Executive Committee as well as any challenges they may be experiencing.

UHIP Operational Committee Quarterly Meetings

The UHIP Operational Committee meets quarterly. The Operational Committee is responsible for planning and facilitating the coalition meetings, regular updates to the coalition, maintaining the UHIP process, and reviewing data updates to the SHA indicators.

Website

Updates on the UHIP can be found online at http://utphpartners.org/ship/ship.html.

Collaboration

Respect

Appendices

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

List of Acronyms

6|18 Initiative – The Centers for Disease Control and Prevention (CDC) is partnering with healthcare purchasers, payers, and providers to improve health and control healthcare costs. By 6|18, we mean that we are targeting six common and costly health conditions—tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes—and 18 proven specific interventions that formed the starting point of discussions with purchasers, payers, and providers.

AK Native – Alaska Native

ASIST – Applied Suicide Intervention Skills Training

AUCH – Association for Utah Community Health

BMI – body mass index

BRFSS – Behavioral Risk Factor Surveillance System

CDC – Centers for Disease Control and Prevention

Center TRT – Center for Training and Research Translation

CHIP – Children's Health Insurance Plan

CMEs – continuing medical education credit hours

CMHC – Community Mental Health Centers

DEQ – Department of Environmental Quality

DSAMH – Division of Substance Abuse and Mental Health

DSM-IV – 4th edition of the Diagnostic and Statistical Manual of Mental Disorders

EMS – emergency medical services

EPICC – Healthy Living through Environment, Policy, and Improved Clinical Care program

FQHC – Federally Qualified Health Center

GED – General Education Development

HHS – U.S. Department of Health and Human Services

HIV – Human Immunodeficiency Virus

ICD-10 – International Classification of Diseases, Tenth Revision

IT – information technology

LDL – low-density lipoprotein

LGBTQ – lesbian, gay, bisexual, transgender, or queer

LHD – local health department

MDEs – major depressive episodes

MME – morphine milligram equivalent

MMWR – Morbidity and Mortality Weekly Report

N/A – not available

NAMI – National Alliance on Mental Illness

NCHS – National Center for Health Statistics

NHLBI – National Heart, Lung, and Blood Institute

OVRS – Office of Vital Records and Statistics

PNA – Prevention Needs Assessment

QPR – Question, Persuade, Refer

SAMHSA – Substance Abuse and Mental Health Services Administration

SHA – Utah State Health Assessment

SHIP – State Health Improvement Plan (refers to state health improvement plan process and improvement plan from 2012–2016. The new plan is referred to as the Utah Health Improvement Plan.)

SMI – serious mental illness

SWOT – strengths, weaknesses, opportunities, threats

UALHD – Utah Association of Local Health Departments

UCOOP – Utah Coalition for Opioid Overdose Prevention

UDOH – Utah Department of Health

UHIP – Utah Health Improvement Plan

UDOT – Utah Department of Transportation

UIHAB – Utah Indian Health Advisory Board

UNIS – Utah Notification and Information System

UTVDRS – Utah Violent Death Reporting System

VIPP – Violence and Injury Prevention Program

WONDER – Wide-ranging Online Data for Epidemiologic Research

YRBS – Youth Risk Behavior Survey

YRBSS – Youth Risk Behavior Surveillance System

Glossary

academic detailing – structured visits by trained personnel to healthcare practices for the purpose of delivering tailored training and technical assistance to healthcare providers to help them use best practices (see https://www.cdc.gov/tobacco/stateandcommunity/pdfs/academicdetailingfaq_120913_cleared_508.pdf)

age-adjusted – a technique used to allow populations to be compared when the age profiles of the populations are quite different (also see listing for crude rate)

American Indian/Alaska Native – a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment (see https://tinyurl.com/OMB-1997RaceStandards)

America's Health Rankings – state-by-state study of the nation's health (see http://www.americashealthrankings.org/)

Applied Suicide Intervention Skills Training – training designed to raise awareness about suicide, increase knowledge of resources, and improve intervention skills (see https://www.livingworks.net/programs/asist/)

Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (see https://tinyurl.com/OMB-1997RaceStandards)

Association for Utah Community Health (AUCH) – the Primary Care Association in Utah, and helps reduce barriers to healthcare through health promotion, community engagement and development, education, and policy analysis (see http://www.auch.org/)

Association of State and Territorial Health Officials State Health Assessment Guidance and Resources – guide intended to be a resource for state health departments developing a state health assessment (SHA) (see http://www.astho.org/Programs/Accreditation-and-Performance/ASTHO-Publishes-State-Health-Assessment-Guidance-and-Resources/)

Bayes estimation – a method of statistical inference (named for English mathematician Thomas Bayes) that allows one to combine prior information about a population parameter with evidence from information contained in a sample to guide the statistical inference process

Behavioral Risk Factor Surveillance System (BRFSS) – the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services (see http://www.cdc.gov/brfss/about/index.htm)

benzodiazepine – sedative often used to treat anxiety, insomnia, and other conditions; combining benzodiazepines with opioids increases a person's risk of overdose and death

Black [or African American] – a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." (see https://tinyurl.com/OMB-1997RaceStandards)

body mass index (BMI) – a person's weight in kilograms divided by the square of height in meters

catchment area – the geographical area served by an institution

CDC 6|18 initiative – CDC is partnering with healthcare purchasers, payers, and providers to improve health and control healthcare costs. CDC provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models. (see http://www.cdc.gov/sixeighteen/faqs/index.htm)

CDC Growth Charts – a set of charts for children and adolescents from ages 2 to 20 years that include weight-for-age, stature-for-age, and body mass index (BMI)-for-age curves

CDC National Center for Health Statistics – The mission of the National Center for Health Statistics (NCHS) is to provide statistical information that will guide actions and policies to improve the health of the American people. As the Nation's principal health statistics agency, NCHS leads the way with accurate, relevant, and timely data. (see https://www.cdc.gov/nchs/about/mission.htm)

Census Bureau – part of the U.S. Department of Commerce; serves as the leading source of quality data about the nation's people and economy (see https://www.census.gov/about/what.html)

Centers for Disease Control and Prevention (CDC) – the nation's health protection agency, and their scientists and disease detectives work around the world to track diseases, research outbreaks, and respond to emergencies of all kinds (see https://www.cdc.gov/about/resources/index.htm)

Children's Health Insurance Program (CHIP) – a state health insurance plan for children; depending on income and family size, working Utah families who do not have other health insurance may qualify for CHIP (see http://health.utah.gov/chip/faq.htm#1)

Collaborative Practice Agreement – formalizes practice relationships between pharmacists and collaborating prescribers

Connect– a suicide prevention program including prevention, intervention, and postvention (see http://www.theconnectprogram.org/)

[Utah] controlled substance database – see listing for Utah Controlled Substance Database

County Health Rankings – The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births in nearly every county in America. The annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities. (see http://www.countyhealthrankings.org/about-us)

crude rate – crude rates are helpful in determining the burden and specific needs for services for a given population, compared with another population, regardless of size (also see listing for age-adjusted)

Department of Environmental Quality – see listing for Utah Department of Environmental Quality

diabetes – a disease that occurs when blood glucose, also called blood sugar, is too high; over time, having too much glucose in the blood can cause health problems, such as heart disease, nerve damage, eye problems, and kidney disease

Diagnostic and Statistical Manual of Mental Disorders – the standard classification of mental disorders used by mental health professionals in the United States

Division of Substance Abuse and Mental Health – see listing for Utah Division of Substance Abuse and Mental Health

dysthymia – a mood disorder consisting of the same mood, cognitive and physical problems as in depression, with less severe but longer-lasting symptoms

endometrial [cancer] – endometrial cancer starts when cells in the inner lining of the uterus (endometrium) begin to grow out of control

epidemiology – the study (scientific, systematic, and data-driven) of the distribution (frequency, pattern) and determinants (causes, risk factors) of health-related states and events (not just diseases) in specified populations (neighborhood, school, city, state, country, global)

ethnicity – Ethnicity can be viewed as the heritage, nationality, lineage, or country of birth of the person or the person's parents or ancestors before arriving in the United States. In 1997, the Office of Management and Budget (OMB) issued the Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. There are two categories for ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino."

evidence-based – evidence-based practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences

gatekeeper training – gatekeeper training generally refers to programs that seek to develop individuals' "...knowledge, attitudes and skills to identify (those) at risk, determine levels of risk, and make referrals when necessary" (Gould et al., 2003)

Get Healthy Utah – a collaborative effort aimed at reducing obesity through improved healthy eating and active living (see http://gethealthyutah.org/)

HealthInsight – a private, nonprofit, community-based organization dedicated to improving health and healthcare, composed of locally governed organizations in four western states: Nevada, New Mexico, Oregon and Utah (see http://healthinsight.org/about-us)

Healthy People [2020] – Healthy People provides science-based, 10-year national objectives for improving the health of all Americans (see https://www.healthypeople.gov/2020/About-Healthy-People)

hepatitis – an inflammation of the liver

Hispanic [or Latino] – a person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race; the term, "Spanish origin," can be used in addition to "Hispanic or Latino" (see https://tinyurl.com/OMB-1997RaceStandards)

House Bill 11 – Overdose Reporting Amendments: this bill provides that a person who reports a person's overdose from a controlled substance or other substance may claim an affirmative defense to specified charges of violating the Utah Controlled Substances Act if the person remains with the person who is subject to the overdose and cooperates with responding medical providers and law enforcement officers; and provides that remaining with a person subject to an overdose and cooperating with medical providers and law enforcement is a mitigating factor when determining the penalty for a related violation of the Utah Controlled Substances Act (see http://le.utah.gov/~2014/bills/static/HB0011.html)

House Bill 28 – Controlled Substance Database: this bill recodifies and amends provisions relating to the Controlled Substance Database and requires an individual, other than a veterinarian, who is licensed to prescribe a controlled substance, who is applying for a license, or who is renewing a license, to register to use the database and to take a tutorial and pass a test relating to the database and the prescribing of a controlled substance (see http://le.utah.gov/~2010/bills/static/HB0028.html)

House Bill 119 – Opiate Overdose Emergency Treatment: this bill defines terms; permits the dispensing and administration of an opiate antagonist to a person who is reasonably believed to be experiencing an opiate-related drug overdose event; establishes immunity for the good faith administration of an opiate antagonist; clarifies that the administration of an opiate antagonist is voluntary and that the act does not establish a duty to administer an opiate antagonist; clarifies that it is not unlawful or unprofessional conduct for certain health professionals to prescribe an opiate antagonist to: a person at increased risk of experiencing an opiate-related drug overdose event or a family member, friend, or other person in a position to assist a person who is at increased risk of experiencing an opiate-related drug overdose; and requires

a person who prescribes or dispenses an opiate antagonist to advise a person to seek a medical evaluation after experiencing a drug overdose and taking an opiate antagonist (see http://le.utah.gov/~2014/bills/static/HB0119.html)

House Bill 137 – Pain Medication Management and Education: this bill modifies Title 26, Chapter 1, Department of Health Organization, establishing a two-year program in the department to reduce deaths and other harm from prescription opiates utilized for chronic pain (see http://le.utah.gov/~2007/bills/static/HB0137.html)

ideation – the capacity for or the act of forming or entertaining ideas

Intermountain Healthcare – a not-for-profit health system based in Salt Lake City, Utah, with 22 hospitals, a broad range of clinics and services, about 1,400 employed primary care and secondary care physicians at more than 185 clinics in the Intermountain Medical Group, and health insurance plans from SelectHealth (see https://intermountainhealthcare.org/about/)

Latino – see listing for Hispanic or Latino

low level offender – an individual who is convicted of, pleads guilty to, or pleads no contest to a misdemeanor or third degree felony

major depressive episodes – a period characterized by the symptoms of major depressive disorder: primarily depressed mood for two weeks or more, and a loss of interest or pleasure in everyday activities, accompanied by other symptoms such as feelings of emptiness, hopelessness, anxiety, worthlessness, guilt and/or irritability, changes in appetite, problems concentrating, remembering details or making decisions, and thoughts of or attempts at suicide; insomnia or hypersomnia, aches, pains, or digestive problems that are resistant to treatment may also be present

Markov Chain Monte Carlo – Markov Chain Monte Carlo (MCMC) simulation is a powerful technique to perform numerical integration; it can be used to numerically estimate complex economometric models

Mental Health First Aid – Mental Health First Aid is an 8-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. (see https://www.mentalhealthfirstaid.org/about/)

morbidity – refers to the state of being diseased or unhealthy within a population

morphine milligram equivalent – a calculation of the total amount of opioids prescribed accounting for differences in drug type and strength

multiple logistic regression – an analysis to predict a categorical outcome on the basis of several continuous or categorical predictors

naloxone – a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone; it blocks opioid receptor sites, reversing the toxic effects of the overdose (see http://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone)

Naloxone Law – see listing for House Bill 119

National Institute on Drug Abuse – The mission of the National Institute on Drug Abuse is to advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health. (see https://www.drugabuse.gov/)

National Survey on Drug Use and Health (NSDUH) – The National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency in the U.S. Department of Health and Human Services (DHHS). (see https://nsduhweb.rti.org/respweb/homepage.cfm)

Native American – see listing for American Indian/Alaska Native

Native Hawaiian/Pacific Islander – see listing for Pacific Islander

non-Hispanic – not Hispanic or Latino (see separate listing)

[UDOH] Office of the Medical Examiner – The Utah Department of Health Office of the Medical Examiner is a statewide system for the investigation of deaths that occur unexpectedly, violently or where the cause of death is unknown (26-4-7 Utah Code – Custody by medical examiner). At the conclusion of the examination, a death certificate is issued certifying the cause and manner of death. The jurisdiction is established by the Utah Medical Examiner's Act. (see https://ome.utah.gov/category/about-us)

[UDOH] Office of Vital Records and Statistics – the Utah Department of Health Office of Vital Records and Statistics administers the statewide system of Vital Records and Statistics by documenting and certifying the facts of births, deaths and family formation for the legal purposes of the citizens of Utah, participates in the national Vital Statistics Systems and responds to the needs of health programs, healthcare providers, businesses, researchers, educational institutions and the Utah public for data and statistical information (see https://vitalrecords.utah.gov/)

opioid – Opioids are medications that relieve pain. They reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes

the effects of a painful stimulus. Medications that fall within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs.

opioid-naïve – a patient was defined as "opioid naive" if they were not dispensed an opioid in the 30 days prior to the initial opioid prescription

osteoarthritis – Osteoarthritis is the most common chronic condition of the joints. It occurs when the cartilage or cushion between joints breaks down leading to pain, stiffness and swelling. (see http://www.arthritis.org/about-arthritis/types/osteoarthritis/)

overdose outreach providers – a law enforcement agency; a fire department; an emergency medical service provider; emergency medical service personnel; an organization providing treatment or recovery services for drug or alcohol use; an organization providing support services for an individual, or a family of an individual, with a substance use disorder; an organization providing substance use or mental health services under contract with a local substance abuse authority, or a local mental health authority; an organization providing services to the homeless; a local health department; or an individual. An overdose outreach provider may obtain an opiate antagonist dispensed on prescription by a healthcare provider or a pharmacist or pharmacy intern; store the opiate antagonist; and furnish the opiate antagonist to an individual who is at increased risk of experiencing an opiate-related drug overdose event or to a family member of, friend of, or other individual who is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; and without liability for any civil damages for acts or omissions made as a result of furnishing the opiate antagonist in good faith.

Pacific Islander [Native Hawaiian or Other Pacific Islander] – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands (see https://tinyurl.com/OMB-1997RaceStandards)

Prevention Needs Assessment (Survey) – the Prevention Needs Assessment (PNA) Survey was designed to measure the need for prevention services among youth in the areas of substance abuse, delinquency, antisocial behavior, and violence (see http://www.bach-harrison.com/BhResources/PnaSurvey.aspx)

psychotherapeutics – pain relievers, tranquilizers, stimulants, and sedatives

QPR – QPR stands for Question, Persuade, and Refer — the three simple steps anyone can learn to help save a life from suicide (see https://qprinstitute.com/about-qpr)

race – The racial categories generally reflect a social definition of race recognized in this country and not an attempt to define race biologically, anthropologically, or genetically. The 1997 Office of Management and Budget (OMB) Standards for the Classification of Federal Data on Race and Ethnicity contain five minimum categories for race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. (see separate listings)

Senate Bill 61 – Education for Prescribing Controlled Substances: this bill requires a prescriber applying for a new or renewed controlled substance license to take four hours of controlled substance prescribing classes each licensing period; requires the Division of Occupations and Professional Licensing, in consultation with the Utah Medical Association and the applicable practitioner licensing boards, to establish educational content of controlled substance prescribing classes to help establish safe and effective practices for prescribing controlled substances, which may include opioid narcotics, hypnotic depressants, and psychostimulants; provides that any controlled substance prescribing class required under this bill does not increase the total continuing professional education requirements for prescriber licensing; and allows the division to establish rules (see http://le.utah.gov/~2011/bills/static/sb0061.html)

Senate Bill 214 – Continuing Education for Prescription Drugs: this bill defines terms; requires certain controlled substance prescribers to complete at least four hours of continuing education as a requisite for license renewal; requires that at least 3.5 hours of the required continuing education hours be completed in controlled substance prescribing classes; establishes criteria for controlled substance prescribing classes recognized by the Division of Occupational and Professional Licensing (DOPL); directs DOPL to consult with other applicable departments and associations when determining whether classes for controlled substance prescribers with a specific license type meet established criteria; grants rulemaking authority to DOPL; and makes technical changes (see http://le.utah.gov/~2013/bills/static/sb0214.html)

sleep apnea – a common disorder in which a person has one or more pauses in breathing or shallow breaths while he or she sleeps

social determinants of health (SDH) – the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life; these forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (see http://www.who.int/social_determinants/en/)

Substance Abuse and Mental Health Services Administration (SAMHSA) – the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation; SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities (see http://www.samhsa.gov/about-us)

Talk to Your Pharmacist Month – a month-long initiative to combat opioid abuse in Utah

Tribal Epidemiology Centers – Indian Health Service, division funded organizations who serve American Indian/ Alaska Native Tribal and urban communities by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities. (see https://www.ihs.gov/epi/tecs/)

U.S. Census Bureau – see listing for Census Bureau

U.S. Centers for Disease Control and Prevention – see listing for Centers for Disease Control and Prevention

Utah Association of Local Health Departments – The mission of the Utah Association of Local Boards of Health is to support and strengthen the role of local health departments by providing leadership in developing a pro-active stance for public health through education, training, and communication among local health board members; to advocate for public health matters before locally elected officials, the Utah State Legislature, and the citizens of the State of Utah; to foster a cooperative forum for an exchange of ideas and the advancement of solutions to common public health concerns, as well as improve communications among the health related organizations and the Utah local boards of health; and to provide a forum for the evaluation of federal, state, and local laws and regulations in terms of their impact on local public health services. (see http://www.ualhd.org/index.html)

Utah Clinical Guidelines on Prescribing Opioids – developed by the Utah Department of Health for primary care and specialty physicians in the state of Utah for guidance on prescribing opioids for both acute and chronic pain (see http://health.utah.gov/prescription/pdf/Utah_guidelines_pdfs.pdf)

Utah Coalition for Opioid Overdose Prevention – The Utah Coalition for Opioid Overdose Prevention (UCOOP) was convened in January 2009 under the former name Utah Pharmaceutical Drug Crime Project (UPDCP) to address the growing problem of prescription drug abuse in Utah. The UCOOP includes private-public multidisciplinary partnerships involving more than 60 experts in the fields of substance abuse prevention and treatment, law enforcement, environmental quality, healthcare, human services and public health. The UCOOP is comprised of an Executive Committee and an Advisory Committee with seven different subcommittees. The mission is to prevent and reduce opioid abuse, misuse, and overdose deaths in Utah through a coordinated response.

Utah Controlled Substance Database – a resource that assists prescribing practitioners and pharmacists in providing efficient care for their patients' and customers' usage of controlled substances (see http://www.dopl.utah.gov/programs/csdb/)

Utah Death Certificate Database – death certificates are filled out for all deaths occurring in Utah

Utah Department of Environmental Quality (DEQ) – DEQ's mission is to safeguard public health and Utahns' quality of life by protecting and enhancing the environment (see https://deq.utah.gov/general/about-deq)

Utah Department of Health Strategic Plan: Healthiest People goals – The first goal of the Utah Department of Health Strategic Plan is that, "The people of Utah will be the healthiest in the country." The three strategies that define this goal are 1) engage public health partners, stakeholders, and the people of Utah to improve our shared understanding of what makes us healthy and to identify statewide priorities for health improvement, 2) promote environments (physical, policy, cultural) that facilitate healthy behaviors, focusing especially on active living and healthy eating, to address the obesity epidemic and associated health outcomes, and 3) focus on the health of women, infants, and young children to assure that Utah children have a healthy start to life. (see page 4 of the Utah Department of Health Strategic Plan 2017–2020, https://health.utah.gov/wp-content/uploads/Strat-Plan-Publish-17_BW.pdf)

Utah Department of Human Services – Utah state agency responsible for assisting with a broad array of human needs. Services are offered to support the safety, well-being, and healthy growth of children, families, and adults (see http://hs.utah.gov/)

Utah Department of Transportation (UDOT) – state agency responsible for improving roads and traffic lights, and providing alternate means of getting from A to B, like bike lanes and public transit (see http://www.udot.utah.gov/)

Utah Division of Occupational and Professional Licensing – The Utah Division of Occupational and Professional Licensing, also known as DOPL, is one of seven agencies within the Utah Department of Commerce. DOPL is legislatively charged to administer and enforce specific laws related to the licensing and regulation of certain occupations and professions. (see https://dopl.utah.gov/info.html)

Utah Division of Substance Abuse and Mental Health (DSAMH) – oversees the publicly funded prevention and treatment system (see http://dsamh.utah.gov/about/)

Utah Indian Health Advisory Board (UIHAB) – according to the bylaws, the mission statement of the UIHAB is, "Through its advisory function, the UIHAB shall assist Tribal, Urban and Indian Health Services (IHS) representatives to carry out a meaningful process through consultation to include, but not limited to, identifying recommendations in addressing AI/AN health policies, issues and concerns. UIHAB's priority is to maintain a positive, working relationship between health programs, organizations, IHS, state and other state agencies" (see http://health.utah.gov/indianh/uihab.html)

Utah Notification and Information System – a secure communication system that exchanges information within and between agencies and disciplines throughout the State of Utah. UNIS utilizes multiple formats to deliver notifica-

tions which include email, phone, fax, pager, and text messaging. (see https://unis.utah.gov/)

Utah State Innovation Model – The State Innovation Models (SIM) initiative provides funding to assist in planning, designing, testing, and supporting evaluation of new health payment and service delivery models. The goal is to create multi-payer models with a broad mission to raise community health status and reduce long term health risks for all insured beneficiaries with special emphasis on Medicare, Medicaid, and the Children's Health Insurance Program.

Utah State Office of Education (USOE) – the state-level bureaucracy that helps the State Board of Education fulfill its constitutional duties to supervise Utah's public education system (see http://www.schools.utah.gov/main/)

Utah Suicide Prevention Coalition – a partnership of community members, suicide survivors, service providers, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah (see http://utahsuicideprevention.org/)

Utah Violent Death Reporting System (UTVDRS) – a surveillance system that collects detailed facts from different sources about the same incident; this information is collected from death certificates, medical examiner records, police reports, crime lab records, and supplemental homicide reports (see http://www.health.utah.gov/vipp/topics/nvdrs/)

Utah's Statewide Standing Order – as authorized by State law, this standing order is intended to increase access to naloxone for those who might be at risk of an overdose or who might be in a position to assist somebody at risk of an overdose (see https://dopl.utah.gov/docs/NaloxoneStandingOrder.pdf)

Violence and Injury Prevention Program – the mission of the Utah Department of Health Violence and Injury Prevention Program is to be "a trusted and comprehensive resource for data and technical assistance related to violence and injury" (see http://health.utah.gov/vipp/)

wellness programs – a program intended to improve and promote health and fitness that's usually offered through the workplace, although insurance plans can offer them directly to their enrollees

White – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa (see https://tinyurl.com/OMB-1997RaceStandards)

Working Minds – program that helps workplaces appreciate the critical need for suicide prevention while creating a forum for dialogue and critical thinking about workplace mental health challenges (see https://utahsuicideprevention.org/education-training/item/27-working-minds-training)

Worksite Elevated – worksites with scores improved 30% or more from prior year's scores on UHIP-O Assessment of Environmental Support and/or Promotion

Youth Risk Behavior Survey – The Youth Risk Behavior Surveillance System (YRBSS) monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including behaviors that contribute to unintentional injuries and violence; sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity. The YRBSS also measures the prevalence of obesity and asthma and other priority health-related behaviors plus sexual identity and sex of sexual contacts. (see http://www.cdc.gov/healthyyouth/data/yrbs/index.htm)

Zero Suicide – the Zero Suicide Initiative is a commitment to suicide prevention in health and behavioral healthcare systems (see https://zerosuicide.sprc.org/)

Healthy People 2020 Objectives Referenced in Report

Mental Health and Mental Disorders

MHMD-1 – Reduce the suicide rate

MHMD-4.2 – Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs)

MHMD-9 – Increase the proportion of adults with mental health disorders who receive treatment

MHMD-9.1 – Increase the proportion of adults aged 18 years and older with serious mental illness (SMI) who receive treatment

MHMD-9.2 – Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment

Nutrition and Weight Status

NWS-9 – Reduce the proportion of adults who are obese

NWS-10 – Reduce the proportion of children and adolescents who are considered obese

NWS-10.2 – Reduce the proportion of children aged 6 to 11 years who are considered obese

NWS-10.3 – Reduce the proportion of adolescents aged 12 to 19 years who are considered obese

NWS-12 – Eliminate very low food security among children

NWS-13 – Reduce household food insecurity and in doing so reduce hunger

Substance Abuse

SA-13.3 – Reduce the proportion of adults reporting use of any illicit drug during the past 30 days

SA-14.3 – Reduce the proportion of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older

SA-15 – Reduce the proportion of adults who drank excessively in the previous 30 days

SA-19.1 – Reduce the past-year nonmedical use of pain relievers

Reducing Obesity and Obesity-related Chronic Conditions

Obesity—Adults

The UDOH EPICC Program
http://www.choosehealth.utah.gov

Utah Worksite Wellness Council
http://utahworksitewellness.org

Making the Healthy Choice the Easy Choice, The Utah Nutrition and Physical Activity Plan 2010–2020
http://choosehealth.utah.gov/documents/pdfs/U-PAN_State_Plan.pdf

The National Center for Chronic Disease Prevention and Health Promotion
https://www.cdc.gov/obesity/index.html

National Heart, Lung, and Blood Institute (NHLBI) Obesity Education Initiative
https://www.nhlbi.nih.gov/about/org/oei

The State of Obesity: Better Policies for a Healthier America
http://healthyamericans.org/report/115/

The Surgeon General's Call to Action to Prevent and Decrease Overweight & Obesity
https://www.surgeongeneral.gov/library/calls/

Information on the BRFSS may be found at
http://www.cdc.gov/brfss/

Trust for America's Health
http://healthyamericans.org/reports/stateofobesity2017

Obesity—Minor

Action for Healthy Kids Program
http://www.actionforhealthykids.org/

Utah Department of Health
http://www.choosehealth.utah.gov/

Reducing Prescription Drug Misuse, Abuse, and Overdose

Prescription Drug Deaths

Use Only As Directed media campaign
http://www.useonlyasdirected.org

Utah Poison Control Center
http://poisoncontrol.utah.edu

National Institutes of Health: National Institute on Drug Abuse
http://drugabuse.gov

Utah Division of Substance Abuse and Mental Health Utah Department of Human Services
https://dsamh.utah.gov/

Partnership for a Drug-Free America
http://www.drugfree.org

Office of National Drug Control Policy
http://www.whitehouse.gov/ondcp

UDOH Naloxone
http://naloxone.utah.gov/

UDOH Violence and Injury Prevention Program
http://www.health.utah.gov/vipp/topics/prescription-drug-overdoses/

Information on addiction resources and tools
https://www.drugrehab.com/addiction/prescriptions/

Illicit Substance Use/Disorder

NATIONAL:
The U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Drug and Treatment Referral Routing Service provides a toll-free telephone number for alcohol and drug information/treatment referral assistance. The number is 1-800-662-HELP (4357).

UTAH:
Edward G. Callister Foundation, Referral and Information Services: (801) 587-HOPE (4673) or toll free (866) 633-HOPE. The service is designed to provide referral and educational resources with respect to substance abuse.

Mental health and substance abuse services in Utah are also provided through community mental health and substance abuse programs and the Utah State Hospital. One responsibility of the Utah Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH) is to ensure that prevention/treatment services for substance abuse and mental health are available throughout the state. The DSAMH oversees the local community mental health centers and the Utah State Hospital in Provo.

Utah Department of Human Services
Division of Substance Abuse and Mental Health
195 North 1950 West
Salt Lake City, Utah 84116
Phone: 801-538-3939
Fax: 801-538-9892
https://dsamh.utah.gov/

More information on drug abuse dangers, treatment, and information sheets on abused drugs is available at http://www.nida.nih.gov/NIDAHome.html.

Improving Mental Health and Reducing Suicide

Mental Health Status

The Utah Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) is the state agency responsible for ensuring that mental health services are available statewide. The DSAMH also acts as a resource by providing general information, research results, and statistics to the public regarding substances of abuse and mental health services. The DSAMH contracts with Community Mental Health Centers (CMHC) to provide these services and monitors these centers through site visits, a year-end review process, and a peer review process.

Address:
Department of Human Services
Division of Substance Abuse and Mental Health
195 North 1950 West
Salt Lake City, Utah 84116
Phone: 801-538-3939
Fax: 801-538-9892
https://dsamh.utah.gov/

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.samhsa.gov/

National Institute of Mental Health
http://www.nimh.nih.gov/

Mental Health: A Report of the Surgeon General
http://www.surgeongeneral.gov/library/mentalhealth/home.html

More information on the BRFSS may be found at http://www.cdc.gov/brfss/

Local mental health centers
http://dsamh.utah.gov/mental-health/#box1

Utah Psychological Association
https://utpsych.org/directory/

Depression

The Utah Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) is the state agency responsible for ensuring that mental health services are available statewide. The DSAMH also acts as a resource by providing general information, research results, and statistics to the public regarding substances of abuse and mental health services. The DSAMH contracts with Community Mental Health Centers (CMHC) to provide these services and monitors these centers through site visits, a year-end review process, and a peer review process.

Address:
Department of Human Services
Division of Substance Abuse and Mental Health
195 North 1950 West
Salt Lake City, Utah 84116
Phone: 801-538-3939
Fax: 801-538-9892
https://dsamh.utah.gov/

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/

National Institute of Mental Health
http://www.nimh.nih.gov/

Suicide

All counties, 24 hours:
National Suicide Prevention Lifeline (800) 273-TALK (8255)

Mobile Crisis Outreach Team—Salt Lake County
801-587-3000

Man Therapy
http://mantherapy.org/

QPR courses
http://www.qprinstitute.com/

National Alliance on Mental Illness (NAMI) Utah
http://www.namiut.org/
801-323-9900
Toll Free 877-230-6264

Utah Suicide & Crisis Hotline
http://www.suicide.org/hotlines/utah-suicide-hotlines.html

The SafeUT Crisis Text and Tip Line is a statewide service that provides real-time crisis intervention to youth through texting and a confidential tip program – right from your smartphone. Licensed clinicians from the University Neuropsychiatric Institute's 24/7 CrisisLine call center respond to all incoming chats, texts, and calls by providing: supportive or crisis counseling, suicide prevention, and referral services. We can help anyone with emotional crises, bullying, relationship problems, mental health, or suicide related issues. The SafeUT app can be downloaded here: https://healthcare.utah.edu/uni/programs/safe-ut-smartphone-app/

Permission to Grieve: For Survivors of a Loved One's Suicide
http://health.utah.gov/vipp/pdf/Suicide/grievebooklet_final0605.pdf

Utah Suicide Prevention Coalition
http://utahsuicideprevention.org/

American Foundation for Suicide Prevention:
https://www.afsp.org/

The Utah Violent Death Reporting System links data from multiple sources to help identify risk factors and understand circumstances in violent deaths, including suicides.
http://www.health.utah.gov/vipp/topics/nvdrs/

Utah Violence and Injury Prevention Plan
http://www.health.utah.gov/vipp/pdf/Combined%20plan_Draft.pdf

Suicide Prevention Resource Center
http://www.sprc.org/states/utah

CDC Suicide Fact Sheets
http://www.cdc.gov/ViolencePrevention/suicide/

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/prevention/suicide.aspx

Collaboration

Respect

Local Health District Summary Tables

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Table 15. Bear River Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	27.7%	29.8%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	8.3%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	8.4	10.1	✓	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	17.2%	16.3%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	19.2%	19.4%	≈	21.0%	N/A
Suicide, 2013–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	17.5	18.7	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 16. Central Utah Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	27.0%	27.4%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	9.9%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	10.3	12.2	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	13.4%	13.5%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	19.3%	19.9%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	29.3	31.3	!	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 17. Davis County Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	26.0%	26.5%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	8.0%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	10.9	11.6	✓	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	16.2%	15.6%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	22.1%	21.7%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	14.3	15.3	✓	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 18. Salt Lake County Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	24.7%	25.1%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	11.0%	–	!	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	15.1	15.1	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	16.6%	16.3%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	22.0%	21.9%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	21.4	22.4	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 19. San Juan Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	32.1%	31.3%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	12.1%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	**	**	–	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	17.8%	20.0%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	14.5%	14.8%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	16.7*	19.4*	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.
**Data are suppressed when the data meet the criteria for confidentiality constraints. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality.

Table 20. Southeast Utah Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	28.8%	28.2%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	9.4%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	28.9	29.9	!	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	17.1%	17.9%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	21.5%	21.1%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	32.2	33.4	!	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 21. Southwest Utah Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	21.4%	23.0%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	10.0%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	13.0	15.1	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	15.0%	15.7%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	18.4%	19.1%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	22.1	24.4	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 22. Summit County Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	12.9%	14.1%	✓	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	5.4%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	*	*	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	13.1%	13.1%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	16.7%	17.1%	✓	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	16.8	15.6	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
* Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable.

Table 23. Tooele County Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	28.5%	28.7%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	10.8%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	16.4	16.8	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	19.7%	19.7%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	24.0%	23.8%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	22.7	25.2	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 24. TriCounty Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	34.2%	33.4%	!	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	6.7%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	15.9	18.2	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	16.8%	16.2%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	18.5%	18.2%	✓	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	31.3	34.8	!	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 25. Utah County Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	22.6%	25.8%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	8.8%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	12.1	14.2	≈	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	17.8%	15.7%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	20.8%	20.6%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	14.4	16.4	✓	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 26. Wasatch County Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	21.5%	22.5%	≈	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	6.8%	–	✓	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	**	**	–	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	11.0%	11.2%	≈	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	17.1%	17.0%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	19.4	19.9	≈	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
** Data are suppressed when the data meet the criteria for confidentiality constraints. More information: http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality.

Table 27. Weber-Morgan Summary

✓ The community is performing BETTER than the state, and the difference is statistically significant.
≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.
! The community is performing WORSE than the state, and the difference is statistically significant.

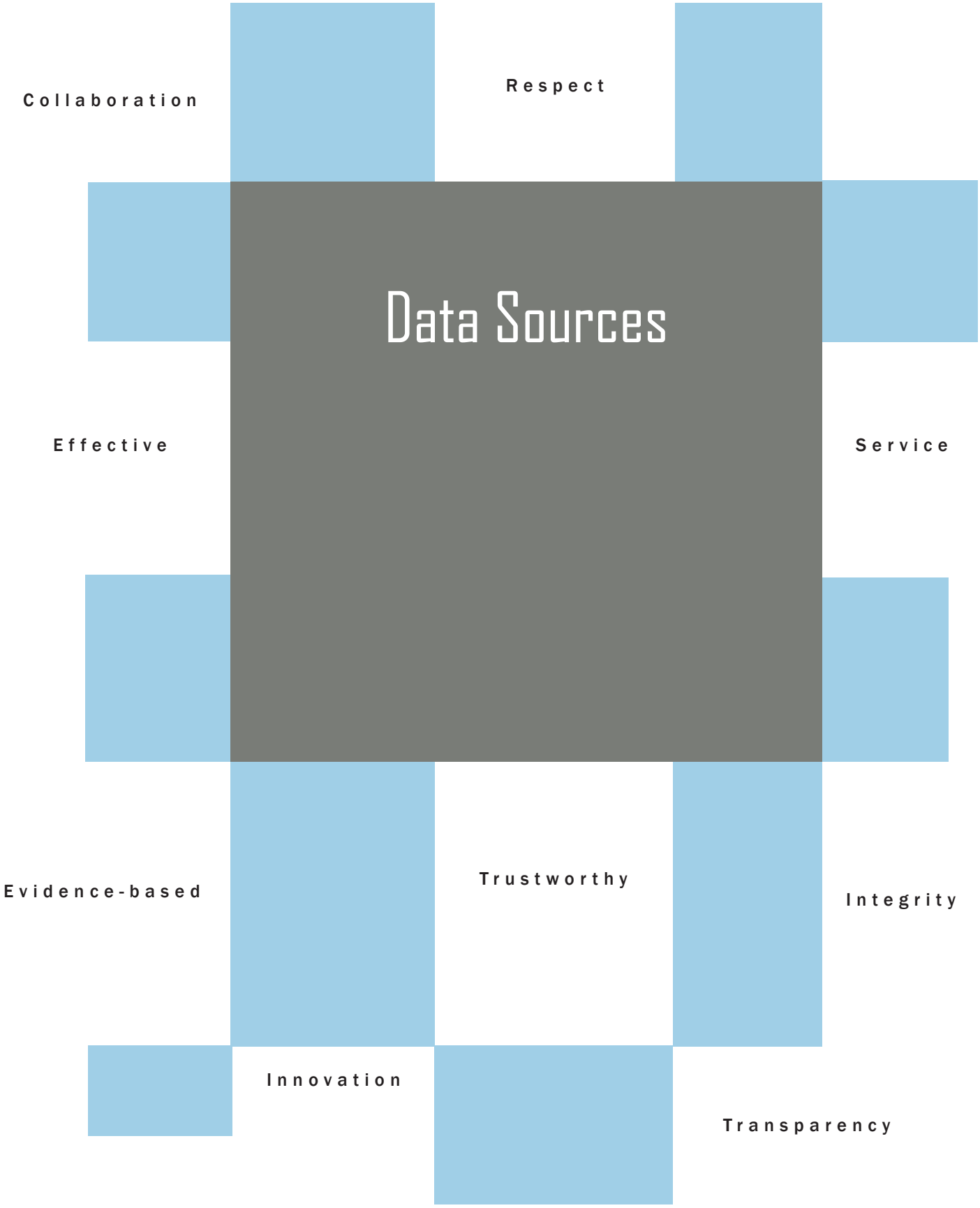
	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS						
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	34.1%	33.8%	!	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	8.8%	–	≈	9.5%	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE						
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	18.4	19.7	!	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	N/A	N/A	N/A	4.9%	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	N/A	N/A	N/A	7.4%	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	N/A	N/A	N/A	2.7%	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE						
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	21.5%	21.5%	!	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	22.7%	22.6%	≈	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	23.9	24.9	!	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.

Table 28. State of Utah Summary

	Page	Community Data		U.S.
		Crude (burden) Rate	Age-adjusted (comparison) Rate	
REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS				
Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)	20	25.4%	26.2%	29.6%
Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)	21	9.5%	–	N/A
REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE				
Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	29	13.7	14.7	10.4
Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)	31	4.9%	–	4.5%
Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	31	7.4%	–	10.4%
Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	31	2.7%	–	2.8%
IMPROVING MENTAL HEALTH and REDUCING SUICIDE				
Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)	41	17.1%	16.5%	17.2%
Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)	43	21.0%	21.0%	N/A
Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	46	19.8	21.2	13.3

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.


Collaboration
Respect
Data Sources
Effective
Service
Evidence-based
Trustworthy
Integrity
Innovation
Transparency

Reducing Obesity and Obesity-related Chronic Conditions

Obesity—Adults (Figures 7 and 8, Tables 1 and 15–28, and Map 3)

National and State Estimates: 2016 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2016 Raked Weights

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah BRFSS. Retrieved on 1/11/2018 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

This output is based on BRFSS data collected through both landline and cellular phones and utilizes an improved weighting methodology. For more information about this methodology visit https://ibis.health.utah.gov/pdf/opha/resource/brfss/RakingImpact2011.pdf.

Denominator includes all survey respondents aged 18 years and older except those with 'missing', 'don't know', and 'refused' answers. If the query was limited to a particular sub-population-group, only those respondents are included in the denominator.

Age-adjusted rates are based on five age groups: 18–24, 25–34, 35–44, 45–54, and 65+ except for estimates by race. Age-adjusted rates for race estimates are based on three age groups: 18–34, 35–49, and 50+.

When there are no observations for one or more of the age categories used for age adjustment, the response categories may not sum to 100%.

The confidence bounds are asymmetric.

Obesity is defined as a body mass index (BMI) of 30 or more. BMI is calculated by dividing weight in kilograms by the square of height in meters. Calculations are done based on the answers to the following questions: "About how much do you weigh without shoes? About how tall are you without shoes?"

Respondents tend to overestimate their height and underestimate their weight leading to underestimation of BMI and the prevalence of obesity.

Obesity—Minor (Figure 9, Tables 2 and 15–28, and Map 4)

National and State Estimates: Laura Kann, PhD, Tim McManus, MS, William A. Harris, MM, et al. Youth Risk Behavior Surveillance — United States, 2015. MMWR Surveill Summ 2016;65(No. SS-6):163–165.

Estimates for Grade, Gender, and Trend: Utah Youth Risk Behavior Survey (YRBS). Retrieved on 1/24/2018 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

The YRBS survey is performed only in odd-numbered years.

YRBS BMI data should be used with caution since individual height and weight are self-reported.

Data are self-reported and subject to recall bias. Data are from a sample survey and subject to selection bias. Comparisons of annual rates must be interpreted cautiously as methods used to collect YRBS data may vary from year to year. With the introduction of active parental consent for Utah school surveys between 1997 and 1999, the student response rate for the YRBS decreased significantly.

Childhood obesity is determined by calculating BMI using the height, weight, age, and sex of the child. The child is considered to be obese if the resulting BMI is greater than or equal to the 95th percentile for age and sex based on the Centers for Disease Control and Prevention (CDC) Growth Charts (2 to 20 years: Boys Body Mass index-for-age percentiles and 2 to 20 years: Girls Body Mass index-for-age percentiles).

Estimates for Race/Ethnicity, and Local Health District: 2017 Prevention Needs Assessment (PNA) Survey

Based on the PNA Survey, Form B.

The PNA is conducted in odd years with Utah students in grades 6, 8, 10, and 12. Data in this report are only for students in grades 8, 10, and 12.

Childhood obesity is determined by calculating BMI using the height, weight, age, and sex of the child. The child is considered to be obese if the resulting BMI is greater than or equal to the 95th percentile for age and sex based on the CDC Growth Charts (2 to 20 years: Boys Body Mass index-for-age percentiles and 2 to 20 years: Girls Body Mass index-for-age percentiles).

Reducing Prescription Drug Misuse, Abuse, and Overdose

Drug Overdose Deaths Involving Opioids per 100,000 by Year, Utah, 1999–2016 (Figure 10)

Annual Estimates: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Multiple Cause of Death 1999–2016 on CDC WONDER Online Database, released December,

2017. Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Jan 11, 2018.

The populations used to calculate standard age-adjusted rates are documented at http://wonder.cdc.gov/wonder/help/mcd.html#2000 Standard Population.

The method used to calculate age-adjusted rates is documented at http://wonder.cdc.gov/wonder/help/mcd.html#Age-Adjusted Rates.

The population figures for year 2016 are bridged-race estimates of the July 1 resident population, from the Vintage 2016 postcensal series released by NCHS on June 26, 2017. The population figures for year 2015 are bridged-race estimates of the July 1 resident population, from the Vintage 2015 postcensal series released by NCHS on June 28, 2016. The population figures for year 2014 are bridged-race estimates of the July 1 resident population, from the Vintage 2014 postcensal series released by NCHS on June 30, 2015. The population figures for year 2013 are bridged-race estimates of the July 1 resident population, from the Vintage 2013 postcensal series released by NCHS on June 26, 2014. The population figures for year 2012 are bridged-race estimates of the July 1 resident population, from the Vintage 2012 postcensal series released by NCHS on June 13, 2013. Population figures for 2011 are bridged-race estimates of the July 1 resident population, from the county-level postcensal Vintage 2011 series released by NCHS on July 18, 2012. Population figures for 2010 are April 1 Census counts. The population figures for years 2001–2009, are bridged-race estimates of the July 1 resident population, from the revised intercensal county-level 2000–2009 series released by NCHS on October 26, 2012. Population figures for 2000 are April 1 Census counts. Population figures for 1999 are from the 1990–1999 intercensal series of July 1 estimates.

Changes to cause of death classification affect reporting trends. For more information visit http://wonder.cdc.gov/wonder/help/mcd.html#ICD-10 Changes.

Deaths with underlying cause of X40–X44, X60–X64, X85, and Y10–Y14 and contributory cause of T40.0, T40.1, T40.2, T40.3, T40.4, T40.6.

Unintentional and Undetermined Opioid Overdose Deaths by Drug Type, Ages 18+, Utah, 2000–2016 (Figure 12)

Annual Estimates: Utah Office of the Medical Examiner

Prescribing Practices in Utah, 2014 and 2015 (Table 3)

Utah Estimates: Utah Controlled Substance Database

Unintentional and Undetermined Opioid Overdose Deaths (Figures 11 and 13, Tables 4–5 and 15–28, and Map 5)

National, State, Age, Gender, Race, Ethnicity, Local Health District, and Trend Estimates): CDC, NCHS. Multiple Cause of Death 1999–2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Mar 13, 2018.

Data are suppressed when the data meet the criteria for confidentiality constraints. More information at http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality.

Death rates are flagged as unreliable when the rate is calculated with a numerator of 20 or less. More information at http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable.

The populations used to calculate standard age-adjusted rates are documented at http://wonder.cdc.gov/wonder/help/mcd.html#2000 Standard Population.

The method used to calculate age-adjusted rates is documented at http://wonder.cdc.gov/wonder/help/mcd.html#Age-Adjusted Rates.

Deaths of persons with age "Not Stated" are included in "All" counts and rates, but are not distributed among age groups, so are not included in age-specific counts, age-specific rates or in any age-adjusted rates. More information at http://wonder.cdc.gov/wonder/help/mcd.html#Not Stated.

Deaths of persons with Hispanic origin "Not Stated" are included in "All" counts and rates, but are not distributed among Hispanic origin groups, so are not included in the Hispanic origin specific counts and rates. More information at http://wonder.cdc.gov/wonder/help/mcd.html#Not Stated.

Information included on the death certificate about the race and Hispanic ethnicity of the decedent is reported

by the funeral director as provided by an informant, often the surviving next of kin, or, in the absence of an informant, on the basis of observation. Race and ethnicity information from the census is by self-report. To the extent that race and Hispanic origin are inconsistent between these two data sources, death rates will be biased. More information at http://wonder.cdc.gov/wonder/help/mcd.html#Racial Differences.

The method used to calculate 95% confidence intervals is documented at http://wonder.cdc.gov/wonder/help/mcd.html#Confidence-Intervals.

The population figures for year 2016 are bridged-race estimates of the July 1 resident population, from the Vintage 2016 postcensal series released by NCHS on June 26, 2017. The population figures for year 2015 are bridged-race estimates of the July 1 resident population, from the Vintage 2015 postcensal series released by NCHS on June 28, 2016. The population figures for year 2014 are bridged-race estimates of the July 1 resident population, from the Vintage 2014 postcensal series released by NCHS on June 30, 2015. The population figures for year 2013 are bridged-race estimates of the July 1 resident population, from the Vintage 2013 postcensal series released by NCHS on June 26, 2014. The population figures for year 2012 are bridged-race estimates of the July 1 resident population, from the Vintage 2012 postcensal series released by NCHS on June 13, 2013. Population figures for 2011 are bridged-race estimates of the July 1 resident population, from the county-level postcensal Vintage 2011 series released by NCHS on July 18, 2012. Population figures for 2010 are April 1 Census counts. The population figures for years 2001–2009, are bridged-race estimates of the July 1 resident population, from the revised intercensal county-level 2000–2009 series released by NCHS on October 26, 2012. Population figures for 2000 are April 1 Census counts. Population figures for 1999 are from the 1990–1999 intercensal series of July 1 estimates. Population figures for infant age groups are the number of live births.

Rates and population figures for years 2001–2009 differ slightly from previously published reports, due to use of the population estimates which were available at the time of release.

The population figures used in the calculation of death rates for the age group 'under 1 year' are the estimates of the resident population that is under one year of age. More information at http://wonder.cdc.gov/wonder/help/mcd.html#Age Group.

Changes to cause of death classification affect reporting trends. More information at http://wonder.cdc.gov/wonder/help/mcd.html#ICD-10 Changes.

MCD - ICD-10 Codes: X40 (Accidental poisonings by and exposure to nonopioid analgesics, antipyretics and antirheumatics), X41 (Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified), X42 (Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified), X43 (Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system), X44 (Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances), Y10 (Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent), Y11 (Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent), Y12 (Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent), Y13 (Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent), Y14 (Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent) AND MCD - ICD-10 Codes: T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Other synthetic narcotics), T40.6 (Other and unspecified narcotics).

UCD - Injury Intent: Unintentional, Undetermined

UCD - Injury Mechanism & All Other Leading Causes: Poisoning

Pain Reliever Misuse (Tables 6 and 15–28)

National, State, and Age Estimates: 2015–2016 National Survey on Drug Use and Health (NSDUH): Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 11. Pain Reliever Misuse in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2015 and 2016 NSDUHs. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, NSDUH, 2015 and 2016. Accessed 1/11/2018 from https://www.samhsa.gov/data/sites/default/files/NSDUHsaeExcelTabs2016/NSDUHsaeExcelTabs2016.xlsx.

Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Prescription psychotherapeutic subtypes were revised in 2016; one effect was the comparability of codeine products between 2015 and 2016.

State estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the total U.S. estimate, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

For 2015, a number of changes were made to the NSDUH questionnaire and data collection procedures. These changes were intended to improve the quality of the data collected and to address current substance use and mental health policy and research needs. Because of these changes, these estimates are not comparable with estimates from prior years. For a detailed report of the questionnaire redesign, see https://www.samhsa.gov/data/sites/default/files/NSDUH-TrendBreak-2015.pdf.

Illicit Drug Use (Tables 7 and 15–28)

National, State, and Age Estimates: 2015–2016 NSDUH: Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 1. Illicit Drug Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2015 and 2016 NSDUHs. SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH. Accessed 1/11/2018 from https://www.samhsa.gov/data/sites/default/files/NSDUHsaeExcelTabs2016/NSDUHsaeExcelTabs2016.xlsx.

Illicit drug use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

State estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the total U.S. estimate, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

For 2015, a number of changes were made to the NSDUH questionnaire and data collection procedures. These changes were intended to improve the quality of the data collected and to address current substance use and mental health policy and research needs. Because of these changes, these estimates are not comparable with estimates from prior years. For a detailed report of the questionnaire redesign, see https://www.samhsa.gov/data/sites/default/files/NSDUH-TrendBreak-2015.pdf.

Illicit Drug Use Disorder (Table 8 and 15–28)

National, State, and Age Estimates: 2015–2016 NSDUH: Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 19. Illicit Drug Use Disorder in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2015 and 2016 NSDUHs. SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH. Accessed 1/11/2018 from https://www.samhsa.gov/data/sites/default/files/NSDUHsaeExcelTabs2016/NSDUHsaeExcelTabs2016.xlsx.

Illicit drug use disorder is defined as meeting criteria for illicit drug dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Illicit drug use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

State estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the total U.S. estimate, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

For 2015, a number of changes were made to the NSDUH questionnaire and data collection procedures. These changes were intended to improve the quality of the data collected and to address current substance use and mental health policy and research needs. Because of these changes, these estimates are not comparable

with estimates from prior years. For a detailed report of the questionnaire redesign, see https://www.samhsa.gov/data/sites/default/files/NSDUH-TrendBreak-2015.pdf.

Marijuana Use in Past Month, Utah Students in Grades 8, 10, and 12, 2017 (Figure 14)

Local Health District Estimates: Utah Prevention Needs Assessment (PNA) Survey

Based on the PNA Survey, Form B.

The PNA is conducted in odd years with Utah students in grades 6, 8, 10, and 12. Data in this report are only for students in grades 8, 10, and 12.

Question text: On how many occasions (if any) have you used marijuana (grass, pot) or hashish (hash, hash oil) during the past 30 days?

Improving Mental Health and Reducing Suicide

Mental Health Status (Figures 18 and 19, Tables 9–10 and 15–28, and Map 6)

National and State Estimates: 2016 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2016 Raked Weights

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah BRFSS. Retrieved on 1/11/2018 from Utah Department of Health (UDOH), Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

As with all surveys, some error results from non-response (e.g., refusal to participate in the survey or to answer specific questions), and measurement (e.g., social desirability or recall bias). Error was minimized by use of strict calling protocols, good questionnaire design, standardization of interviewer behavior, interviewer training, and frequent, on-site interviewer monitoring and supervision.

This output is based on BRFSS data collected through both landline and cellular phones and utilizes an improved weighting methodology. For more information about this methodology visit https://ibis.health.utah.gov/pdf/opha/resource/brfss/RakingImpact2011.pdf.

Denominator includes all survey respondents aged 18 years and older except those with 'missing', 'don't know', and 'refused' answers. If the query was limited to a particular sub-population-group, only those respondents are included in the denominator.

Age-adjusted rates are based on five age groups: 18–24, 25–34, 35–44, 45–54, and 65+ except for estimates by race. Age-adjusted rates for race estimates are based on three age groups: 18–34, 35–49, and 50+.

When there are no observations for one or more of the age categories used for age adjustment, the response categories may not sum to 100%.

The confidence bounds are asymmetric.

Question Text: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?"

Depression (Figure 20, Tables 11–12 and 15–28, and Map 7)

National and State Estimates: 2016 BRFSS; U.S. 2016 Raked Weights

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, Trend, and LHD Summary Table: Utah BRFSS. Retrieved on 1/11/2018 from UDOH, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

As with all surveys, some error results from non-response (e.g., refusal to participate in the survey or to answer specific questions), and measurement (e.g., social desirability or recall bias). Error was minimized by use of strict calling protocols, good questionnaire design, standardization of interviewer behavior, interviewer training, and frequent, on-site interviewer monitoring and supervision.

This output is based on BRFSS data collected through both landline and cellular phones and utilizes an improved weighting methodology. For more information about this methodology visit https://ibis.health.utah.gov/pdf/opha/resource/brfss/RakingImpact2011.pdf.

Denominator includes all survey respondents aged 18 years and older except those with 'missing', 'don't know', and 'refused' answers. If the query was limited to a particular sub-population-group, only those respondents are included in the denominator.

Age-adjusted rates are based on five age groups: 18–24, 25–34, 35–44, 45–54, and 65+ except for estimates by race. Age-adjusted rates for race estimates are based on three age groups: 18–34, 35–49, and 50+.

When there are no observations for one or more of the age categories used for age adjustment, the response categories may not sum to 100%.

The confidence bounds are asymmetric.

The question asks about lifetime diagnosis and does not reflect current major depression. Question Text: "Has a doctor, nurse, or other health professional EVER told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Rate of Suicides per 100,000 Population, Ages 10+ by Year, Utah and U.S., 1999–2016 (Figure 21)

Utah Estimates: Utah Death Certificate Database. Retrieved on 2/12/2018 from UDOH, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

Population estimates provided by the National Center for Health Statistics (NCHS) through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2016.

Suicides are determined using ICD-10 codes X60–X84, Y87.0, *U03, which is consistent with the External Cause of Injury Mortality Matrix for ICD-10 found on the NCHS website at http://www.cdc.gov/nchs/data/ice/icd10_transcode.pdf.

ICD stands for the International Classification of Diseases. It is a coding system maintained by the World Health Organization and the NCHS used to classify causes of death on death certificates. These codes are updated every decade or so to account for advances in medical technology. The U.S. is currently using the 10th revision (ICD-10) to code causes of death.

Death certificates in Utah are required to be filed by funeral directors. Funeral directors obtain demographic information from an informant or a close family member of the decedent. The cause of death is certified by the decedent's physician or the physician that attended the death. Accidental and suspicious deaths are certified by the Medical Examiner. Death certificate data go through extensive edits for completeness and consistency. The Office of Vital Records and Statistics (OVRS) does annual trainings for funeral directors and local registrars.

When death certificates are received, the cause of death literals are keyed into software locally by OVRS, then shipped to NCHS where they are machine coded into ICD-10 codes. NCHS returns the ICD-10 codes to OVRS where the death records are updated. On August 13, 2013, the 2010 and 2011 cause of death data have been updated using the NCHS Revised Causes of Death Mortality data set.

Crude rates.

For rates where the count is zero, a numerator of "3" was used to calculate the confidence interval (per Lillienfeld and Stolley, Foundations of Epidemiology, 1994).

National Estimates: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. Retrieved on 1/19/2018 from the Centers for Disease Control and Prevention (CDC) WISQARS website https://webappa.cdc.gov/sasweb/ncipc/mortrate.html.

Suicides are determined using ICD-10 codes X60–X84, Y87.0, *U03, which is consistent with the External Cause of Injury Mortality Matrix for ICD-10 found on the NCHS website at http://www.cdc.gov/nchs/data/ice/icd10_transcode.pdf.

Suicide (Figures 22 and 23, Tables 13–14 and 15–28, and Map 8)

National and Other State Estimates: CDC, NCHS. Compressed Mortality File 1999–2016 on CDC WONDER Online Database, released December 2017. Data are from the Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/cmf-icd10.html.

Population figures for states are bridged-race postcensal estimates of the July 1 resident population, from the Vintage 2016 series released by NCHS on June 26, 2017.

The populations used to calculate standard age-adjusted rates are documented at http://wonder.cdc.gov/wonder/help/cmf.html#2000 Standard Population.

The method used to calculate age-adjusted rates is documented at http://wonder.cdc.gov/wonder/help/cmf.html#Age-Adjusted Rates.

Deaths for persons of unknown age are included in counts and crude rates, but are not included in age-adjusted rates.

The method used to calculate 95% confidence intervals is documented at http://wonder.cdc.gov/wonder/help/cmf.html#Confidence-Intervals.

Estimates for State of Utah, Age, Gender, Race, Ethnicity, Local Health District, Trend, and Age by Sex: Utah Death Certificate Database. Retrieved on 2/12/2018 from UDOH, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

Population estimates provided by the NCHS through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2016.

Suicides are determined using ICD-10 codes X60–X84, Y87.0, *U03, which is consistent with the External Cause of Injury Mortality Matrix for ICD-10 found on the NCHS website at http://www.cdc.gov/nchs/data/ice/icd10_transcode.pdf.

ICD stands for the International Classification of Diseases. It is a coding system maintained by the World Health Organization and the NCHS used to classify causes of death on death certificates. These codes are updated every decade or so to account for advances in medical technology. The U.S. is currently using the 10th revision (ICD-10) to code causes of death.

Death certificates in Utah are required to be filed by funeral directors. Funeral directors obtain demographic information from an informant or a close family member of the decedent. The cause of death is certified by the decedent's physician or the physician that attended the death. Accidental and suspicious deaths are certified by the Medical Examiner. Death certificate data go through extensive edits for completeness and consistency. The OVRS does annual trainings for funeral directors and local registrars.

When death certificates are received, the cause of death literals are keyed into software locally by OVRS, then shipped to NCHS where they are machine coded into ICD-10 codes. NCHS returns the ICD-10 codes to OVRS where the death records are updated. On August 13, 2013, the 2010 and 2011 cause of death data have been updated using the NCHS Revised Causes of Death Mortality data set.

Age-adjusted rates are based on 11 age groups (0, 1–4, 5–14, 15–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, 85+). Age-adjusted rates for race and ethnicity estimates are based on three age groups: 0–44, 45–64, and 65+. Rates are age-adjusted to the 2000 U.S. standard population.

For rates where the count is zero, a numerator of "3" was used to calculate the confidence interval (per Lillienfeld and Stolley, Foundations of Epidemiology, 1994).

Percentage of Suicides by Age Group and Method of Injury, Utah, 2014–2016 (Figure 24)

Utah Estimates: Utah Death Certificate Database. Retrieved on 3/14/2018 from UDOH, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website http://ibis.health.utah.gov/.

Suicides are determined using ICD-10 codes X60–X84, Y87.0, *U03, which is consistent with the External Cause of Injury Mortality Matrix for ICD-10 found on the NCHS website at http://www.cdc.gov/nchs/data/ice/icd10_transcode.pdf.

Firearm suicides were defined as ICD-10 codes X72–X74; Suffocation suicides were defined as ICD-10 code X70; Poisoning suicides were defined as ICD-10 codes X60–X69.

ICD stands for the International Classification of Diseases. It is a coding system maintained by the World Health Organization and the NCHS used to classify causes of death on death certificates. These codes are updated every decade or so to account for advances in medical technology. The U.S. is currently using the 10th revision (ICD-10) to code causes of death.

Death certificates in Utah are required to be filed by funeral directors. Funeral directors obtain demographic information from an informant or a close family member of the decedent. The cause of death is certified by the decedent's physician or the physician that attended the death. Accidental and suspicious deaths are certified by the Medical Examiner. Death certificate data go through extensive edits for completeness and consistency. The OVRS does annual trainings for funeral directors and local registrars.

When death certificates are received, the cause of death literals are keyed into software locally by OVRS, then shipped to NCHS where they are machine coded into ICD-10 codes. NCHS returns the ICD-10 codes to OVRS where the death records are updated. On August 13, 2013, the 2010 and 2011 cause of death data have been updated using the NCHS Revised Causes of Death Mortality data set.

Individuals

Note that several individuals served on more than one group.

Name	Agency	Group/Contribution
Allyn Nakashima	UDOH State Epidemiologist	Utah Health Improvement Plan Coalition
Amy Bate	UALHD - PIO Affiliate	Utah Health Improvement Plan Coalition
Amy Frandsen	Utah Department of Human Services DSAMH	Utah Health Improvement Plan Coalition
Ana Maria Lopez	University of Utah Health Sciences & School of Medicine Huntsman Cancer Institute	Utah Health Improvement Plan Coalition
Angela Stander	UDOH Violence and Injury Prevention Program	Utah Health Improvement Plan Coalition
Anna Dillingham	Davis County Health Department	State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee
Anna Fondario	UDOH Violence and Injury Prevention Program	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair
Barbara Crouch	Utah Poison Control Center	Utah Health Improvement Plan Coalition
Brenda Ralls	UDOH EPICC Program	Utah Health Improvement Plan Coalition
Brian Bennion	Weber-Morgan Health Department	Community Advisory Panel State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Brian Hatch	Davis County Health Department	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Brook Carlisle	American Cancer Society Cancer Action Network	Utah Health Improvement Plan Coalition
Bruce Costa	Central Utah Health Department	Community Advisory Panel Utah Health Improvement Plan Coalition
Bryce Bird	Utah Department of Environmental Quality	Utah Health Improvement Plan Coalition
Carrie Bennett	Utah County Health Department	Utah Health Improvement Plan Coalition
Carl Hanson	Brigham Young University	Utah Health Improvement Plan Coalition
Cristie Chesler	UDOH Bureau of Epidemiology	Utah Health Improvement Plan Coalition
Cynthia Boshard	Intermountain Healthcare	Community Advisory Panel
Danny Bennion	Salt Lake County Health Department	State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee
David Blodgett	Southwest Utah Public Health Department	Utah Health Improvement Plan Coalition
David Cunningham	Southeast Utah Health Department	Utah Health Improvement Plan Coalition
David Lewis	UDOH Development and Performance Improvement	Utah Health Improvement Plan Coalition
Dean Penovich	UDOH EMS and Preparedness	Utah Health Improvement Plan Coalition
Debbie Marvidikis	Southeast Local Health District	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair
Dennis Cechinni	Advocate	Utah Health Improvement Plan Coalition

Name	Agency	Group/Contribution
Don Wood	UDOH Primary Care and Rural Health	State Health Assessment Workgroup
Donna Singer	Utah Indian Health Advisory Board Utah Navajo Health Systems	Utah Health Improvement Plan Coalition
Doug Thomas	Utah Department of Human Services DSAMH	Utah Health Improvement Plan Coalition
Dulce Diez	UDOH Health Disparities Reduction	Utah Health Improvement Plan Coalition
Dustin Jones	UDOH EPICC Program	Utah Health Improvement Plan Coalition
Ed Napia	Urban Indian Center of Salt Lake	Utah Health Improvement Plan Coalition
Fahina Tavake-Pasi	Minority Community Representative	Utah Health Improvement Plan Coalition
Farrin Wiese	UALHD - ULACHES Affiliate	Utah Health Improvement Plan Coalition
Gary Edwards	Salt Lake County Health Department	Community Advisory Panel Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Greg Bell	Utah Hospital Association	Utah Health Improvement Plan Coalition
Greg Williams	UDOH Environmental Public Health Tracking	State Health Assessment Workgroup
Heather Borski	UDOH Disease Control and Prevention	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee Utah Health Improvement Plan Operational Committee
Heather Bush	UDOH Prevention, Treatment and Care Program	Utah Health Improvement Plan Coalition
Heidi Goedhart	Utah Department of Transportation	Utah Health Improvement Plan Coalition
Hope Jackson	Sacred Circle Facility (Confederatges Tribes of the Goshute Reservation)	Utah Health Improvement Plan Coalition
Isa Perry	Davis County Health Department	Community Advisory Panel State Health Assessment Workgroup
Janae Duncan	UDOH Bureau of Health Promotion	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee
Jeffrey Coombs	Tooele County Health Department	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee
Jennifer Brown	UDOH Disease Control and Prevention	Utah Health Improvement Plan Coalition
Jennifer Bryant	UDOH Development and Performance Improvement	Utah Health Improvement Plan Coalition
Jenny Johnson	UDOH Public Information and Marketing	Utah Health Improvement Plan Coalition
Jeramie Tubbs	TriCounty Health Department	Utah Health Improvement Plan Workgroup Co-Chair
Jeremy Christensen	Utah Department of Human Services	Utah Health Improvement Plan Coalition
Jim Davis	Utah Health Advisory Council Utah State University	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Jim VanDerslice	University of Utah	Community Advisory Panel
Jonelle Fitzgerald	Wasatch County Local Health District	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair
Jordan Mathis	TriCounty Health Department	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee

Name	Agency	Group/Contribution
Joseph Miner	UDOH Executive Director	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Josey Hill	UDOH Development and Performance Improvement	Utah Health Improvement Plan Coalition
Julianna Preston	HealthInsight	Utah Health Improvement Plan Coalition
Kael Forsythe-Barker	Student	Maps
Karen Kwan	Salt Lake Community College	Utah Health Improvement Plan Coalition
Ken Johnson	National Association of Local Boards of Health Weber State University	Utah Health Improvement Plan Coalition
Kevin Condra	Salt Lake County Health Department	Utah Health Improvement Plan Coalition
Kim Myers	Utah Department of Human Services DSAMH	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair
Kim Neerings	UDOH Public Health Assessment	State Health Assessment Workgroup Report Formatting and Data Analyst
LeAnna VanKeuren	Urban Indian Center of Salt Lake	Utah Health Improvement Plan Coalition
Lewis Singer	Utah Commission on Aging	Utah Health Improvement Plan Coalition
Lincoln Nehring	Voices for Utah Children	Utah Health Improvement Plan Coalition
Lisa Kane	UDOH Public Health Assessment	Community Input Support
Lisa Nichols	Intermountain Healthcare	Community Advisory Panel Utah Health Improvement Plan Coalition
Liz Joy	Intermountain Healthcare	Community Advisory Panel
Lloyd Berentzen	Bear River Health Department	Utah Health Improvement Plan Coalition
Luis Garza	Comunidades Unidas	Utah Health Improvement Plan Coalition
Lynne Nilson	UDOH Maternal and Child Health	Utah Health Improvement Plan Coalition
Marc Babitz	UDOH Family Health and Preparedness	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Marc Watterson	American Heart Association of Utah	Utah Health Improvement Plan Coalition
Maria Montes	Comunidades Unidas	Utah Health Improvement Plan Coalition
Marina Haddock Potter	Intern	Other Health Assessment Review and Summary
Mark Hiatt	Regence BlueCross BlueShield of Utah	Utah Health Improvement Plan Coalition
Mary Lou Emerson	Commission on Criminal and Juvenile Justice	Utah Health Improvement Plan Coalition
Matt LaFrance	Tooele County Health Department	State Health Assessment Workgroup Utah Health Improvement Plan Operational Committee
Matt McCord	UDOH Environmental Public Health Tracking	Maps
Matt Slonaker	Utah Health Policy Project	Utah Health Improvement Plan Coalition
Melanie Wallentine	Utah Division of Occupational and Professional Licensing	Utah Health Improvement Plan Coalition
Melissa Zito	UDOH Indian Health Liaison	Utah Health Improvement Plan Coalition
Michael Friedrichs	UDOH Bureau of Health Promotion	State Health Assessment Workgroup
Mikelle Moore	Intermountain Healthcare	Community Advisory Panel Utah Health Improvement Plan Coalition

Name	Agency	Group/Contribution
Mimi Ujiie	UDOH Development and Performance Improvement	State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee
Nathan Checketts	UDOH Medicaid and Health Financing	Utah Health Improvement Plan Coalition
Navina Forsythe	UDOH Public Health Assessment	Community Advisory Panel State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee
Pam Goodrich	Central Utah Local Health District	Utah Health Improvement Plan Workgroup Co-Chair
Patrick Poulin	International Rescue Committee	Utah Health Improvement Plan Coalition
Paul Patrick	UDOH Family Health and Preparedness	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Ralph Clegg	Utah County Health Department	Community Advisory Panel Utah Health Improvement Plan Coalition
Randy Probst	Wasatch County Health Department	Community Advisory Panel Utah Health Improvement Plan Coalition
Rebecca Fronberg	UDOH EPICC Program	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair
Richard Bullough	Summit County Health Department	Community Advisory Panel Utah Health Improvement Plan Coalition
Robert Rolfs	UDOH Deputy Director	Community Advisory Panel Utah Health Improvement Plan Operational Committee
Robyn Atkinson	UDOH Utah Public Health Laboratory	Utah Health Improvement Plan Coalition
Sam LeFevre	UDOH Environmental Epidemiology	State Health Assessment Workgroup
Sarah Hodson	Get Healthy Utah	Utah Health Improvement Plan Coalition
Scott Hess	Wasatch Front Regional Council	Utah Health Improvement Plan Coalition
Scott McLeod	United Way	Utah Health Improvement Plan Coalition
Scott Zigich	Davis County Board of Health/School District	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee
Sean Meegan	Intermountain Healthcare	Community Advisory Panel
Shaheen Hossain	UDOH Data Resources Program	State Health Assessment Workgroup Utah Health Improvement Plan Operational Committee
Shari Watkins	UDOH Fiscal Operations	Utah Health Improvement Plan Coalition
Sheila Walsh-McDonald	UDOH Government Relations	Utah Health Improvement Plan Coalition
Stephanie Croasdell Stokes	Intermountain Healthcare	Community Advisory Panel Utah Health Improvement Plan Coalition
Steve Eliason	Utah House of Representatives University of Utah Health Care	Utah Health Improvement Plan Coalition
Steven Phillips	UDOH Fiscal Operations	Utah Health Improvement Plan Coalition
Sydnee Dickson	Utah State Office of Education	Utah Health Improvement Plan Coalition
Tamara Hampton	UDOH Executive Director's Office	Utah Health Improvement Plan Coalition
Tamara Sheffield	Intermountain Healthcare	Community Advisory Panel

Name	Agency	Group/Contribution
Teresa Brechlin	UDOH Violence and Injury Prevention Program	Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair
Teresa Whiting	UDOH Child Development	Utah Health Improvement Plan Coalition
Terry Foust	Intermountain Healthcare	Community Advisory Panel
Tim Butler	Select Health	Utah Health Improvement Plan Coalition
Tom Hudachko	UDOH Public Information and Marketing	Utah Health Improvement Plan Coalition
Trish Barrus	University of Utah	Utah Health Improvement Plan Coalition
Troy Nordick	Utah State Office of Education	Utah Health Improvement Plan Coalition
Valerie Flattes	University of Utah College of Nursing	Utah Health Improvement Plan Coalition
Wade Moon	Skull Valley Band of Goshute	Utah Health Improvement Plan Coalition
Worthy Glover	San Juan Public Health Department	Utah Health Improvement Plan Coalition
Wu Xu	UDOH Health Data and Informatics	Utah Health Improvement Plan Coalition

As there were so many people who contributed to this process we may have inadvertently left someone off the list. If you participated and we do not have you listed we apologize, please let us know so we can update the list.